HARD LABOR: PURSUING ECONOMIC CITIZENSHIP AND LEGAL RECOGNITION OF CERTIFIED PROFESSIONAL MIDWIVES IN ALABAMA

by

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To JRA. "Feminists [and midwives,] are like bees."

To all the mothers who have chosen to work with me. All 40 of you.

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ABSTRACT

Until 1976, women in Alabama could choose to make use of a midwife when they gave birth. In that year, the Alabama state legislature outlawed the practice. This dissertation explores the consequences of that decision as well as the efforts of contemporary non-nurse midwives, also known as Certified Professional Midwives (CPM's), to re-establish the practice as an option available to birthing women in the state.

In order to address the consequences of outlawing non-nurse midwives in the state of Alabama a mixed methodology approach is applied. Two years of ethnographic data collection approached with a feminist and cultural anthropology lens, reveal that the lack of medical infrastructure within the state of Alabama prohibits the ability for CPM's to practice safely. This is owed to historically grounded stigma in racism and classism. As a result, the current CPM community within the state of Alabama, along with their clientele, is predominantly white. This is reflected in the case studies within the dissertation as all the families and care providers, regardless of clinical expertise, are all white. An examination of cesarean rates via quantitative analysis supports the historical and ethnographic findings. Cesarean rates are highest within counties that have a low median household income, and a population that is predominately African American.

The dissertation features five case studies of women who gave birth attended by a CPM. By relating the experiences of the birthing mothers, a CPM, and certified medical professionals, the dissertation offers evidence of the kind of supplemental medical care and knowledge that can be offered by practitioners of midwifery. At the same time, while contemporary midwives such as the one featured here offer important medical service to their clients, they are not equipped to or knowledgeable about political work necessary to push for the re-legalization of midwifery.

This dissertation thus sheds light on the challenges facing midwives who would prefer to work openly and legally in the state.

Ultimately what is revealed is the value of supplementary healthcare networks within the state. While care and birth services provided by CPM's is not readily accessible to all, those giving birth in Alabama can find support within the current system through supplementary healthcare networks. These networks include doulas, lactation support groups, babywearing groups, etc. It is a piecemeal system to be sure, but it is a piecemeal system that is working diligently to unlearn biases, and support women and birthing families. However, it is important to understand that the supplemental networks cannot fully address the larger structural crisis that is a lack of infrastructure within the state's medical system. Ideally, a system that utilizes Obstetricians, Nurse Midwives, and Non-nurse Midwives, all with mutual respect for their own expertise, would exist to provide quality care to women throughout the state.

INTRODUCTION AND METHODS: WHY MIDWIFERY? WHY MIDWIFERY IN ALABAMA?

During the last year of my master's program at the University of Alabama, the fall of 2009, I took an American Studies seminar entitled "Protest Movements," with Dr. Mike Innis-Jimenez.[1] The course explored various protest movements within the US during the 20th century including the Civil Rights Movement, Environmental Movement, and Chicano/Latino Movement, among others. At one seminar meeting a representative of the Alabama Birth Coalition came and presented a historical overview of birth trends in the US, the national campaign The Big Push for Midwives, and how the campaign to legalize certified professional midwifery can be considered a protest movement. Having worked for a nursery since I was sixteen, I was familiar with birth stories, particularly those of a hypermedicalized narrative, but had no real concept of midwifery, or natural childbirth until that presentation. Over the course of the next year and a half I began exploring the history of birth and midwifery, and how birth is portrayed on television.

At the end of the 2011 spring semester, and my first year as a PhD student at Purdue University, an F4 tornado hit Tuscaloosa, and while the University of Alabama remained intact, most of the city did not. I made plans to travel down to Alabama as soon as I could to help with recovery efforts. The night before I left, I received a message from Mike, asking how long I planned to be in town. I had no specific departure date in mind and told him that as long as I had a place to stay, I'd be in Tuscaloosa as long as possible. He reminded me that he and his wife,

[1] I have permission from both Dr. Innis-Jimenez and Dr. Kopelson to include the birth story of their daughter Alessandra in this project. Advocates of midwives, they were interviewed by and featured on the front page of The Tuscaloosa News regarding their utilization of CPM care in 2012.

Dr. Heather Kopelson, were expecting a baby, due May 31st. He then asked if I might be willing to watch their three-year-old son when the time came, which would most likely include witnessing the birth, as they wanted Teo present if he was willing. I was beyond flattered, and quite ecstatic, and committed to the job right away. I was particularly excited because Heather was planning to have a home-birth, assisted by a Certified Professional Midwife (CPM).[2] A CPM "is a knowledgeable, skilled and professional independent midwifery practitioner who has met the standards for certification set by the North American Registry of Midwives (NARM) and is qualified to provide the midwifery model of care. The CPM is the only international credential that requires knowledge about and experience in out-of-hospital settings." Currently, only twenty eight of fifty states legally recognize the practice and care of CPMs. CPMs are not legally recognized in Alabama, and technically a planned home-birth with a CPM is illegal. However, as Mike planned to catch the baby, putting the CPM in a role of witness, technically, the baby's birth would be legal, and no repercussions would come after the fact. Upon the discovery of a planned home-birth in Alabama, a CPM can be arrested and charged with a class c misdemeanor. There is also the possibility that upon the discovery of a home-birth the parents could be reported to Child Protective Services. Heather had looked into receiving care from a "natural birth friendly OB" in Tuscaloosa, but desired a less medicalized birth experience, ultimately deciding on CPM care.

On May 30th, I received the inevitable message: "it's time." I was at the house by seven am, playing with Teo, drinking lattes, and being briefed on labor progression. Heather had been laboring since about one in the morning, a friend had arrived at three, the CPM and her apprentice arrived at four, and since Heather was laboring comfortably, all were upstairs

[2] For extensive definitions of, and clear distinction between types of midwives, please see Appendix 1. The Midwives Model of Care is found in Appendix 2.

asleep. Around eight another friend arrived with bagels and coffee for everyone at the house, observing, "Well, if y'all wanted to keep the birth under the radar it's gonna be difficult. Every car in the driveway has a 'Free the Midwives' bumper sticker on it!" About an hour later Heather ventured downstairs to get something to eat. Passing me in the kitchen, she said, "Hi Emma. How are you doing?" Somewhat taken aback by her relaxed state, I responded, "Well, you know, I'm fine. How 'bout you?" "Eh," she said, shrugging her shoulders, "I thought we'd be done by now." After that Teo and I headed out for a couple of play dates, checking in periodically to see how everyone was faring. We got back to the house about one thirty and made our way upstairs as Teo wanted to check in with Heather. Teo led the way to his parents' room, where Heather labored in a birthing tub, while Mike helped relieve pain, the CPM and her apprentice checked the baby's progress, and two close friends stood by waiting for instruction. It was a quiet, intimate setting, and not long after Teo and I arrived, Heather began to push. Baby Alessandra was born at 2:20 pm, caught by her father. The only complication arose when the umbilical cord broke before the placenta was expelled; however, the CPM deemed Heather fine once a vaginal exam was given to confirm that the placenta had not fragmented and had completely expelled. After the vaginal exam, the CPM and apprentice handed out various tasks to anyone nearby, explaining to everyone what was being done, and why. At one point I found myself crawling onto to the bed to place herbal drops on Alessandra's temples and forehead, which Mike gently rubbed into her skin. I had not expected this level of involvement but was thrilled. A couple hours later, after all post birth procedures were completed the CPM and apprentice left to assist in another birth, and Heather's friends and I took to various cleanup, and housekeeping tasks. Later Teo and I ran errands, and after dinner I gave him a bath, and put him

to bed. When I got back to my place it was about ten pm. I was exhausted, but excited and eager for more practical experience with birth and midwifery.

Being at Alessandra's birth, seeing midwives in action, the continuous care of the professionals, and friends, was a pivotal moment for how I view my research on midwifery and birth. After attending a successful home-birth, I found it incredibly problematic that women are not allowed the choice to birth where, and with whom, they wish. I also found it inherently problematic that women who pursue the internationally recognized Certified Professional Midwife status are not legally recognized as professionals within all fifty states. From Mike's class I knew there was a statewide group, The Alabama Birth Coalition, pursuing legal recognition of CPMs, but I began to wonder what were their specific strategies and goals? Additionally, what is the history of midwifery in Alabama? As CPMs continue to practice despite legal recognition, what communities do they serve within the state? Who are the women pursuing CPM care? How does Alabama's history in regard to race, and gender affect the history and current status of midwifery in the state? Why are CPMs illegal? What were the motivations to criminalize midwifery? Are practicing CPMs able to make a living? And, most importantly, what are the consequences of criminalizing non-nurse midwifery in the state of Alabama?

Methodology and Positionality

In order to address these questions, I have found Cultural Studies and Cultural Anthropology theory and methods the most effective. Utilizing the state of Alabama as a case study to explore birth culture, and how certified professional midwives fit within that culture, has allowed my project to evolve, and remain open to whatever changes may have occurred within the state birth culture. Additionally, throughout the process of participant observation within the

field of birth culture, I discovered that what I want most to do is continue working with pregnant and birthing women. Ultimately, I want to become a midwife.

I have acquired an ethnographic data set from two years of participant observation with a CPM in Alabama. Active participant observation has included: CPM continuing education courses, observing CPM attend home-births, and activity within CPM advocacy groups, including The Alabama Birth Coalition, and the Alabama Midwives Alliance. Additional ethnographic data related to Alabama's birth culture at large, comes from semi-structured interviews. I also attended state house and senate hearings when bills to legally recognize, or decriminalize midwifery were put before the legislature. Originally, the intended data set was meant to include multiple out of hospital births with multiple CPMs across the state. However, many CPMs either did not respond to my attempts at outreach, were concerned about anonymity, or were not inclined to work with me based on the relationship with the one midwife who allowed me into her practice. I very quickly learned the politics of the midwifery community are no different than any other. Working with only one CPM impacts my data in terms of the sheer quantity of births attended. However, working with one midwife allowed me to have an apprentice style experience and for the two of us to develop a close working relationship. Within the larger document the data collected with this midwife will serve as one thread, bringing to light not only the depth of knowledge required for a CPM to practice, but the struggle of being a young midwife, at the beginning of her career in a state that does not recognize her profession.

Throughout the data collection experience, I was present at 15 births. Half of those births I attended as a doula, a paid labor support person. The other half I attended exclusively in the role of researcher. I realized that in utilizing methods of participant observation it is nearly impossible to separate research from any other aspect of life. I took on doula work in order to

supplement my income and observe hospital births in the state. These doula clients gave birth in the months that the midwife did not have clients due. To be clear, a doula is a labor support person, whose scope is that of providing non-medical pain management. It is important to note that a doula is not a medical professional, although a medical professional can be a doula. The lack of distinction between participant observation and non-research life came one night with a doula client. The first-time mother who had hired me was experiencing prodromal labor,[3] was tired of it, and decided that we would go to the hospital, if for no other reason than to confirm that her body was doing "something." After checking into the local hospital, I sat, bouncing on a birth/exercise ball, with my client laying in bed, and her partner in a rocking chair, in a triage room. After an hour or so, with a couple of check-ins from a nurse, the on-call doctor came to assess labor. I continued to sit on my birth ball, as the doctor swept in, walked over to my client, spread her legs, put his hand into her vagina, turned to me and asked, "What was she, when you last checked her?" I was caught extremely off guard. "I don't know. I'm the doula. I don't perform vaginal exams." The doctor pressed me, as he continued to perform a cervical dilation check on my client, "I'm not saying it's bad if you've checked her. I need to know so we can gauge progress." Looking at my client, and back at the doctor, I responded, "I'm the doula. I don't know how to give vaginal exams. Vaginal exams are outside my scope." The doctor looked at me, and then to my client, "Well, you're not dilated. Baby is high in your pelvis, not engaged. You are not in active labor." The exchange with this doctor was frustrating for several reasons, the first being the way in which he did not address my client prior to conducting a vaginal exam. My client was not given the opportunity to give her consent for this doctor to touch her, let alone give her a vaginal exam. The other frustration was the assumption by the OB/GYN that I knew

[3] Prodromal labor is also known as pre-labor, and includes irregular contractions which resolve after a time.

how to, and had performed, a vaginal exam. In chatting with a variety of people later, it seemed that there was a general consensus that the OB/GYN's behavior was a result of him either not knowing what a doula is, or, the more likely reason, he thought I was a midwife. Several people pointed out this possibility, noting "that was attempted entrapment, Emma." It was an experience that forced me to reflect on the depth of opposition toward the midwifery profession in Alabama.

Taking on doula clients has also allowed me the opportunity to juxtapose the experience of hospital births, with the experience of out of hospital births. One evening having just attended a hospital birth as a doula, the labor and delivery nurse looked at my client and said, "Well you got the last available postpartum room!" This struck me as such an odd thing to say to a patient, until I remembered, the hospital we were in serves not just our county, but at least five of the surrounding counties. There was no snark or malice behind the nurse's comment, it was merely an observation of the busy night, and if anything, a plea to consider that the on-call nurses and OB/GYNs were stretched a bit thin. Additionally, positive conversations with nurses about non-medical pain management revealed "they don't teach us those things in nursing school. I wish they did." Attending births in the hospital setting proved that the larger healthcare system is flawed.

The flaws in the larger medical system became evident several times with the news that several labor and delivery wards across the state were in the process of closing. The reasons varied, but often cited the high cost of maintaining and staffing an L&D unit within low populated areas. As a result, this means that the women of childbearing age are left with anywhere between a 30 minute to two-hour drive to the nearest OB/GYN, and/or L&D unit depending on their geographic location. Both my doula work and work with the midwife

introduced me to the women and families choosing to drive anywhere from one to three hours to receive care from a provider that shared their approach to prenatal, childbirth, and postpartum care. For some women and families this includes driving out of state, to Atlanta, Georgia, to receive care. However, this quick fix problem to specific individuals does not improve the overall issue of the lack of access to reproductive health care providers in the state of Alabama. It is also not just the birthing woman and her family that suffers. It seems fairly intuitive that care providers who serve their own county, as well as five others, are subject to a high-stress working environment.

In contrast to the women and families that travel for care, be it to the closest care provider or the provider of their choice, are the families that choose unassisted childbirth. Unassisted childbirth, sometimes referred to as "free birth," is birth without a qualified care provider present. This is in direct contrast to an emergency birth, a birth that occurs en route to the hospital, or when a care provider arrives late to a planned home-birth or hospital birth. An emergency birth is not the same as unassisted childbirth. Unassisted childbirth is a birth planned to take place without a care provider. Unassisted births are not uncommon in Alabama, and there is a large community of, what I refer to as "unassisted birthers" in the southern half of the state.

Working with a midwife highlighted the importance of having a care provider present at an out-of-hospital birth. A midwife with the CPM credential has training and a depth of knowledge in neonatal resuscitation, birth physiology, and anatomy and physiology that most lay people do not. Several times over the course of field-work the midwife had to make an emergency call, or transfer care when she identified something beyond her scope of practice. For example, one mother received a second-degree laceration during childbirth, and transferred into the hospital for repairs. Later, in discussing this transfer with the CPM she stated, "Could I have

repaired that laceration? Sure. But it was a significant second degree, and I'd prefer that the mother have the best repair job to her pelvic floor possible. Remember, your pelvic floor holds everything up and in." This non-emergency transfer of care was one of the many times the CPM showcased her respect for her client, as well as her own scope of practice, and depth of knowledge.

There were a few times that I had the opportunity to observe the midwife in a hospital setting. These instances varied. I attended several continuing education opportunities with her, which occurred in hospital lecture halls. I also followed her to the hospital if a transfer of care was necessary.[4] Neutral experiences occurred the most often, but frequently she, and by default myself, was met with dislike from both nurses and OB/GYNs. The most alarming in-hospital experiences were ones in which the client's attitude or behavior toward the midwife shifted. Such a shift is not unwarranted, given the rigid power structure of the medical model of care, and the transfer of care itself. However, it is striking how the midwife could lose any authority with her clients, merely by entering the hospital space.

While the midwife could lose her authority as a care provider merely by stepping into a different space, she retained her overall privilege as white, cisgender, woman living and working in the state of Alabama. Likewise, I was able to successfully collect my ethnographic data set due to my white, cisgender, female identity. I was afforded the status of insider to a degree due to being a practicing doula, and having previously lived in Alabama. Groups that focused on some aspect of birth or post-partum care were usually willing to include me in conversations as soon as mentioned that I was a midwifery advocate. These groups were predominately white, and

[4] I must note that when I was present in the hospital with the CPM, I followed IRB protocol and had no recording devices, or research paraphernalia. I was present merely as an observer.

middle class, with little racial or ethnic diversity. Throughout the course of my data collection experience I began to notice the lack of diversity more and more. While I did not completely understand the implications of the absence of women of color beyond racism at the beginning of my data collection experience, it has become clear that the lack of inclusion of women of color in such spaces is reflective of a larger crisis in reproductive and maternal healthcare that midwifery can help solve. However, the birthing and midwifery communities in Alabama are not necessarily open to this inclusion.[5]

Theoretical Foundation

The question that guides each chapter is "what are the consequences of criminalizing midwifery in Alabama?" I consider the consequences of criminalizing non-nurse midwifery as it relates to gendered aspects of knowledge and labor. I focus on knowledge and labor, as a result of the gap in the literature on midwifery considering the criminalization of midwifery, as a women's labor issue. I address these issues via theories of economic citizenship, authoritative knowledge, intersectionality, and structural violence. These four theoretical threads have significant bearing on understanding the historical and current moment of midwifery in the United States, and specifically the state of Alabama, which serves as my case study. Each thread highlights a specific issue within midwifery, and while each thread can be discussed on its own, all four threads can be coherently woven together, revealing the complexity of midwifery in Alabama.

A theory key to the study of midwifery is that of authoritative knowledge. Prior to physicians and OB/GYNs, midwives were the authority on childbirth and women's

[5] I will expand on this in chapter one.

health.[6] With the professionalization of the medical field in the mid nineteenth century, midwives began to lose authority in the birth place, while doctors and OB/GYN's gained authority. Key to understanding this shift in authority is anthropologist Bridgette Jordan's theory of "authoritative knowledge." Jordan explains that:

> Sometimes equally legitimate, parallel knowledge systems exist and people move easily between them, using them sequentially or in parallel fashion for particular purposes. But frequently, one kind of knowledge gains ascendance. To legitimize one way of knowing as authoritative, devalues, often totally dismisses all other ways of knowing (152).[7]

Most importantly, Jordan articulates that: "The power of authoritative knowledge is not that it is correct, but that it counts" (author's emphasis, 154).[8] This is the case with midwifery and professional medicine. As the field of Obstetrics developed in the nineteenth-century United States, OB/GYNs became the authorities on birth and women's health.

In support of how medical knowledge is the authority, but may not be correct, is a 2011 study which highlights evidence-based decisions made by ACOG affiliated care providers. The study found that "one third of the recommendations put forth by the College in its practice bulletins are based on good and consistent scientific evidence."[9] The remaining recommendations were made utilizing opinion, or inconsistent evidence. Ultimately, practitioners are exploiting their expertise, knowledge, and the cultural authority that comes with it. Likewise, medical knowledge and positions abroad vary greatly from that of the US. "A recent analysis comparing [ACOG's] recommendations with those of the Royal College of

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[6] I will expand on this in chapter one.

[7] Davis-Floyd, Robbie E. and Carolyn F. Sargent ed. *Childbirth and Authoritative Knowledge.* Los Angeles: University of California Press, 1997.

[8] Ibid.

[9] Wright, Jason D. et al. "Scientific Evidence Underlying the American College of Obstetricians and Gynecologists' Practice Bulletins." American College of Obstetrics & Gynecologists: VOL. 118, NO. 3, SEPTEMBER 2011

Obstetricians and Gynecologists noted that only 28% of obstetric recommendations were the same, 56% were not comparable, and 16% were opposite."[10]

The impact of authoritative knowledge is significant. An example of this impact is most obvious with national and state cesarean rates, discussed in Amnesty International's 2011 "Deadly Delivery," a study looking at maternal health in the US. "Recent data show that the cesarean rate rose for the 13th consecutive year to reach an all-time high of 32.9% in 2009. The cesarean rate is now more than double the World Health Organization (WHO) recommended range of 5% to 15%." Amnesty International also notes that "New analysis shows that states with high cesarean rates (over 33%) were associated with a 21% higher maternal mortality risk." Specifically, Alabama's state cesarean rate is 35.5%. And hospital cesarean rates range in the state from 15% to 61.4%.[11] In contrast, first world countries such as the UK, which encourages and grants midwives the authority to practice throughout the country, have lower rates of cesarean surgeries, postpartum depression, and maternal and infant deaths.[12] To be fair, countries such as the UK have a national healthcare system structured radically different than the US. And not only is the UK healthcare system structured differently, but obstetricians endorse the knowledge and work of midwives.[13]

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[10] Ibid.

[11] These stats come from the most recent CDC study, and effective visuals utilizing this data can be found here: http://www.cesareanrates.com/alabama-cesarean-rates/

[12] Recent NICE paper. http://www.nice.org.uk/news/article/midwife-led-units-safest-for-straightforward-births
Mkherjee, et al. "Structural Violence: A Barrier to Achieving the Millennium Development Goals for Women." Journal of Women's Health, Vol. 20, No. 4 (2011), pp. 593-597
Additionally, Marsden Wagner has written on the discrepancy of US maternal health and the rest of the first world at length:
Wagner, Marsden. *Born in the USA: How a Broken Must be Fixed to Put Women and Children First*. Berkeley: University of California Press, 2006.

[13] "RCOG statement on revised NICE intrapartum care guidelines." 12/3/2014
https://www.rcog.org.uk/en/news/rcog-statement-on-revised-nice-intrapartum-care-guidelines/

In effect, the authority of medical knowledge is playing out via structural violence in the United States. Criminalizing midwifery prohibits women from practicing their profession of choice, de-legitimizes midwives' knowledge, and prohibits women from accessing maternal healthcare. Here violence is understood in a broad definition, beyond that of physical harm, and includes "when human beings are being influenced so that their actual somatic and mental realizations are below their potential realizations."[14] That is to say, violence is enacted when people are prohibited from reaching their potential. Or, in the case of maternal healthcare, violence is enacted when women are prohibited from achieving positive outcomes, lack access to care, etc.

Dr. Paul Farmer explores the idea of structural violence in his medical anthropology work, and actively works against structural violence in his own medical practice. Farmer asserts "whenever we talk about medicine or policy, a hierarchy of suffering begins to take shape because it is impossible to relieve every case at once."[15] Farmer is explicit in Pathologies of Power that the social and economic disadvantage, as well as access to medicine or healthcare in the first world does exist, however that lack of access does not exist in the same way in the third world. This is true; yet, I find the theory of structural violence, and Farmer's analysis of the relationship between limited social and economic opportunity, and access to healthcare, is useful in understanding access to non-nurse midwifery care in the United States.

The impact of social and economic violence is uneven across the United States, but in areas such as the Southeast, the violence is significant. Census data regularly reveal that the South is home to states with the lowest median household income, and the highest rates of

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[14] Galtung, Johan. "Violence, Peace, and Peace Research." Journal of Peace Research, Vol. 6, No. 3 (1969), pp. 167-191.

[15] Farmer, Paul. *Pathologies of Power: Health, Human Rights, and the New War on the Poor*. Berkeley: University of California Press, 2004, p. 30.

poverty.[16] The CDC regularly reports that the South has the highest cesarean birth rates, premature birth rates, and the lowest number of care providers per capita.[17] In Alabama access to hospitals, and more specifically reproductive or maternal healthcare providers, is limited. Of the sixty-seven counties in the state, thirty of those counties have at least one hospital that can provide care to a birthing woman.[18] In the twenty-four county Crescent that is the Black Belt of Alabama,[19] there are a total of eight hospitals in six counties that provide maternal healthcare. The cesarean rates of these hospitals range from 31.3%-57.9%.[20] An area where structural violence has a long history within the context of civil rights, when coupled with the lack of access to care, and the high rates of birth intervention, structural violence becomes a useful lens to consider maternal healthcare in Alabama.

Within the larger issue of structural violence and midwifery is that of economic citizenship. Labor Historian Alice Kessler-Harris defines economic citizenship as:

> the right to work at the occupation of one's choice (where work includes child rearing and household maintenance); to earn wages adequate to the support of self and family; to a nondiscriminatory job market; to the education and training that facilitate access to it; to the social benefits necessary to sustain and support labor force participation; and to the social environment required for effective choice, including adequate housing, safe streets, accessible public transport, and universal health care.[21]

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[16] Noss, Amanda. "Household Income 2013." *American Community Survey Briefs*. September 2014. http://www.census.gov/content/dam/Census/library/publications/2014/acs/acsbr13-02.pdf. Bishaw, Alemayehu and Kayla Fontenot. "Poverty 2012 and 2013." *American Community Survey Briefs*. September 2014. http://www.census.gov/content/dam/Census/library/publications/2014/acs/acsbr13-01.pdf.

[17] Bernardo, Richie. "2014's Best and Worst States to Have a Baby." http://wallethub.com/edu/best-and-worst-states-to-have-a-baby/6513/.

[18] http://www.adph.org/healthstats/assets/MCH%20book_Final%2013.pdf.

[19] The black belt refers to the rich, black fertile soil of the area, and then later the large demographic of black residents.

[20] http://www.adph.org/healthstats/assets/MCH%20book_Final%2013.pdf, pg24-25.

[21] Kessler-Harris, Alice. *In Pursuit of Equity: Women, Men, and the Quest for Economic Citizenship in 20th Century America*. Oxford University Press, 2001. Print. Pg 160.

The economic citizenship of those wishing to practice, and those illegally practicing midwifery, has seriously been encroached upon. In Alabama in 1976, state title 34, chapter 19 midwives, was written to define the practice of midwifery as Certified Nurse Midwifery. "It shall be unlawful for any person other than a licensed professional nurse who has received a license from the State Board of Nursing and the Board of Medical Examiners to practice nurse midwifery in this state" (AL Public Health Laws, 439). The act then goes on to say that lay midwifery will not be prevented as long as the lay midwife holds a valid health department permit, until that permit is revoked. There is no mention of CPMs or DEMs within the act.[22]

When considering the impact of midwifery as it relates to authoritative knowledge, economic citizenship, and structural violence, it becomes clear that midwifery must also be considered within the context of the feminist theory intersectionality.[23] Historically midwifery is most often associated with the Southeastern United States, and a profession dominated by women of color. Race and gender have a significant impact on what kind of woman is able to pursue economic citizenship via midwifery, and what kind of women receive midwifery care. Yet, a discussion of race is not prevalent among midwives, or midwifery scholars, unless the discussion is historical. In 2012 the Midwives of Color (MOC) officially separated from the Midwives Alliance of North America (MANA). MOC states:

> MANA continues to spout canned responses in support of: various race, gender, social justice issues; 20,000 midwives by 2012; more midwives of color to serve communities of color; end racial disparities in health care, etc…, while not

[22] There is mention of home-birth in the act, stating that CNMs may not attend them. However, in recent articles there has been discussion of the possibility of CNMs attending home-births in AL, and at the federal level CNMs are recognized as able to attend home-births.
http://www.wbhm.org/News/2010/midwives.html

[23] Crenshaw, Kimberle. Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. Stanford Law Review, Vol. 43 No. 6 (Jul., 1991), pp. 1241-1299.

> actually developing workable strategies and expending resources (and if so, begrudgingly supporting after endless negotiations) to achieve any of them.[24]

Indeed, the accusations made by MOC are severe, but MANA's response was that of a generic response:

> MANA is fully aware of its history of privilege and the issues related to cultural and systemic hierarchies in decision-making. We are committed to working towards a structural change in the way our organization operates in light of the repeated failures to address the needs of our midwives of color. We recognize the disproportionate impact of perinatal disparities and poor outcomes for women, infants and communities of color.[25]

While MANA admits their privilege, it seems that there has been no significant change in the operations of the organization at large since 2012.

In utilizing feminist theory, one must consider whether midwifery is a feminist profession. While midwifery is inherently a woman centered profession, both in practitioners and clientele, this does not mean that midwifery is a feminist profession. Feminism is a challenge to structural violence, authoritative knowledge, and a lack of economic citizenship. Yet, as evidence by the separation of MOC from MANA, it seems that intersectionality and feminism are not critically applied within the midwifery community at large. As the MOC point out, this lack of attention to the intersecting issues of gender and race have a significant impact on women of color across the US:

> In the United States, "Births to Black mothers made up 16% of U.S. births, but 30.4% of US infant deaths in 2008″)[26]

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[24] "Interesting Conversations in North American Midwifery" https://midwivesofcolor.wordpress.com/2012/05/23/interesting-conversations-in-north-american-midwifery/.

[25] Ibid.

[26] The U.S. Infant Mortality Rate: International Comparisons, Underlying Factors, and Federal Programs – Elayne J. Heisler Analyst in Health Services April 4, 2012.
Interesting Conversations in North American Midwifery" https://midwivesofcolor.wordpress.com/2012/05/23/interesting-conversations-in-north-american-midwifery/.

These statistics illustrate not only the frustration of the MOC, but the dramatic need for MANA and the larger midwifery community to take interest and action as it relates to issues of intersectionality.

In utilizing the theoretical threads above, I attempt not only to fill a gap in the literature on midwifery but build upon the recent literature. Current publications regarding midwifery in the US provide examples as to the legalization process of midwifery, and how midwives can be effectively integrated into the existing medical system. Most notably is Christa Craven's Pushing for Midwives: Homebirth Mothers and the Reproductive Rights Movement. Craven examines the legalization of CPM/DEMs in Virginia. Her field research observing the Virginia midwifery advocates began in 1995, and ended ten years later in 2005, after legal recognition to CPM/DEMs was granted. Craven credits the victory of CPM advocates in Virginia receiving licensure to "speak the language" of the legislature by utilizing a "consumer right/choice," neoliberal rhetoric and discourse. Despite the victory, Craven observed that

> For those pursuing midwife licensure, then, arguing for the "consumer's right" to choose a birthcare practitioner remains an essential and a strategic use of market based terminology. What I question, however, is how historically uneven access to reproductive healthcare services will ultimately play out for the socioeconomically diverse families who currently seek access to midwifery care in areas such as Virginia.[27]

Currently in Alabama, advocates of midwifery utilize the same neoliberal rhetoric in arguing for the legal recognition of CPMs. Earnestine Tucker, a woman's health practitioner in Tuscaloosa, Alabama, recently explained to The Tuscaloosa News that "over 95 percent of these women [choosing home-birth and CPM care] are educated and have strong support systems... They are

[27] Craven, Christa. *Pushing for Midwives: Homebirth Mothers and the Reproductive Rights Movement*. Philadelphia, PN: Temple University Press, 2010. Print. Pg116.

well aware of the advantages and disadvantages... I think that it [home-birth and CPM care] should be a choice for women."[28] Speaking of her own decision to utilize CPM care, Dr. Heather Kopelson, whom I spoke of earlier, explained to the same reporter, "We did our research and knew we wanted a trained midwife, and I felt all the way through that the attendants were paying attention with what was going on with my labor and what was going on with me." Heather's view of her own birth speaks to the understanding that midwives did, and continue to do, more than "catch" babies. Historical studies of midwives reveal that the care providers' skill set included and currently includes "teaching pregnant women how to care for themselves during pregnancy, what to expect during the ordeal of childbirth, and, afterward, how to care for their newborns."[29] It is historian Laurel Thatcher Ulrich who suggests in A Midwife's Tale that one should "consider midwifery in the broadest possible context, as one specialty in a large neighborhood economy, as the most visible feature of a comprehensive and little-known system of early health care, as a mechanism of social control, a strategy for family support, and a deeply personal calling." Dr. Kopelson's highlighting of both her choice, and the skill of the CPMs who attended her, emphasizes not only her right to choose where and with whom she gives birth, but also the right to the occupation of Certified Professional Midwife, a skilled and educated birth attendant.

Melissa Cheyney's Born at Home: The Biological, Cultural and Political Dimensions of Maternity Care in the United States, provides examples of how legally recognized CPM/DEM care providers may effectively integrate into a state medical system such as Alabama's. To be sure Cheyney's work is situated within Oregon, a state that has been friendly to midwifery for

[28] http://www.tuscaloosanews.com/article/20120311/NEWS/120319977/1007/news02?p=4&tc=pg.

[29] Wilkie, Laurie. (2003). *The Archeology of Mothering: An African American Midwife's Tale*. New York: Routledge.

years. However, with a PhD in Medical Anthropology, as well as being a practicing CPM, Cheyney has practical insight to both the medical, traditional, and practical aspects of birth, and birthing practices. Thus, I see her suggested "Policy for Increased Collaboration Between Direct-Entry Midwives (DEMs) and Obstetricians for Homebirth Clients," as a guide for discussing and supporting the legal recognition of CPMs in a state such as Alabama.[30] In doing so, advocates of CPM/DEMs would shift their rhetoric and discourse to emphasize midwifery as a labor issue, as well as an issue of choice, moving away from the neoliberal rhetoric and discourse that Craven finds limiting. However, the ability to implement such a policy is dependent on not just the legal recognition of midwives, no matter their certification or training, but the ability of midwives and OB/GYNs to effectively communicate and work together. In Alabama this seems impossible. When midwives, be they CPM/DEM, present bills before the state Health Committee seeking legal recognition of their profession, and regardless of whether or not they're supported by CNMs, the Medical Association of the State of Alabama opposes the legislation.[31] Midwives are given little professional courtesy in states where they are not legally recognized. In considering the consequences of criminalizing midwifery in the state of Alabama, it is my hope that there will be a greater understanding of what a midwife is, the care she provides, and how a midwife can contribute to her community.

Chapter Outline

Chapter one is a historical overview of midwifery. The chapter addresses the cultural history of midwives as primary care providers for women within a National, and Alabama

[30] Please refer to Appendix 3.

[31] Flanagan, Michael. "Alabama Should Not Authorize the Practice of Midwifery (opinion)." AL.com, February 3, 2014; http://www.al.com/opinion/index.ssf/2014/02/alabama_should_not_authorize_t.html.

specific context. These two histories emphasize the variety of everyday lived experience as a midwife, which is locationally dependent. While there are National trends in midwifery as they relate to standards of care and practice, but the case study of a specific state reveals how and when such standards were able to be implemented. This historical discussion will focus on race relations, as prior to criminalization in Alabama midwives were predominantly African American, while post criminalization practicing midwives have predominantly been white.

The second chapter is a statistical analysis and geographical mapping of cesarean rates in Alabama. This statistical analysis and mapping is useful in identifying if and where evidence based reproductive healthcare is being offered in the state. Additionally, the of cesarean data reveals where the state has failed its residents in regard to basic infrastructure, and access to care.

Chapter three is an account of my observation of non-nurse midwifery in Alabama. At the start of my ethnographic data collection I was convinced, and to a degree remain convinced, that granting the legal recognition of non-nurse midwives could resolve a denial of economic citizenship, and drastically impact birth outcomes for the better. However, while the potential for this impact exists, what I observed revealed how significant the relationship between the statistical data is to not only a midwife and her practice, but the larger narrative of women's reproductive justice.

Chapter four begins with an examination of a crisis in midwifery advocacy in the state, followed by a close look at supplementary healthcare networks. Here I identify the role of supplementary healthcare networks and discuss the impact of the most readily available network locally, BirthWell Partners Community Doula Project. I will utilize both qualitative and quantitative data to consider the impact of these supplementary healthcare networks. This data

includes interviews of various group leaders and members, as well as statistics that the networks themselves track. In a state with little reproductive and maternal health resources, and where little progress is being made in guaranteeing healthcare in general, supplementary healthcare networks are proving extremely important to women seeking non-intervenes care.

The afterword brings the document up to date in our current moment. I discuss how the process of working on and completing the dissertation has informed my decision to become a midwife, and where I am in that process.

CHAPTER 1. "MIDWIVES HELP PEOPLE OUT": A CULTURAL HISTORY OVERVIEW OF MIDWIFERY IN THE UNITED STATES, AND ALABAMA

The history of midwifery in the U.S. is difficult to trace. Since the professionalization of obstetricians in the 19th century, they and other medical practitioners have sought to eliminate the midwife. The 19th and early 20th century saw anti midwife campaigns throughout the US. In the mid 20th century state legislation barring or limiting midwifery practice passed in a majority of states. Yet, for all these efforts, midwifery has persevered. For varying reasons women and families continued, and continue, to employ a midwife.

In this chapter I examine the history of the midwife in the United States. First, I look at the midwife and the impact of the vocation in a national context. This will include an examination of the formation of the Frontier School of Nursing, and the National College of American Midwives. Specific examples of midwives and their impact on the vocation will range regionally, from Martha Ballard, who provided care in the late 1700s in Maine, to Ina May Gaskin, who has provided care in California and now Tennessee. Secondly, I look at the midwife specifically within the context of the state of Alabama. The experience of midwives Margaret Charles Smith, who provided midwifery care in West Central Alabama, and Onnie Lee Logan, who provided care in South West Alabama, are highlighted. Additionally, the attempts to institute midwifery education programs in the 20th century, and the legislation that ultimately prohibits the practice of non-nurse midwifery in the state are closely examined.

Both the National and State sections will follow midwifery chronologically, beginning in the late 18th century. I trace socio-cultural practices and trends that have both challenged and allowed midwifery to remain a desirable and hirable profession. Such trends and practices

include, but are not limited to, the idea of social birth, twilight sleep birth, and Lamaze Childbirth Education. Additionally, following the socio-cultural trends allows for a better understanding of how race, class, and gender impact the profession of midwifery both nationally, and within the specific context of Alabama.

Midwifery Care in the US

During the 18th and 19th centuries birth occurred at the birthing woman's home, with the help of a midwife, and other knowledgeable women. This was known as "social birth," in which the midwife orchestrated the events of labor and delivery, and the women neighbors and relatives comforted and shared advice with the parturient. This experience allowed for women to educate each other on various birthing techniques and comforts, and form bonds within the women's domestic community.[32] At this particular time, due to the lack of birthing technology, i.e. painkillers and cesarean sections, childbirth was an event that was extremely painful and for many birthing women resulted in death. This was a fact that women did not take lightly and another reason that the social birth, and sharing of birthing information was so important.

Perhaps the earliest recorded US midwifery narrative is that of Martha Ballard, which historian Laurel Thatcher Ulrich explores in *A Midwife's Tale: The Life of Martha Ballard, Based on Diary, 1785-1812*. In analyzing Ballard's diary, Ulrich asserts that "the structure of the diary forces us to consider midwifery in the broadest possible context, as one specialty in a large neighborhood economy, as the most visible feature of a comprehensive and little-known system of early health care, as a mechanism of social control, a strategy for family support, and a deeply

[32] Leavitt, Judith Walzer. (1988). *Brought to Bed: Childbearing In America, 1750 to 1950.* New York: Oxford University Press. Pg 37.

personal calling."[33] Through Ulrich's analysis of Ballard's diary it is revealed that the role of the community midwife was more than a birth assistant. Although, to be sure, the midwife's role as a birth assistant meant making prenatal visits, staying with the birthing mother until the baby arrived, and providing postnatal care.

Fear of maternal and infant mortality associated with pregnancy and birth continually motivated women to seek improvements in the experience of birth. The search for improved birth coincided with the professionalization of the medical field. The transition from midwifery to doctor care was a difficult and delicate transition. Nineteenth-century American culture operated under strict gender roles. Under the practice of separate spheres, women resided within the private and domestic, and thus it is only natural that birth, a domestic experience, be centered around, and attended by women. However, with professionalization and the increasing reliance on pain medication, male doctors began appearing at more and more births. This was a delicate and somewhat slow shift as there was a belief that "strange men witnessing intimate female events produced, at the least, a fear of loss of female modesty."[34] Socioculturally, the appearance of the male in the domestic sphere, even as a physician, was seen as destructive to gender roles, and many male physicians were not comfortable within the context of the home-birth in the nineteenth century. Judith Walzer Leavitt, author of *Brought to Bed*, notes that "physicians found it difficult to assert their authority in the presence of many friends, especially those who had considerable birth experience, and it is likely that their perception of the non-usefulness of female friends in the birthing room was influenced by their own discomfort in their presence."[35] Prior to the physician becoming a regular attendant of birth, a doctor was called in

[33] Ibid., Pg 33.
[34] Leavitt, Judith Walzer. (1988). *Brought to Bed: Childbearing in America, 1750 to 1950.* New York: Oxford University Press. Pg 109.
[35] Ibid., Pg103

to assist a midwife only in the event of difficulties requiring the use of forceps. For everyone involved in birthing, the pregnant woman, the midwife, and the physician, the nineteenth-century transition from midwife to doctor, and home to hospital birth, was a struggle for control within the context of the birthing process. A logical solution to the gendered complications surrounding birth may have been solved with the encouragement of women to become physicians, and in fact about six percent of physicians nationwide were women. However, remember the United States was not yet occupied with fifty states or a population comparable to today. These numbers reveal little, and only serve to emphasize separate spheres for men and women during this time period, and prove that the field of medicine was male dominated.[36]

The growing shift in birth attendants during a time of strict gender roles begs the question, how were the male physicians acquiring their knowledge of obstetrics and gynecology? Male physicians, in the south, at least, acquired gynecological knowledge from enslaved African American women. Slaveholders in the antebellum era were keenly interested in maintaining and increasing their workforce, and as a result, encouraged physicians to search for a cure for infertility, as well as increased reproductive health knowledge. Due to these factors, "women's childbearing capacity became a commodity that could be traded in the market for profit."[37] In addition, in order to gain clientele, experience with the childbirth was necessary. Schwartz points out that "Because elite women spurned inexperienced doctors, the majority of medical men in all likelihood attended their first case or cases of childbirth in the slave quarter, thus according black women an important role in the furthering of medical

[36] Leavitt, Judith Walzer. (1988). *Brought to Bed: Childbearing In America, 1750 to 1950.* New York: Oxford University Press. Pg 113.

[37] Schwartz, Marie Jenkins. (2010). *Birthing A Slave: Motherhood and Medicine in the Antebellum South*. Harvard University Press. Pg 10.

knowledge."[38] However, it should be noted that physicians' lack of advancement was owed to the same reasons that allowed them to gain knowledge from these women: the women's lack of status. For example, "when medical conditions were not urgent or desperate, owners preferred to place their trust in the slave's root-and-herb doctor or midwife, if only to save the expense of the physician's visit but also to save the trouble of imposing particular treatment that might meet resistance."[39] As a result, Schwartz points out that "no one expected midwives to cease serving enslaved women at childbirth, but doctors were exhibiting increased interest in the subject and claiming that they could improve chances for a successful outcome when complications developed."[40] Due to the implication that midwives served women of a lower socioeconomic status, and/or enslaved women, allowed for midwifery and the emerging obstetricians and gynecologists to practice in tandem. However, the implication that doctors could have a better success rate than midwives was an appeal to slave owners. In a post slavery US, the disagreement over who provides better care, a midwife or doctor, becomes the driving force of conflict between the two practitioners.

20th century

The division of maternal care providers in the late 19th century was reinforced by larger policy and cultural changes such as Jim Crow, the rise of immigration, and a growing reliance on scientific problem solving. With the normalization of "separate but equal," and a strong sense of Nationalism, the early 20th century that saw the most hateful anti-midwife campaigns, fueled by anti-immigrant, racist, and misogynistic sentiments. "Writing for the Illinois Medical Journal in

[38] Ibid., Pg 37.
[39] Schwartz, Marie Jenkins. (2010). *Birthing A Slave: Motherhood and Medicine in the Antebellum South*. Harvard University Press. Pg 51.
[40] Ibid., pg 36.

1920, Dr. Rudolph W Holmes demanded: "How can the crude mind of a midwife appreciate the gravity of an impending eclampsia, a contracted pelvis, or heart disease, etc, and secure adequate assistants at any early moment?"[41] Considering the historical context in which Dr. Holmes was speaking, women were not afforded the same educational opportunities as men in the late 19th and early 20th century. Typically a midwife of this time had no formal training, only the experience of birthing her own children, assisting other female relatives and community members, or possibly serving an apprenticeship with an older midwife. Formal midwifery education facilities such as Bellevue Hospital in New York, and what is now known as Frontier University were still in their infancy. Frontier University, formerly Frontier School of Nurse Midwifery, was not established until 1918, two years prior to Dr. Holmes's comments. It was not that midwives could not appreciate the gravity of such a situation, but at this moment in history they lacked the formal vocabulary to engage in such a discussion with physicians and OB/GYNs.

The establishment of the Frontier School of Nurse Midwifery in rural Kentucky is of particular importance to midwifery history. The Frontier Nursing Service, Laura Ettinger explains, made up of certified midwives with registered nursing skills (CNMs), provided not only maternity, pre and postnatal care, but domestic help and early child health care. The FNS provided health care to a region which few professional doctors were willing to travel or move to in order to provide care. The Deep South, including Georgia and Alabama, also suffered from this issue. Ettinger notes that "attempts to get young physicians to practice in rural areas had failed to meet physicians' needs. The unequal distribution of physicians, combined with poverty and the desire for midwives among African Americans, indicated a continuing need for

[41] Litoff, Judy Barrett. (1978). *American Midwives 1860-the Present*. Praeger. Pg 69

traditional midwives."[42] CNMs played a large role in helping traditional midwives in the Southeast acquire midwifery certification in the 1930s and 1940s. Frontier University alumnus Hannah Mitchell was a CNM of particular importance as she not only trained traditional Georgia midwives in CNM skills, but acted as a nurse midwife consultant for "All My Babies," an educational film completed in 1952 through the Georgia State Department of Health. Another FNS affiliate, Aileen Hogan, was a founding member of the American College of Nurse Midwives.[43]

Despite the establishment of institutions such as Frontier University, reproductive health care via physicians and obstetricians became normalized for middle-class American women, and the practice of midwifery continued to be marginalized. Judy Litoff notes that many of the criticisms heaped upon the midwife resulted from the anti-immigrant and anti-black prejudices of the late 19th and early 20th century. "William R. Nicholson, a Philadelphia physician, argued in 1917 that the midwife problem in the United States was due to the "unrestricted immigration of the past years, with the consequent establishment of colonies in every large city, as well as in many rural communities."[44] Magazines such as *Ladies' Home Journal* also took to condemning midwives, "treating immigrant midwives as curious anachronisms, repeating horror stories replete with racial and ethnic slurs about "rat pie" among black midwives or deformed babies allegedly delivered by Italian or Russian Jewish midwives."[45] Anti-black sentiments were particularly noticeable in the anti-midwife arguments developed by Southern physicians. Dr. Felix J. Underwood, who served as the director of the Bureau of Child Hygiene for Mississippi during the 1920s, described the conditions surrounding the birth of black infants as follows:

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[42] Ettinger, Laura E. *Nurse Midwifery: The Birth of a New American Profession*. Ohio State. Pg 139
[43] Ettinger, Laura E. *Nurse Midwifery: The Birth of A New American Profession*. Ohio State. Pg 169.
[44] Litoff, Judy Barrett. (1978). *American Midwives 1860-the Present*. Praeger. Pg 77.
[45] Ibid., pg 216.

"what could be a more pitiable picture than that of a prospective mother housed in an unsanitary home and attended in this most critical period by accoucheur, filthy and ignorant, and not far removed from the jungles of Africa, laden with its atmosphere of weird superstition and voodooism."[46] Too be sure, African American midwives relied on a body of midwifery knowledge that had roots in slavery and pre-slavery African traditions of healing and conjuring. However, stories of African American women's mistreatment at the hands of physicians and OB/GYN's remained community knowledge, and resistance to physician and OB/GYN care existed. Additionally, due to the geography of the South, the problem of finding a substitute for the rural midwife was very complicated. Many Southern physicians reluctantly conceded that she was a "necessary evil" because "the distances are too great" and "the fees are too small to support a greater number of physicians."[47]

The cultural perception of midwifery then shifted as a reproductive health care provider for any woman, to the perception of a midwife as a reproductive health care provider of low income women, and women of color. With the failed attempts of recruiting physicians to set up practice, as previously mentioned by Ettinger, midwifery regulation and licensure began in earnest in the South in the late nineteen teens. Alabama began midwifery regulation in 1918, and Florida began writing policy for midwifery regulation in 1915, although no laws appeared until 1931.[48] And yet, the attempts to eliminate midwives continued, even in areas that required their care. Susan Smith notes that in the state of Mississippi, "from 1948 on, not only was there a policy of retiring midwives but all new midwives had to get a physician to testify that there was a

[46] Ibid., pg 78.
[47] Litoff, Judy Barrett. (1978). *American Midwives 1860-the Present*. Praeger. Pg 75.
[48] Susie, Debra Anne. (1987). *In the Way of Our Grandmothers: A Cultural View of Twentieth Century in Florida*. University of Georgia Press. Pg 34.

need for their services in their community before they could receive a permit."[49] Physicians could ultimately ensure the disappearance of midwifery in Mississippi if they felt there was no need for the service. This policy regarding retiring and new midwives was not unique to Mississippi, such policies were the norm in Alabama, Florida, and other southern states. With midwives retiring without replacements, and physician and OB/GYN care accepted by the mainstream, midwifery took on an antiquated identity. However, the retiring of midwives without a replacement did not have a detrimental effect on rural areas with limited access to reproductive healthcare until the late 1970s. It was during the late 1970s that not only were midwives' licenses not renewed, but also many states redefined midwifery and midwives were prosecuted if found to be practicing medicine without the proper credentials.

Aiding in the decline of midwives was the perception of midwifery within the African American community. Christa Craven notes that "when African American women finally gained access to hospitals after being denied even basic medical care for many years, most rejected home-birth as a way to distance themselves from the pejorative racial stereotypes associated with the African American midwife."[50] Clearly the anti-midwifery campaigns were successful. However, the success of these campaigns came at the expense of rural women in need of maternity care, and those who attempted to provide such care. Dr. Jesse Howard, a Selma doctor, noted that, "in the 1960s, midwives taught him hand skills while he was completing a residency at the Tuskegee Institute."[51] Dr. Howard confirms that despite the rumors that anti-

[49] Litoff, Judy Barrett ed. (1999)*Women and Health in America*, 2nd edition. Madison, WI: University of Wisconsin Press. Pg 452.

[50] Craven, Christa. (2010). *Pushing for Midwives: Homebirth Mothers and the Reproductive Rights Movement*. Philadelphia, PA: Temple University Press. Pg 197.

[51] Smith, Margaret Charles and Linda Janet Holmes. (1996). *Listen to Me Good: The Life Story of an Alabama Midwife*. Columbus: Ohio State University Press. Pg 138.

midwife campaigns were being run by the American Medical Association, the idea that midwives could help alleviate the work of local physicians, as well as educate them, was true.

What is most generally recognized as the "natural birth movement," begins in 1959 with the publication of *Thank You, Dr. Lamaze: A Mother's Experience's in Painless Childbirth*. Marjorie Karmel's text, part memoir, part tribute to her OBGYN while in France, Dr. Lamaze, with practical exercises for pregnant women in later editions, would help popularize the return to "natural childbirth" in the United States. In the first pages Karmel relays the story of her own birth, which causes her to have anxieties about her own upcoming experiences:

> [My mother,] was left alone after the delivery. My father happened to walk in and notice a pool of blood under the bed... it was dripping right through the mattress. Mother wasn't even breathing--they had to revive her with the rescue squad. What would have happened if [father] hadn't been there?[52]

It is clear why Karmel wanted to be experience childbirth awake and alert.

Karmel describes the explanation of "painless" childbirth via Dr. Lamaze's methods as "making use of conscious mental and physical control of the birth process... attained through exercises and education designed to build conditioned reflexes which will stand up during the stress of labor.[53]" In short, Dr. Lamaze's method was woman- and baby-centered: "You [the mother] have your baby yourself. I am only there to assist you."[54] This concept was incredibly radical for the time, but became increasingly popular over the next two decades. The encouragement to be awake and alert, and the opportunity to make one's own decision about birth allowed for an opportunity to revive midwifery care. However, it is important to note that during this time, while "natural childbirth" became popular, the process still included a hospital

[52] Karmel, Marjorie. (1959). *Thank You, Dr. Lamaze: A Mother's Experience's in Painless Childbirth*.
[53] Ibid., 32.
[54] Ibid., 32.

and anesthetic if the mother wanted it. "Natural childbirth" did not, nor does it currently mean, childbirth drug free. For many, natural childbirth includes epidurals and local anesthetic to "take the edge off."

It is most likely that Karmel's mother experienced "Twilight Sleep" birth. Ultimately, "Twilight Sleep" was not about creating a pain-free birthing experience, the birthing mother was not conscious during the final stage of labor and birth of the baby, as much as the procedure was about creating a controlled environment for the assisting doctor. The "Twilight Sleep" procedure was to be implemented only after labor began, with injections of 1/150 grain of scopolamine, along with a 1/2 grain of narcophin or morphine. Forty-five minutes later another injection of scopolamine would occur, and could reoccur depending on whether the laboring woman failed a memory test. Upon failure of the test the laboring woman would receive more amnesic.[55] The birthing woman was ultimately removed from participating in the birth of her child.

Midwifery and the practice of home-birth grew popular once again in the late 1960s and early 1970s, alongside the emergence of the women's liberation movement and, a backlash against "Twilight Sleep" birth. Coupled with "natural childbirth" methods, birth practices began to resemble those of the 18th and 19th centuries. A key player at this particular point in time is Ina May Gaskin, who established the Midwifery Center at The Farm in Tennessee, and published the first edition of her text *Spiritual Midwifery*, in 1975. The farm is a communal living space, led by Gaskin's husband Stephan, a preacher. *Spiritual Midwifery* is an account of different births at The Farm, as well as notes to expectant parents, and instructions to midwives. The text is a call for radical change in birth culture, as Gaskin and her fellow midwives declare:

[55] Sandelowski, Margarete. *Pain, Pleasure, And American Childbirth: From the Twilight Sleep to the Read Method, 1914-1960*. Westport, Conn.: Greenwood Press, 1984. Print. Pg 10.

> We feel that returning the major responsibility for normal childbirth to an abundance of well trained midwives, rather than have it rest with a profit oriented medical establishment, would lower rates of premature birth, infant mortality, induced births, and cesarean sections, not to mention skyrocketing costs.[56]

However, this changed yet again in the 1980s and 1990s. There was a national movement to re-inscribe the "traditional" gender role binary which had been challenged via women's lib. As a result, birth trends, and those with agency in the birthing room, shifted yet again to the hospital, and resulted in heavily medicalized birthing practices. The 1980s saw the emergence of fetal rights, which jumpstarted an increase in cesareans and other medical birth interventions.[57] Since the mid-to-late 1980's the cesarean rate in the US has increased steadily and is currently 32.9%. This is 22% higher than the World Health Organization's recommended rate, and means that one in every three babies is born via cesarean.[58] Pushing back against this trend, the North American Registry of Midwives implemented the Certified Professional Midwife in 1994. The CPM is similar to the community midwives of previous centuries, like Martha Ballard, who were trained through apprenticeship, and were an integral part of the local community. The education of a CPM includes both didactic and clinical skill, and can be fulfilled via a formal accredited program or the Portfolio Evaluation Process (PEP). Student midwives must serve under the supervision of a senior midwife, and sit for the National Association of Registered Midwives exam to achieve the CPM credential. Maintaining standards, and the evolution of the profession:

> Qualifications [for the CPM credential] are based on periodic surveys of practicing midwives (task analysis) to determine what midwives need to know and be able to do. This process, including the task analysis, is mandated by the

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[56] Gaskin, Ina May. (2002, reprint). *Spiritual Midwifery*. Book Publishing Company. Pg 12.

[57] Faludi, Susan. *Backlash: The Undeclared War Against American Women*. New York: Crown, 1991. Print. Pg 430.

[58] (Elton).

> National Commission for Certifying Agencies (NCCA)which accredits national health credentials in the U.S., including the CPM, CNM and CM.[59]

In addition to meeting the testing standards, all CPM's must have their own written practice guidelines, a process for informed disclosure and consent with clients, and a HIPAA privacy policy. Maintaining the credential is just as rigorous: "Certification is renewed every three years, and all CPMs must obtain continuing education and participate in peer review for recertification... Evidence of ongoing continuing education is required to maintain the CPM credential."

21st century

In our current moment, midwifery is once again drawing attention. In areas such as the Pacific Northwest, as well as the Southwest, the practice of midwifery has undergone little change or resistance when compared to midwifery in the South. Midwife Ina May Gaskin continues to be a driving force behind advocating for and educating midwives. Her recent text, *A Midwife's Manifesta*, is centered on the mission to educate young men and women on the birth process. This education-centered approach is important, because, as Gaskin asserts: "the way a culture treats women in birth is a good indicator of how well women and their contributions to society are valued and honored."[60] The intent of writing the manifesta Gaskin states, "is to call for greater involvement of women in the formulation of maternity healthcare policy and in the education of young men and women about birth."[61]

[59] NARM
[60] Gaskin, Ina May. (2011). *Birth Matters: A Midwives Manifesta*. New York: Seven Stories. Pg 6.
[61] Ibid., 6.

In a national context, insurance coverage is available to Certified Nurse Midwives, as well as those utilizing the care of CNMs, through the Patient Protection and Affordable Care Act of 2010. And Congresswoman Chellie Pingree (D-ME-1) introduced HR 1054, the "Access to Certified Professional Midwives Act of 2011" in the U.S. House of Representatives in 2011. However this does not prevent insurance companies from increasing rates and preventing midwives, both CPM and CNMs, from providing care. And states like Alabama that refuse to implement the Affordable Care Act do not extend the benefits to their citizens, no matter the benefit to the state in the larger economic context.

The State of Alabama

Laurie Wilkie's text *The Archeology of Mothering* is an important example of the role of midwifery in the Post Civil War South. Wilkie, a trained archeologist, documents and analyzes the findings of a Mobile, Alabama, home that was owned by an African American woman practicing midwifery at the turn of the twentieth century. Through the various findings at the dig site, which included medicinal containers, herbs and garden clippings, and different household objects, Wilkie has physical evidence that midwives role extended beyond overseeing births and included "how to care for themselves during pregnancy, what to expect during the ordeal of childbirth, and, afterward, how to care for their newborns."[62] This physical information complements WPA Slave narratives which discussed midwifery and reproductive health traditions amongst African American women. The post-Civil War/Reconstruction era history brings attention to the important role of midwives as reproductive health providers. Varying homeopathic approaches, in addition to commercial products of birth control allowed women

[62] Wilkie, Laurie. (2003). *The Archeology of Mothering: An African American Midwife's Tale*. New York: Routledge.

who had previously not had control of their bodies or reproductive patterns a way to have/establish a family on their own terms. However, this was detrimental to the continuing practice of midwifery. "In the United States, the movement to abolish lay midwifery was in part justified by the American Medical Association as a means to halt what was perceived as an epidemic of abortion in American society."[63] Lucinda Perryman, the practicing midwife who occupied the home at Wilkie's archeological site, was not directly affected by such campaigns as she passed on in the 1920s. While Lucinda Perryman was not directly affected by the AMA's anti-midwifery campaigns, there were larger ramifications for younger generation of African Americans, as well as those women who might consider practicing midwifery.

Gertrude Fraser's *African American Midwifery in the South* discusses the loss of knowledge that occurred with the all but elimination of midwifery in the region. Fraser takes a more generalized approach to her research than Wilkie, looking at the practice of midwifery in the state of Virginia during the mid-twentieth century. The jump in time period, and larger scope of study builds on, and confirms Wilkie's assertion that "Midwives, through their apprenticeships to older women, created a cross generational chain of magical and medical continuity."[64] Fraser confirms this through her ethnographic research of interviews with women who gave birth with the assistance of a midwife. The interviews reveal that midwifery knowledge, and the cross-generational sharing of knowledge, is lost with the elimination of the practice. The archival research supports this, as articles from the *Virginia Journal of Medicine* provide published accounts of the direct call for the end and outlawing of midwifery practices by physicians. As Fraser and previously mentioned authors explain, midwifery knowledge is not limited to birth, and includes home remedies, plants, pre- and postnatal care. In addition, for

[63] Ibid., 154.
[64] Ibid., 120.

many this cross-generational form of knowledge of midwifery within the African American community can be traced as a direct connection to families' pre-slave history in Africa. Historical accounts of midwifery in the US reveal a huge amount of lost knowledge in regard to women's reproductive health, why the current ethnomedical system in the United States is the way it is, and underlying conflicts of racial conflict and structural violence.

Granny Midwives and Regulation

Perryman's story is built upon by Onnie Lee Logan of Mobile, Alabama, and Margaret Charles Smith of Eutaw, Alabama. Both Logan and Smith practiced midwifery after Perryman, during the middle twentieth century, and considered the practice "a deeply personal calling, and a strategy for family support," as had Martha Ballard.

In 1918 a state law was passed in Alabama requiring that midwives pass an exam and register with the State Board of Health.[65] Some midwives in the state enrolled in midwifery courses at Tuskegee University, but most midwives enrolled in courses offered through the county health department. For the majority of practicing midwives in the state, this training was acquired after participating in an apprenticeship with an older, experienced midwife within the same community. The mentoring midwife also underwent the same training for licensure. As a result of additional education and licensure, Alabama midwives gained status within their own communities. Smith acquired her midwifery license in 1949, although she had assisted in births prior to acquiring legal status to do so, and acted as a liaison between the local community and health officials.[66] Logan acted very much within the same parameters after acquiring her license

[65] Smith, Margaret Charles and Linda Janet Holmes. (1996). *Listen to Me Good: The Life Story of an Alabama Midwife*. Columbus: Ohio State University Press. Pg 64.
[66] Smith, Margaret Charles and Linda Janet Holmes. (1996). *Listen to Me Good: The Life Story of an Alabama Midwife*. Columbus: Ohio State University Press. Pg xvii.

in 1947, although she practiced in the Mobile county area, on the Alabama Gulf Coast. However, as racial tensions increased throughout the next thirty years, African American midwives found it harder to acquire licensure. And if midwives could not be found women were forced to rely on public hospitals, often far from home or unaffordable. The women most affected by the declining service of midwives, were women living in rural areas of the state, and in particular African American women. "Black residents of Greene and other counties depended on the services offered at Tuskegee's Andrew Memorial Hospital, nearly two hundred miles from Eutaw."[67] According to the Final Report of the Effect of Nursing Care on Selected Aspects of Premature Infant Welfare in the Home, one public hospital, Andrew's served 42 counties. "Several of these 42 counties have no hospital while those with hospitals are in most instances reluctant to admit indigent Negro mothers and their premature infants."[68] And while this specific observation refers to infant care, public hospitals and health programs were often the only care available to African Americans in Alabama, which is why "granny" midwives were so important to communities in Alabama.

The documents examined below are what Margaret Charles Smith and Onnie Lee Logan completed in order to practice midwifery in Alabama. What is found in the documents is a detailed policing of the midwifery community, that does not regulate midwifery practice so much as it polices the midwives themselves. From the Alabama state records it is clear that the majority of midwives throughout the state's history were Black women. The rigorous standards regarding the health and physical appearance of the midwives is reflective of the stereotype that Black women were "dirty" and "carriers of disease," rather than victims of structural violence and Jim Crow laws that perpetuate poverty and deny social and economic mobility. To be fair,

[67] Ibid., 86
[68] Ibid., 115

the desire for care providers to be free of communicable disease is understandable and reasonable. Yet, a midwife's quality of care and education, as well as woman's access to maternal healthcare, are presented as secondary to a midwife's personal presentation and private home. Women applying to be licensed midwives provided health department with basic demographic information but are followed by inquiries into their socioeconomic status and living conditions, for example:

Apparent Economic Status: Comfort_____ Necessities_____ Poverty____
Water Supply: Safe:_____ Questionable_____ Unsafe_____
Excreta disposal: Sanitary_____ Insanitary_____

Additionally, while the County Health Department sought to verify a midwifery applicant's ability via the local physician, the focus remains on the physicality of the midwife. Their letter to the physician reads as follows:

Dear Doctor,

The State Board of Health is endeavoring to make a survey of the practice of midwifery in Alabama. In order that the information gathered from this study may be as useful as possible, will you not kindly answer the questions regarding _____ who practices as a midwife in _____ County, and who states that you are familiar with her work?

1. *If you have ever made a physical examination of her, what were your findings?*
2. *Is she cleanly in her person and habits?*
3. *Does she seem to recognize abnormal labor or difficult cases of labor and call for medical assistance?*
4. *Does she carry out orders: A) Well? B) Promptly? C) Never?*
5. *Are her services needed in your community?*
6. *Is she, in your opinion, fit or unfit to practice midwifery?*

Your reply may be made on this sheet, using the reverse side for any further information that you care to give. Your cooperation in this matter will be much appreciated.

Very sincerely yours,

State Health Officer

Once accepted, the actual License to Practice Midwifery was indeed focused on the midwife's scope of practice and ability to provide care. The front of the document certifies the named individual is eligible to practice as a midwife. The back of the document is a list of "Midwife Safety Rules." The state-imposed rules are not unreasonable. A detailed reading of the rules reflects the desire for midwives to work within their scope of knowledge, maintaining a safe space for themselves and the birthing mother, and to ask for help when necessary. It is evident that any preoccupation with a midwife's cleanliness or physical appearance is closely linked to the health and safety of the birthing mother and baby. The only item that is missing on the rules, and any other document for that matter, is a procedure outlined for if a situation in which a physician is unavailable, or transport to a hospital is not possible. Due to the rural nature of the state of Alabama, and the scarcity of hospitals and variability of transportation, this is a grave oversight.

Midwifery licenses were renewed yearly. The yearly renewal was contingent on a variety of factors including attendance at local midwifery education events conducted by public health nurses, midwife bag inspections also conducted by public health nurses, a physical exam, and the completion and filing of all birth-related documents including birth certificates or a midwife investigation. A midwife investigation was conducted in the event of a miscarriage, stillbirth, infant loss within the first few days of birth, or maternal death. The midwife investigation

paperwork is straightforward, and while the "findings" vary in detail from birth to birth, rarely ever is an "action taken" outlined. For example, Midwife Ella Garrett of Talladega was investigated due to a "premature stillbirth." Upon conference with the Public Health Nurse, the findings read: "Patient had pains for about 3 days and Ella made two trips to the case. She fell through porch that started her in labor." Other findings indicate the mother's Wassermann test results were positive.[69] All of the findings indicate that the reasons for the stillbirth were beyond a midwife's control, and mainly were the result of poverty.

While midwives often cared for women and families living in poverty, they also resided in poverty themselves. The Midwife application and Record documents ask for not only a physical assessment of the midwife herself, but of her home. County Public Health nurses, usually white and formally educated, conducted home visits, and made note within each midwife's record. There is no indication as to what the county and state did with the assessment of midwives' varying living conditions. A midwife's own position within poverty did not necessarily prevent her from practicing or securing a physician's verification or a physician's own letter of recommendation. Generally the information reflects the poverty of the area, and reinforced the stereotype that people and midwives of color were "dirty and carriers of disease," providing a basis for rigorous regulation.[70] This stereotype can also be reflected in the "Midwife Safety Rules," which are outlined on the back of the "Permit to Engage in Midwifery," as follows:

Rule 1. *A midwife, before attending a woman in confinement, must wash her hands and arms thoroughly with warm water and soap.*

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[69] (photo 1 in ipad photo stream).

[70] Hodnett, E. D., Gates, S., Hofmeyr, G. J., and Sakala. C. 2012. Continuous support for women during childbirth. Cochrane Database of Systematic Reviews 2012, Issue 10. Art. No.: CD003766. DOI: 10.1002/14651858.CD003766.pub4.

Rule 2. *She must keep herself clean, and also her patient, bed, clothing, and all that comes in contact with her.*

Again, these rules are both intuitive, and lack the consideration of how to best care for a woman and her family if there is no access to clean water, bedding, or clothing.

Rule 3*. She must not pass her fingers or any instrument into the birth canal of the woman, for the purpose of making an examination or for any other purpose.*

Rule 4. *A midwife must endeavor to secure the assistance if the child is not born after twelve hours of labor.*

Rule 5. *A midwife is not permitted to give drugs of any kind to hasten or increase labor pains, but may give castor oil or other laxative as needed.*

Rule 6. *She must not give an injection of any kind into the birth canal without orders from a doctor, but may use an enema of warm water to produce a movement of the bowels.*

Rule 7. *If the child's hand or the cord comes down, the baby is lying in a cross position; or if there is dark greenish discharge from the birth canal during labor, the baby's buttocks are being born first, or the baby is suffering. Send for a doctor at once telling him what you have noticed.*

Rule 8. *If the mother has a spasm, or bleeds either before or after the child is born, send at once for the physician. Do the same thing if the mother is very weak or her labor is slow. If the mother shows signs of fever, send for the physician at once and do not wait until she is worse. Unless treated promptly, she may die. Do not rely upon yourself if there is anything unusual about the case--send for the physician as quickly as you can.*

Rules three through eight ask a midwife to reflect upon her scope of practice and knowledge. While this reflection is important these rules indicate that any complementary medicine, be it in

the form of herbal supplement or any other practice, is unacceptable. Margaret Charles Smith recalled that a fellow midwife got "ripped" about giving a client root tea. "They [the doctors and public health nurses] better not catch nobody giving nobody no tea of no kind. If they do, she was going to jail and from there the pen."[71]

Rule 9. *Every midwife must report the births she attends within 5 days on the blanks furnished her. There is a fine for failing to report births. Use pen and ink.*

Rule 10. *TO PREVENT SORE EYES AND BLINDNESS, the law now requires every midwife and doctor to put drops into the eyes of each child as soon as born. Drops are furnished free by the State Board of Health.*

Rule 11. *The holder hereof is required to report to the county Board of Health the name of any person who is known to be engaging in midwifery without a permit.*

Taken at face value, the majority of the Midwife Safety Rules are reasonable, in that they ask midwives to be self-reflective and aware of their own knowledge and scope of practice. However, when we consider the safety rules, juxtaposed with the following memorandum from Harold Klinger, M.D., Director of the Bureau of Maternal and Child Health, it becomes clear that the motivation of strict and invasive regulation of midwives was to assist in the demise of these practitioners.

[71] Smith, Margaret Charles and Linda Janet Holmes. 1996. *Listen to Me Good: The Life Story of an Alabama Midwife*. Columbus: Ohio State University Press. Pg 100

"May 4th, 1968

Memorandum

To: County Health Officers
From: Harold Klinger, M.D., Director of the Bureau of Maternal and Child Health
Subject: Midwife Activity in Alabama
Over the past few years midwife activity has decreased. There are now about one-half of the number of deliveries made by midwives as there were a few years ago. It is interesting to see that nine of Alabama's counties have an incidence of midwife deliveries of 10 or less, three counties having reported no midwife deliveries.
It is equally interesting to note that twenty-seven counties have over 100 recorded midwife deliveries, and two counties had about 500 during 1966.
It is hoped that the 24 hour plan for hospitalization will continue to decrease the activity of "granny" midwives in Alabama, and help to reduce our incidence of maternal mortality as well as infant mortality."

This memorandum makes it clear that the health department believed that women of color practicing as midwives were responsible for Alabama's maternal and infant mortality rates. It should be noted that organizations such as the CDC and WHO did not start collecting data on maternal mortality until 1986. While state and county data are available for the years prior to 1986, it is not reliable. The memorandum above compares graphs of live births by attendant, but does not reveal any maternal mortality comparisons in regard to birth attendant. According to National Vital Statistic data, the maternal mortality rate in Alabama was 24.5% overall, 16.6% for whites, and 63.6% for people of color, in 1968. There is no recognition that the structural violence of Jim Crow Laws which result in a lack of access to basic resources such as water, education, transportation to medical facilities, and the racialization of space might have a direct relation to these rates. Additionally, there is no acknowledgement that the counties which

maintain a strong midwifery presence at this time are counties in Alabama's Black Belt. These are counties that in our current moment still lack access to basic resources. The counties that have the least midwifery presence at the time of this memorandum are more urbanized areas such as Birmingham in Jefferson County, or counties that simply have a smaller population, such as Coosa County.

"The New Old Way of Delivering Babies"

In the late 1970s, the state of Alabama legally redefined midwifery, to certified nurse midwifery. A 1975 *New York Times* article: "The New Old Way of Delivering Babies; Now, the Nurse Midwife," provides hints, but no concrete evidence. The author asserts that due to the requirement of an RN degree, followed by a Master of Science in Midwifery "today's nurse-midwives are far better educated that the old-time granny midwives." It is here that Alabama takes a hit, as author reveals that "in Alabama, for instance, while 'granny' midwives are still legally delivering babies under county by county permits, the attorney general has ruled that the practice of nurse-midwifery 'violates the present Alabama laws." The implication is that Alabama's midwifery policy is backward: "granny" midwives are allowed to practice, but the medically trained CNMs are not. The implication of being backward in regard to maternal healthcare policy, coupled with the state's Health department's belief that midwives were the cause of Alabama's maternal and infant mortality rates, may have been enough to motivate a redefinition of midwifery in the state. Redefining midwifery as specifically Nurse Midwifery in Alabama would allow the policy makers and maternal health practitioners to look progressive and up to date. Likewise, the redefinition might not cause any major conflict with those in the state who might consider themselves part of the Natural Birth Movement at the time, as those

women would still be able to utilize the care of a midwife, and midwives would still be able to practice.

The consequences of this redefinition resulted in limited maternal health care to those of low socioeconomic standing, and those in rural communities, particularly African American women. These consequences were not seen immediately as many granny midwives, such as Onnie Lee Logan and Margaret Charles Smith, continued to practice until legal action was threatened. With midwives losing their legal recognition physician's case-loads increased. Little relief was offered to the doctors practicing in these areas, as physician recruitment to the black belt has been, and continues to be unsuccessful.

In 1976, midwifery was redefined within the state to mean only certified nurse midwifery.[72] Although title 34 chapter 19 does not "prevent lay midwives holding valid health department permits from engaging in the practice of lay midwifery," the act continues, revealing that midwives other than CNMs may practice as "until such time as said permit may be revoked by the county board of health."[73] Three years later the definitive blow came to Alabama midwives when in June of 1979 it was mandated under the recommendation of Dr. Robert Goldenburg, the state health director of maternal and child health, that "No new granny midwives are to be certified after April 1, 1978."[74] Both Smith and Logan's narratives point to the fear of "granny" midwives being too elderly to adequately care for pregnant and birthing women. And with the decrease in licensed midwives overall in the state, those lay or "granny" midwives who had continued to practice were of an older generation, and the next generation of midwives was not a large one. Despite the mandate many midwives continued to practice.

[72] AL Public Health laws, 439.
[73] Ibid.,439.
[74] Smith, Margaret Charles and Linda Janet Holmes. (1996). *Listen to Me Good: The Life Story of an Alabama Midwife*. Columbus: Ohio State University Press. Pg 135.

Smith practiced until 1981, and Logan practiced until 1984. "She [Logan] received a rather abrupt letter from the board of health indicating there was no longer a "need" for her services and that her permit would not be renewed."[75] With the forced retirement of licensed midwives, one would think that CNMs would be able to supplement the midwifery need. But this was not possible. Tuskegee University had attempted to implement a CNM program within their Nursing School in the 1940s, but the program was short lived due to failure to recruit committed faculty, despite a substantial number of students. Likewise, University of Alabama at Birmingham also attempted to implement a CNM program in the late 1980s and early 1990s, but failed due to the same reasons as the Tuskegee program. As of today there are no CNM programs, and as of 2010 only 18 CNMs currently practice within the state of Alabama and all of them received their certification out of state. Non-Nurse Midwives practicing in Alabama today are not lay, or "granny," but have most likely received their education via the Certified Professional Midwife path. As indicated by the CDC, and Alabama Department of Health data, as well as parents speaking on behalf of CPMs belonging to the Alabama Birth Coalition, home-births attended by CPMs are occurring within the state.

Efforts are being made to make both non-nurse midwifery and nurse midwifery more accessible to women and families within the state. There is the previously mentioned Alabama Birth Coalition, and two other organizations: the Alabama Midwives Alliance, and Safer Birth in Bama. The Alabama Midwives Alliance "*(ALMA)* is a not-for-profit organization whose membership is open to midwives and aspiring midwives who wish to provide the Midwives Model of Care in Alabama." The Alabama Birth Coalition "is a 501(c)(4) non-profit, grassroots organization created in 2004 exclusively for social welfare and educational purposes." The ABC

[75] Logan, Onnie Lee. (1989). *Motherwit: An Alabama Midwife's Story*. New York: Plume Books. Pg xiii.

is the organization that lobbies the state legislature each year for the legal recognition of non-nurse midwives in the state. Safer Birth in Bama is the newest organization in the state working to improve access to midwifery care. A newly filed 501(c)(3) non-profit, Safer Birth in Bama is "dedicated to improving access to evidence based care, improving outcomes, and informing Alabama citizens about the need for change regarding the maternity care crisis in the state of Alabama." Ultimately each organization wants to reinstate the community midwife into Alabama, and increase maternal healthcare accessibility. However, when the Granny Midwife was removed from practice in Alabama, and the Certified Professional Midwife emerged, so did a new representation and understanding of who is a midwife. The Granny Midwives were African American women, all the Certified Professional Midwives in the state are white. On the surface this may not seem significant, but due to the hierarchies and history of race and class in Alabama, the racial shift in midwifery is particularly significant. As the varying historical public health documents indicate, African American women were impacted by a varying lack of resources, and the erasure of a key community member. Every CPM in Alabama is white, and while they are not legally recognized as care providers, they benefit from the cultural and social privileges of being white. Likewise, the current campaign to increase access to non-nurse midwifery in Alabama is largely white, and lacks a nuanced view and understanding of how the structural violence enacted by Jim Crow Laws has upon this history. When taking the time to consider the lack of diversity within the current campaign for the legalization of non-nurse midwifery, it becomes clear that the campaign does not so much ask for the revival of the community midwife, as it asks for the increased privileges within an already privileged community.

Conclusion

The history of midwifery is difficult to trace, as a result of the historical attempts to eliminate the profession. These attempts to eliminate the midwife have resulted not in the elimination of the profession, but in shifting the racial makeup and the accessibility of the profession, both to aspiring midwives and women who wish to receive midwifery care. The lack of diversity within the Alabama midwifery community is a reflection of national trends. Within the context of Alabama, the lack of diversity is particularly disturbing as it relates to the state's history, and a reminder of the continued structural violence enacted upon women of color in the state. More so, the lack of diversity reflects the larger issue of accessibility to maternal healthcare across the state. This lack of access to care includes not only non-nurse midwifery, or nurse midwifery care. There is a lack of access to general and family practitioners, obstetricians and gynecologists, as well as hospitals. In the following chapter, I will examine the current access, or lack thereof, to maternal healthcare in Alabama, and its impacts upon women of varying race and class.

CHAPTER 2. ALABAMA CESAREAN DATA ANALYSIS

Currently in the United States there is disagreement regarding what is considered acceptable perinatal and birth care. Nationally over ninety-eight percent of women give birth in a hospital with the assistance of an obstetrician or gynecologist. By contrast, alternative care provided by a midwife is rare, and only utilized by two percent of birthing women in the United States.[76] The ideals and goals of the natural birth movement have remained a strong subculture in the US birth community, and recent studies indicate that midwifery care and home birth, or alternative birth care, as some refer to it, is once again on the rise. A recent study released by the US Center for Disease Control (CDC), reveals that between 2004 and 2009 home-birth increased by twenty-nine percent. Midwives attended sixty-two percent of these home-births, Certified Nurse Midwives (CNMs) attended nineteen percent of the births, and Certified Professional (CPMs)/Direct Entry Midwives (DEMs) attended forty-three percent of the births.[77] The increased utilization of midwifery care and home-birth continue to be a response to medical intervention, but also the overall dissatisfaction with the care of birthing women in US hospitals.

Additionally, the current dissatisfaction with hospital birth and OB/GYN assistance stems from the frequent use of cesarean section surgery. As indicated by Amnesty International's 2011 study entitled "Deadly Delivery":

> Recent data shows that the cesarean rate rose for the 13th consecutive year to reach an all-time high of almost thirty-three percent [32.9%] in 2009. The cesarean rate is now more than double the WHO recommended range of five percent to fifteen percent... and new analysis shows that states with high cesarean

[76] MacDorman MF, Mathews TJ, Declercq E., "Home births in the United States, 1990– 2009." NCHS data brief, no 84. Hyattsville, MD: National Center for Health Statistics. 2012.

[77] MacDorman MF, Mathews TJ, Declercq E., "Home births in the United States, 1990– 2009." pg 3

> rates (over thirty-three percent) were associated with a twenty-one percent higher maternal mortality risk.[78]

The risks of cesarean section include: infection, hemorrhage, injury to organs, adhesions, reactions to medications, additional surgeries, maternal mortality, and a variety of emotional reactions.[79] In fact, due to the high risks associated with cesarean sections, the high costs, and the increased reliance on the procedure, some insurance companies are now encouraging OB/GYNs to avoid performing the surgery. A recent article in *Bloomberg Businessweek* reveals that:

> As costs climb, insurers are shedding a reluctance to intervene in an area as sensitive as childbirth, Corry said. Aetna, the third-biggest U.S. health plan, is seeking to adjust prices for cesareans, which now earn hospitals as much as twice the rate of traditional deliveries. Cigna is considering a similar move, along with bonuses for hospitals that reduce early C-sections and inductions.[80]

What the *Bloomberg Businessweek* article reveals is that there has been, and continues to be, a great monetary incentive to perform cesarean sections. Additionally, the article also points to

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[78] Amnesty International. *Deadly Delivery: The Maternal Health Care Crisis in the USA: One Year Update (2010). http://www.amnestyusa.org/research/reports/deadly-delivery-the-maternal-health-care-crisis-in-the-usa.*
A cesarean rate "beyond 10-15% of the population are unlikely to yield any improvements of maternal or perinatal outcomes." There is one study that I can find one study, the third link below, that suggests that the target recommendation by the WHO for cesarean rates is too low and could be as high as 19%. However, even at 19% the US as a whole and Alabama as a state, are significantly higher than recommended. The overall current US cesarean rate is 32%, and the overall Alabama rate is 35%, having varied hardly at all within the last 8 years.
WHO Statement on Cesarean Section Rates, 2015
http://apps.who.int/iris/bitstream/handle/10665/161442/WHO_RHR_15.02_eng.pdf;jsessionid=127C0BB08F3D9437E9399FA456FCF4EE?sequence=1
The Troubling Epidemic of Unnecessary C-sections around the world, explained
https://www.vox.com/science-and-health/2018/10/25/17990880/c-section-surgery-cesarean-pregnancy-risks?fbclid=IwAR1ZL1e95YGCwTyat7Ilhrb1FP1oVqIcr03HZcgegGZyUZibvQ7-GJVWIZ8
Relationship Between Cesarean Delivery Rate and Maternal and Neonatal Mortality Rate.
https://www.ncbi.nlm.nih.gov/pubmed/26624825.

[79] "Risk of a Cesarean Procedure." *American Pregnancy Association*. http://americanpregnancy.org/labornbirth/cesareanrisks.html.

[80] Nussbaum, Alex. "Aetna Urges Moms to Avoid Cesareans Births to Reduce Risk." *Bloomberg Businessweek*. July 13, 2012.
http://www.businessweek.com/news/2012-07-13/aetna-urges-moms-to-avoid-cesareans-births-to-reduce-risk.

"preserve incentives," such as avoiding litigation, as an incentive to perform cesarean sections.[81]

Birth Statistics in Alabama

The increased utilization of home-birth and midwifery care across the US varies from region to region. As previously discussed, Alabama has a rich history of midwifery. However, the state ranks fifth in the US in regard to state cesarean rates in 2009, and sixth as of 2010.[82] Cesareans makeup thirty-five and a half percent of all births in Alabama, and the county cesarean rates range from fifteen percent to sixty-one percent.[83] Some of these county-specific rates are extremely high, and point to the possibility of over-reliance on medical technology in the birthing process. Only one hospital in the state falls within the WHO cesarean rate recommendation: Jacksonville Medical Center in Calhoun County, which has a cesarean rate of fifteen percent.[84] It is not exactly clear why the cesarean rates are so high in Alabama, but certain key factors point to a number of possibilities, including socioeconomic status, geography, lack of access to maternal healthcare, and restrictive policies regarding midwives.

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[81] Ibid.

[82] Births: Preliminary Data 2010." *Center for Disease Control and Prevention*. http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_02_tables.pdf

[83] "Births By Method Of Delivery And Hospital Of Occurrence With Cesarean Section And Vaginal Birth After Cesarean Rates, Alabama, 2009." *Alabama Center for Health Statistics*. http://www.adph.org/healthstats/index.asp?id=1513

[84] Ibid.

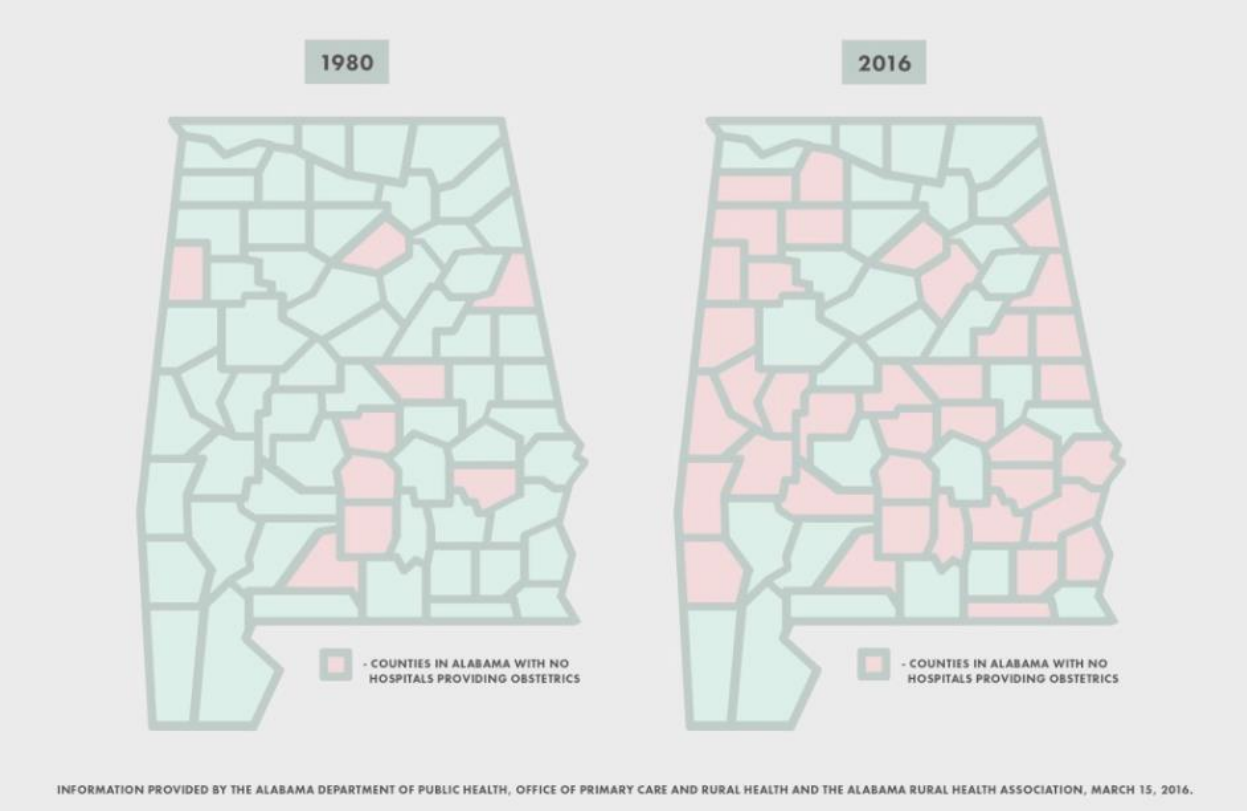

Figure 1. The state maps of Alabama highlight the loss of maternal healthcare by county, indicated by pink shading.

Methods

To evaluate possible causal factors to explain variation in rates of cesarean sections in Alabama, I analyze the state's recent statistical data that are available from the Center for Disease Control and National Census Bureau databases for the years 2009, 2010,[85] and 2011.[86] These databases provide economic, demographic, and medical information by county including population, population density, population percentage by race (Black, White, Latino), median household income, Medicaid County Impacts (payment amount and number of folks eligible), and the percentage of population receiving Medicaid. The data for these variables are

[85] "AL QuickLinks." *United States Census Bureau*. http://quickfacts.census.gov/qfd/states/01000lk.html
[86] "Births: Preliminary Data 2010." *Center for Disease Control and Prevention*. http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_02_tables.pdf.

from 2010; cesarean section rates of each hospital in the state offering women's healthcare are from 2009.

To discover patterns in the county-level demographic data, I used a hierarchical clustering method (Ward's minimum variance method) using as my variables: population, population density, median household income, and poverty percent. From the resulting dendrogram I identify four distinct clusters of counties, labeled Rural (R), Suburban (S), Black Belt (B), and Urban (U). These clusters form the basis for my subsequent analyses and maps of the social geography of Alabama. The counties in the Rural group are predominantly white and rural, and are found mostly in the northeastern, and north-central areas of the state. The Suburban group reflects the suburban geography of the state's major cities of Tuscaloosa, Auburn, as well as areas between Mobile and Pensacola, FL.

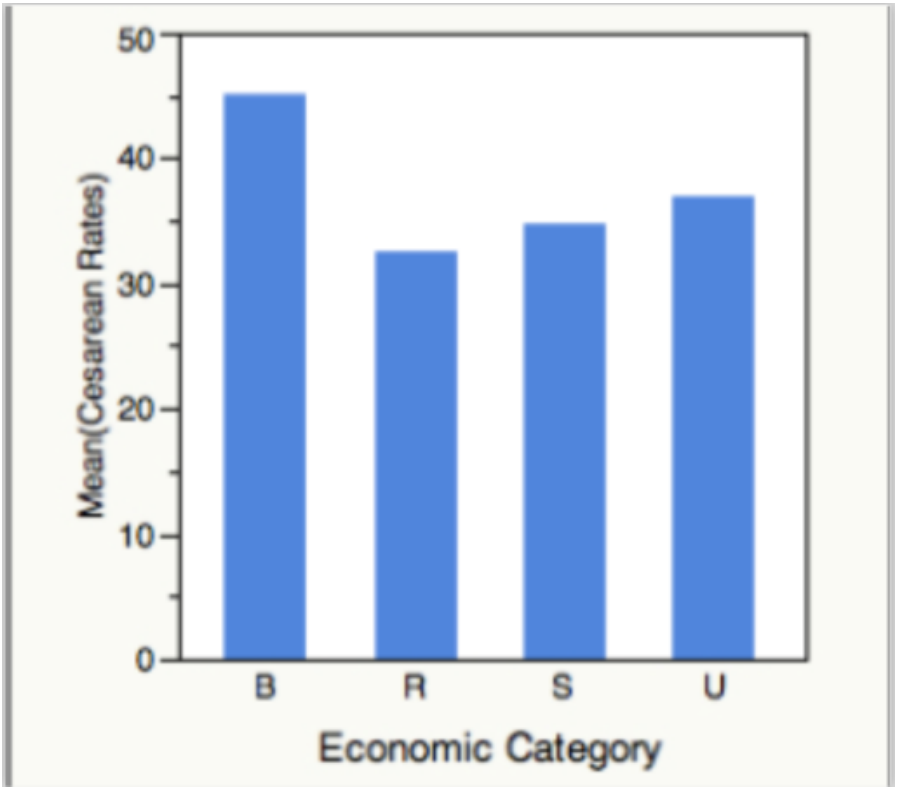

Figure 2. The resulting Dendrogram with each economic category.

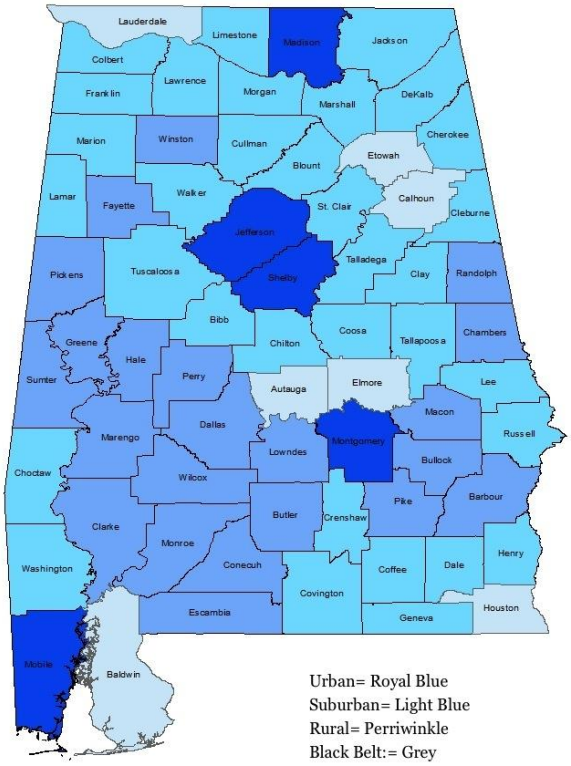

Figure 3. Each county's economic category is indicated by a varying shade of blue.

The Black Belt label borrows from the term used to describe the soil quality of the predominantly rural southwest and south-central area of the state. “Black Belt” is also used to reference the proportionately large Black population in the south, and south-central part of the state, and is recognized as an area of relative poverty and rural lifeways. The counties that are considered “Black Belt” can be seen below in Figure 4. The Urban cluster of counties includes the major Alabama cities of Mobile, Birmingham, Huntsville, and Montgomery.

Figure 4. The counties which are socioculturally and historically considered "Black Belt" Counties

Analysis of Demographic and Social Data in Relation to Cesarean Section Rates

In order to discover if cesarean rates in Alabama are related to the county data, I plotted cesarean rates by the county clusters. Cesarean rates in Alabama are not available by county, but by hospital. In order to relate the county demographic data to the hospital cesarean rates, I identified which hospitals belong in which county. The resulting graph illustrates considerable variation, with the highest cesarean rates concentrated in the Black Belt, while the lowest values are found in the Urban areas.

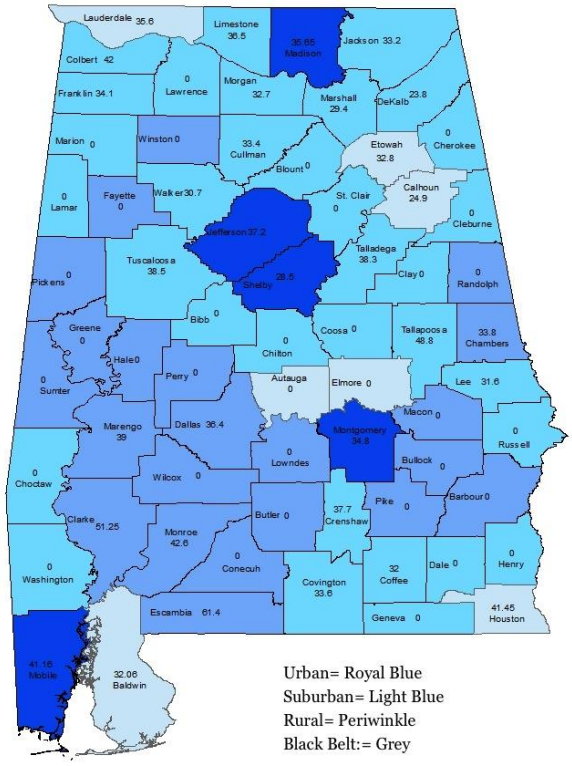

Figure 5. Each county with economic category shading, in addition to the county cesarean rate.

My next analytical step was to identify possible causal factors that might explain the variation of cesarean rates with county clusters. Possible causal factors I considered included the number of individuals in the state that are eligible for Medicaid, as according to Census data from 2010, Alabama's average income is at least ten thousand dollars less than the national average and most of the state is considered low income. However, a regression analysis revealed no statistically significant correlations between cesarean section rates and number of eligible Medicaid recipients. A possible explanation to these specific results is that the State of

Alabama's Medicaid program is suffering from serious budget issues and is having trouble offering sufficient services to residents.[87]

The strongest correlations I discovered are between cesarean rates, population density, and race. Lower population density, and a higher proportion of Black people both predict higher cesarean section rates.

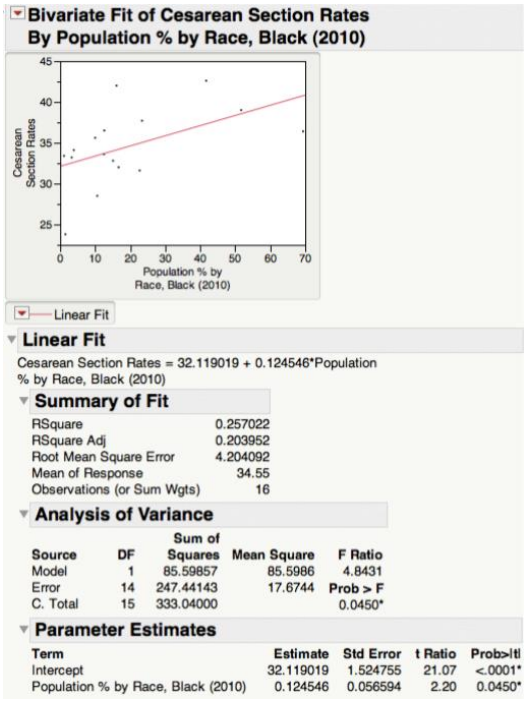

Figure 6. The bivariate confirming that counties with a high population of Black Women are more likely to have a cesarean section.

[87] "Agency Projected To Be At Least $100 Million Short if Sept. 18 Vote Fails." Alabama Medicaid Agency. http://medicaid.alabama.gov/news_detail.aspx?ID=6813.

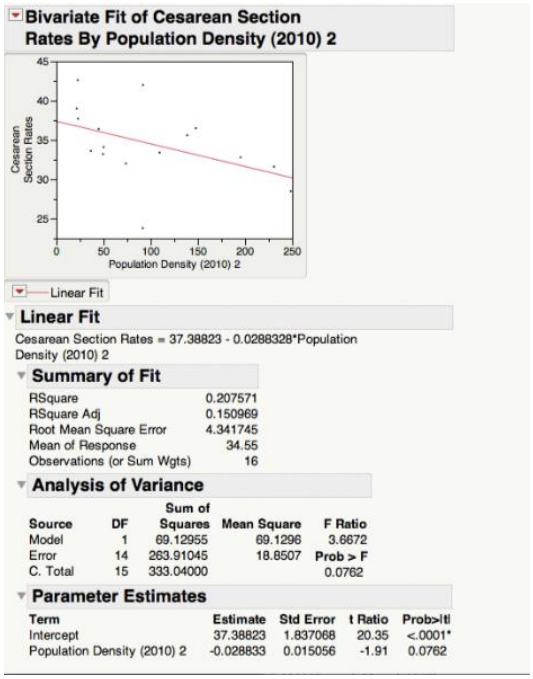

Figure 7. Bivariate of small sample confirming that those counties with an overall lower population density are more likely to have cesarean sections.

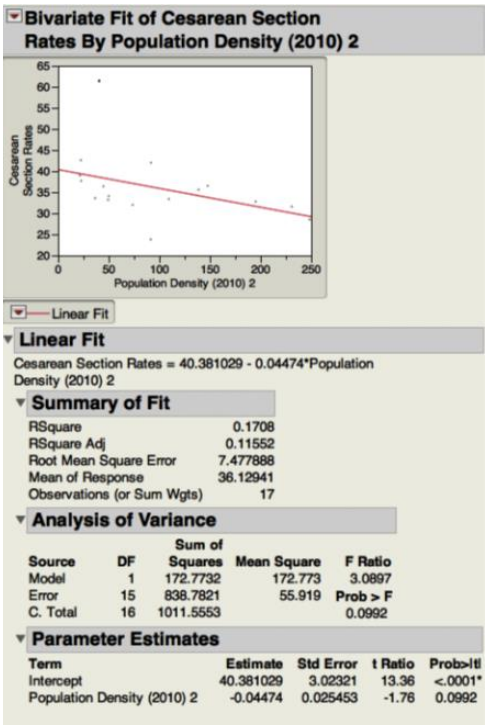

Figure 8. Bivariate of full sample confirming that those counties with an overall lower population density are more likely to have cesarean sections.

Overall, Black women throughout the state have a higher chance of giving birth via cesarean than either White or Latina women. Additionally, Black women living in the Black Belt (B), have a higher chance of giving birth via a cesarean than their peers in the three other clusters. In order to confirm these trends, the same tests were run with a small sample of counties. The small sample is made up of counties containing only one hospital. The tests of the small sample reflect the results of the complete data set, confirming patterns in the state-wide data discussed above.

Figure 9. Randomly selected counties, which reflect and confirm the analysis of the larger data set.

Conclusions

I conclude that cesarean section rates in Alabama are highest among Black women, and that cesarean sections are being performed most often in rural areas. Due to the geography of the state, as well as the lack of maternal health facilities in areas such as the Black Belt, as well as the criminalized status of CPMs, it seems likely that an additional possible contributing factor to the state's high cesarean rates is scheduled inductions. In the case of an induction, a pregnant woman and her OB/GYN schedule a day to artificially start labor. Scheduled inductions likely occur in order to have women give birth in the perceived safest place possible: the hospital. Thus, scheduled inductions are used as a means to avoid birth at home, or the possibility of giving birth en route to the hospital. While all inductions do not lead to cesarean sections, the

induction of labor is a medical intervention in the birth process and does increase the likelihood of a cesarean section.[88]

In addition to scheduling inductions, I would point to the possible importance of bans, or de-facto bans, on Vaginal Births After Cesareans (VBACs). In examining the availability of Vaginal Birth After Cesarean in conjunction with hospitals in Alabama, bans or de-facto bans are more likely to exist in rural, and suburban areas. Of the four categories examined in this paper, women in the Black Belt and the Suburban area of the state are more likely to encounter an OB/GYN or hospital that has a ban, or de-facto ban on VBACs.

[88] It should be noted that when I refer to a medical induction I am referring to scheduled inductions when labor has not occurred spontaneously, and pharmaceuticals are utilized. There are a variety of induction of labor methods that do not involve pharmaceuticals that are utilized by OB/GYNs. A meta-analyses has recently been published indicating that long held beliefs that induction of labor leads to cesarean is misguided. While these are significant findings and will impact birth culture immediate, and long term, it should be noted that a previous meta-analysis by Henci Goer and Amy Romano indicated otherwise. Goer and Romano indicate that their meta-analysis is specific to studies limited to induction in healthy women, at term, confined to outcomes clinically relevant to safety and effectiveness, and confined to randomized trials (158). The release of this new meta-analysis indicates that induction of labor may not be a contributing factor to high cesarean rates in the state of Alabama, however, it does not provide any resolution to the question: what are the contributing factors to Alabama's cesarean rates? Romano and Goer's meta-analysis suggests simply to let nature take its course and offers strategies for optimal care if an induction of labor is required. While an induction of labor may not be a contributing factor in our current national cesarean rate, it is still possible to be a contributing factor within the state of Alabama, where many residents find themselves further than an hour drive to a care provider. The two meta-analysis are found here:
Goer, Henci and Amy Romano. *Optimal Care in Childbirth: The Case for a Physiologic Approach*. Classic Day Publishing, Washington. 2012
Mishanina, Ekaterina et al. "Use of labour induction and risk of cesarean delivery: a systematic review and meta-analysis" *CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne* vol. 186,9 (2014): 665-73.

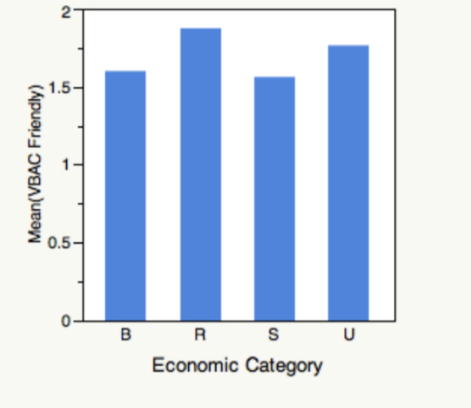

Figure 10. Economic categories that indicate the likelihood of a VBAC (Vaginal Birth After Cesarean).

This information regarding VBACs is particularly important considering the different socioeconomic and geographical makeup of these two regions. Group S is predominately white, home to the majority of the state's universities, and the women in these areas are more likely to have a higher level of education in regard to pregnancy and birth procedures, interventions, and the effects thereof. As a result, women are more likely to refuse a subsequent cesarean. On the opposite end of this spectrum are the women that make up the Black Belt, who are predominantly Black, and have overall the lowest socioeconomic status in the state. Additionally this area has overall less access to maternity care or other healthcare facilities as indicated by simply gleaning the directory of Alabama Hospital Association directory of facilities and the services offered at these facilities.[89] With limited access to healthcare and education regarding pregnancy and birth procedures and intervention, it can be concluded that women are less likely to refuse a subsequent cesarean, or know that they have the right to do so. The information regarding cesarean sections and (de-facto) bans on VBACs, indicates a very

[89] "List of All Hospitals." *Alabama Hospital Association*. http://www.alaha.org/dir_print.aspx.

controlled environment for women in suburban and rural areas, and indicates a limited access to choice in Alabama's labor and delivery methods.

Possible Steps to be Taken

Efforts are being made to improve healthcare in the state. In the spring of 2012 Alabama Medicaid created the Alabama Perinatal Excellence Collaborative (APEC). The mission of APEC is to lower infant mortality and improve maternal and infant health in the state, ultimately to improve pregnancy outcomes. In order to meet this goal the APEC mission will be implemented via "1) Implementation and utilization of evidence-based obstetric care and protocols 2) Assessment of meaningful quality benchmarks 3) Enhanced communication and collaboration with providers, both primary and subspecialty, and patients."[90] However, when looking at the Midwife Model of Care, it becomes obvious that the evidence based care approach is how midwives, whether CPM, DEM, or CNM, are initially trained, and the method used when providing care. The Midwives Model of Care reads:

"The Midwives Model of Care is based on the fact that pregnancy and birth are normal life processes.

The Midwives Model of Care includes:

- Monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle
- Providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support

[90] "Town Hall (Slide Presentation)." *Alabama Perinatal Excellence Collaborative*. http://medicaid.alabama.gov/CONTENT/4.0_Programs/4.4.0_Medical_Services/4.4.7.5_APEC.aspx.

- Minimizing technological interventions
- Identifying and referring women who require obstetrical attention

The application of this woman-centered model of care has been proven to reduce the incidence of birth injury, trauma, and cesarean section."[91]

While adopting such an initiative is a progressive move for the Alabama community, the legalization of CPMs could aid in the long-term goals that APEC seeks to meet. As indicated by the Midwives Model of Care, CPMs are trained in the evidence-based care methods that APEC hopes to add to state OB's skill set. Additionally, by legalizing CPMs at the next opportunity, the number of perinatal care providers already trained in evidence-based care methods immediately increases, allowing greater care access to quality prenatal care for pregnant women. The increase of maternal care providers in Alabama by roughly a dozen. At first glance this appears to be an insignificant increase in the numbers of care providers within the state. However, data reveals that in 2012 there were only 4.83 obstetricians per 10,000 reproductive aged women.[92] While increasing care providers via legalizing midwifery may not cause an immediate substantial impact, it will have a direct and immediate impact in the communities in which these midwives reside.

While there is a serious lack in studies regarding midwives and/or home-birth in the US, studies in Canada and the UK indicate that planned home birth with a qualified care provider, CPM/DEM, for low risk women is safe. Dr. Patricia Janssen, et al.'s paper "Outcomes

[91] "The Midwives Model of Care." *Citizens for Midwifery*. http://cfmidwifery.org/mmoc/define.aspx.
[92] Rayburn, William F. et al, "Distribution of Obstetrician–Gynecologists." VOL. 119, NO. 5, MAY 2012

of Planned Home Birth with Registered Midwife vs Hospital Birth with Midwife or Physician," came to the following conclusion:

> Our study showed that planned home birth attended by a registered midwife was associated with very low and comparable rates of perinatal death and reduced rates of obstetric interventions and adverse maternal outcomes compared with planned hospital birth attended by a midwife or physician. Our population rate of less than 1 perinatal death per 1000 births may serve as a benchmark to other jurisdictions as they evaluate their home-birth programs.[93]

Alabama needs to address the legalization of midwives, critically examining the current data available regarding maternal health in the state. While I do believe that access to out of hospital midwifery care will help lower the state and county cesarean rates, it is only part of the solution. It is due to a statewide suppression of people of color that access to medical care is non-existent. Legally recognizing midwifery while increasing support for birthing women statewide, would not increase for women who find themselves diagnosed or identified with a "high risk" pregnancy for any reason, or in an emergent situation.[94] The women, statistically speaking, both in Alabama and over all in the US, that find themselves diagnosed/identified with a "high risk" pregnancies or increased risk of adverse birth outcomes are predominantly women of color.[95]

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[93] Janssen, Patricia, et al. "Outcomes of Planned Home Birth with Registered Midwife Versus Planned Hospital Birth with Midwife or Physician." Canadian Medical Association Journal, vol. 181 no. 6-7 (2009): 377–383. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2742137/

[94] High risk pregnancies can include, but is not limited to multiples (twins, triplets, etc), hypertension, pre-eclampsia, preterm birth, gestational diabetes, etc., and varies exclusively on the health of the birthing woman. Midwives are always able to transfer care to an OB/GYN if a birthing woman becomes high risk late in pregnancy.

[95] Collins, James W., Kristin M. Rankin, and Richard J. David. 2016. "Paternal Lifelong Socioeconomic Position and Low Birth Weight Rates: Relevance to the African-American Women's Birth Outcome Disadvantage." *Maternal and Child Health Journal*, no. 8: 1759. doi:10.1007/s10995-016-1981-5.
Alio, A.P., Richman, A.R., Clayton, H.B., Jeffers, D.F., Wathington, D.J., and Salihu ,H.M.. 2010. "An Ecological Approach to Understanding Black-White Disparities in Perinatal Mortality." *Maternal & Child Health Journal* 14 (4): 557–66. doi:10.1007/s10995-009-0495-9.

Out of hospital birth midwives could provide prenatal care to women with high risk pregnancies, ultimately transferring these clients to an OB/GYN at the time of birth. However, with the lack of medical infrastructure in Alabama, this does not seem likely in our current moment. Moreover, if it were possible, the average driving distance from a rural county to the nearest hospital remains over an hour. Ultimately it is unlikely that cesarean rates will change, unless the medical infrastructure in our state is improved. This is a scenario that is unlikely to occur, as both labor and delivery units and hospitals continue to close across the state of Alabama.

CHAPTER 3. SWEET HOME-BIRTH, ALABAMA

I met Jane Kate at the first birth I had the privilege of attending. At that time, she was an apprentice midwife, working towards her Certified Professional Midwife (CPM) credential. The birthing parents made a point to introduce me to both the preceptor and apprentice midwives and connect us in order to help me with my research. I stayed connected to both the midwives via social media, and upon returning to Alabama approached them both about working together. While Jane Kate's preceptor was preparing to move out of the country and not able to assist, Jane Kate was willing to chat with me about the possibility of working together.

I met with Jane Kate at her home at the end of summer of 2013 to discuss what working together would look like and answer any questions. We chatted over coffee in her kitchen, while her five kids ranging in age from two to eleven ran back and forth interjecting their own questions. Jane Kate proved to be enthusiastic about my project. Practicing without legal recognition was a risk that she did not take lightly, and she was, and is, supportive of efforts to educate people about midwifery, and the campaigns to legally recognize her credentials within the state. However, she was more concerned about my stamina in regard to attending and observing prenatal appointments and births. Jane Kate lived in a part of the state where she could not cross state lines into a CPM- "friendly" state, and where she was not always guaranteed a backup midwife. Most of the births she attended, she did so on her own, with her clients' consent. Additionally, due to her geographical location, and lack of fellow midwives in the area, Jane Kate had a travel radius of up to three hours in any direction from her home. Geography and lack of backup impacted more than travel. Jane Kate had to limit the number of clients she committed to, and whose estimated due dates were two to three weeks apart. She stressed to me that it is unethical for midwives with lack of access to back-up care, be it other midwives or

OB/GYNs, to take on more clients simply for the sake of income. Her income was complemented by the income from her husband's full-time job. Navigating ethics, both medical and financial, could be difficult, but Jane Kate proved to be savvy in both areas. Jane Kate's travel time did not necessarily translate for me. It was not uncommon that our commutes to clients' homes for a birth would differ by up to two hours. It was clear that if we were going to work together, I needed to have the stamina to endure being on the road for hours in addition to assisting women during hours of labor. I also needed to be comfortable in the birth setting, and that Jane Kate and I needed to be able to quickly read one another and react accordingly if an emergency situation were to arise.

Due to geography and wanting to increase my exposure to differing care styles, I reached out to other midwives in the state. Jane Kate encouraged this and spoke with several midwives on my behalf. A fetal loss during a home-to-hospital transport with a non-nurse midwife in the early 2000s made most non-nurse midwives hesitant to embrace my presence in the birth room. The loss was a result of a prolapsed umbilical cord, which led to the arrest of a non-nurse midwife.[96] Ultimately, I worked only with Jane Kate. The result is a small sample size, but a particularly in-depth study of an out-of-hospital birth midwifery practice. It became apparent as I observed Jane Kate in practice that she is a conservative midwife. While it is clear that she is most comfortable providing care in the home of her clients, she is ready and willing to transport if and when necessary. Jane Kate also refused to take on clients with contraindicating risk factors for home birth. During our time together, Jane Kate only turned away two potential clients at a consultation appointment. As indicated in the remainder of this chapter, Jane Kate planned for every transfer of care, and emergency experience to the best of her ability. Jane Kate was at the

[96] http://america.aljazeera.com/articles/2014/11/9/alabama-midwivesbannedfromathomedeliveries.html

time of the births we attended, and remains today, a conscientious care provider. Reflective after each birth experience, necessary changes were always made to improve the quality of care, or efficiency in handling an emergency situation.

Jane Kate saw clients once a month in the first two trimesters, followed by every other week in the beginning of the third trimester. Weekly appointments began at 36 weeks, once a pregnancy was considered "term." In addition to prenatal appointments, Jane Kate was available to her clients via phone and text message from approximately 8:00 a.m. to 8:00 p.m. At the 36-week mark Jane Kate became available to her clients 24 hours a day. A home visit also happened at 36 weeks, something that Jane Kate thoroughly enjoyed. At this particular visit she found out everything important: where the family wanted to set up the birth pool, where to keep the emergency contact list and telephone, and most importantly the location of the coffee maker.

Up until week 36, all prenatal appointments were typically held in Jane Kate's home office. Office visits always proved to be interesting. If the families had older children, they were encouraged to tag along to appointments with the opportunity to play with Jane Kate's children, and the family's menagerie of pets. Partners' attendance was preferred for any and all appointments. The last summer Jane Kate and I worked together the July and August families got to know one another fairly well, agreeing to group prenatal visits which they took turns hosting. This particular structure was incredibly fun to be a part of as Jane Kate's clients got to know one another, commiserating over pregnancy symptoms, and sharing excitement over the impending arrival of their respective children. Additionally, the structure of group prenatal visits allowed a one-stop shop for questions pertaining to breastfeeding, circumcision, vaccines, what to do with a placenta, delayed cord clamping, etc. Questions for Jane Kate were usually prompted by someone's well intentioned friend or family member sharing a horrifying or traumatic birth

experience. Jane Kate would direct them to their "book," a spiral bound collection of research essays. Supplemental reading on circumcision, bed sharing, and breastfeeding, alongside DVDs about birth, was housed in her own community library, a bookcase in the hall that could be explored while waiting for a one-on-one with Jane Kate. For a short-lived moment, Jane Kate made a secret group on Facebook which served as a space to share digital resources such as Dr. Jack Newman's website,[97] general positive birth affirmations, and opportunities to advocate for Alabama midwives.[98]

Not all of Jane Kate's clients were able or willing to participate in the group prenatal visits. Some clients were simply uncomfortable in a group setting, while others were unwilling to travel. As long as Jane Kate had childcare**,** traveling to see clients was not necessarily a problem. Driving to visit clients in East Central Alabama was particularly enjoyable because of the beautiful Coosa Valley, and the tail end of the greater Appalachian Mountain range. In addition to visually enjoying the drive, if Jane Kate and I drove together our time was spent talking about how we each became interested in midwifery, what was going on in our lives at the time, and what we were seeing with clients. If we weren't able to ride together, we'd try to caravan, making time to stop for food and to chat. The time that Jane Kate and I spent together in this context was particularly important in terms of developing a relationship in which Jane Kate and I could communicate effectively in the birth setting, that I understood everything I was observing, and that I was at most a positive presence and at the least, a presence she could rely on if needed.

Jane Kate and I developed a trusting rapport quickly. This was due to the birth of her youngest child being the first birth I attended alongside her. I attended prenatal appointments

[97] https://ibconline.ca/

[98] The group was short lived simply due to having taken on a significant amount of work as the sole provider of a practice and within that acting as prenatal educator, her own secretary, managing payments etc. in addition to homeschooling all six of her children.

with her, and she would use her own pregnancy as an example in teaching opportunities. I later realized that Jane Kate's own midwife, who had been her preceptor, had a completely different style of care. I quickly learned that Jane Kate was a quiet observer who never strayed far from a laboring mother. Judy, in contrast, spent most of Jane Kate's birth looking on from a chair on the opposite side of the room, fully gloved, but relaxed. I sat in the opposite corner from Judy, with Jane Kate's 3 daughters piled in my lap. They had been told that if they wanted to, they could observe their sibling's birth, and as I had become a somewhat permanent fixture in their home, they were quite content to sit with me. In the middle of watching Jane Kate handle a particularly intense contraction right before she began to push, three-year-old Chrissy looked at me and said, "Mommy's being real loud and scary." We whispered back and forth for a few minutes about why it was scary and why mommy was being so loud. When Jane Kate revealed she had the urge to push, the girls stood up, and watched as Judy moved closer and encouraged Jane Kate's husband to catch their new baby. Gripping the edge of her bed in nothing but a sports bra, Jane Kate gave birth to a girl, caught by her husband. Judy immediately appeared at the edge of the bed, watching as Jane Kate moved onto the bed, and held her daughter for the first time.

While we waited for the arrival of the placenta, the older girls met their sister, and I was given the job of letting the boys know their new sister had arrived. Once back in the birth room I was able to witness the placenta be born. Immediately after, Judy checked Jane Kate for vaginal tearing. She told Jane Kate, "you have no tears—I mean there are a couple of marks, but nothing that warrants the need of stitches. Can I show Emma?" Jane Kate nodded, and Judy pointed out two different spots on Jane Kate's vaginal wall that looked like faint scrapes. "There's no real way to go about repairing those—they'll heal nicely on their own." Judy then recruited me to accompany Jane Kate to the bathroom. "You just might be a bit wobbly, and I want someone to

be able to help steady you. Also, throw a couple drops of peppermint oil into the toilet. It will help you pee," Judy told Jane Kate. Jane Kate rolled her eyes and took the oil, "yeah, yeah… Midwives make the worst clients." More than a couple of drops of peppermint oil went into the toilet and we both gagged, but it had the desired effect. While Jane Kate used the restroom, we could hear Judy teasing the older girls about the placenta, as she inspected it. After Jane Kate finished, and got settled in bed with the new baby, her husband decided it was time for breakfast. As it was about 7:00 a.m**.**, the girls ran to help, taking everyone's orders and waking up their brothers. "Come on Aunt Emma, it's nap time," Judy teased. After a well-earned nap, I was handed a plate of hash browns and observed the well-baby exam. Judy conducted the exam on the bed, in between sips of coffee, while Jane Kate and her husband ate their breakfast.

After the exam and the reassurance that Jane Kate would take it easy, I headed home, anticipating about a three-week break from birth work. Despite having a newborn, Jane Kate kept in contact with me daily after her birth. Ten days after her birth she called me, which only happened if a client was in labor. Her end-of-the-month client had called certain that she in labor. Jane Kate was not convinced, but she packed up her newborn, and we met at the client *'*s home. Jane Kate and I had begun to develop a strong rapport that was strengthened by attending the birth of her daughter. This proved incredibly important, as the birth of her daughter was the smoothest birth we would attend together.

Gloria's Birth Story

The first birth I observed with Jane Kate proved to be a learning experience for me, and a pivotal moment for her as a midwife. The birthing family was one that was not able to attend group prenatal meetings, but with whom we had multiple home visits. The family was particularly active in their local chapter of the Alabama Birth Coalition, and they expressed that

their home birth was as much a political act as it was a deeply held desire. This birth had many in attendance: older siblings, a doula, a birth photographer, Jane Kate, and myself. The doula had previously practiced as a non-nurse midwife overseas with the same credentials as Jane Kate for about twenty-five years. But as she was now in Alabama, Grace worked primarily as a birth educator and doula. Grace insisted that despite her experience and Jane Kate's newness, she would defer to anything that Jane Kate wanted. Grace was there when we arrived, alternating between playing with the older siblings, and checking in on Gloria. I was put in charge of nine-day-old Harmony and Jane Kate took Gloria's vitals.

Still not convinced that she was in labor, Jane Kate agreed to stay for dinner. Afterwards it became clear that Gloria was in labor. Once Jane Kate brought in her bags she instructed everyone to get rest rather than stay up and chat. She and I chatted briefly, and she explained what all she had brought in the oversized bag. The bag had a warming tray (a cutting board with an electric blanket taped to it), charts, blood pressure cuff, stethoscope, and two toiletry bags that held medication, a neonatal stethoscope, a hanging scale to weigh new babies, clamps, forceps, suturing kits, and laid on top of everything was a bright blue ambu bag[99] in the event of neonatal resuscitation. We headed to bed, only to be awakened a couple hours later by Gloria. The older siblings were restless, and her labor had become uncomfortable. Gloria was planning for a water birth, and so the portable, blow up tub was pulled out and set up. However, Joe had not followed Jane Kate's instructions of doing a birth tub set up test run, and we found ourselves unable to fill up the tub with a hose hooked up to the washing machine hook up. I spent the early morning hours taking turns with Grace boiling pots of water and dumping them in the tub. Jane Kate would later tell me that the job of boiling pots of water is a rite of passage in the midwifery

[99] An AMBU Bag (Artificial Manual Breathing Unit) is a manual resuscitation device, within Mary Kate's practice on hand in the event that a newborn or mother needed resuscitation.

world. “It’s where we all start.” Once the tub was filled, Gloria found comfort in the water. I sat with Harmony, tucked away in the corner while Jane Kate monitored Gloria every 15 minutes, and Grace offered comfort measures. Over the next couple of hours, the baby’s heartbeat moved lower and lower down Gloria’s belly, making fantastic labor progress. Twice during taking vitals I saw Jane Kate make a concerned face and look at me. She gently told Gloria in these moments that she could not find a heart rate. Gloria wanted to stay and have her birth at home. Jane Kate deferred to Gloria, as immediately after not being able to find the baby’s heart rate, it suddenly, much to our relief, could be heard. Although she deferred to Gloria, Jane Kate could pull rank as the care provider, and I could tell that after an hour she was feeling uncomfortable. The tub was no longer comfortable, and Jane Kate had Gloria do lunges around the house to continue a progressive labor. Gloria soon said she felt the urge to push, but she also felt a burning pain when she attempted to push. Gloria made her way to the bathroom, moaning, while Jane Kate followed behind, placing a towel over the toilet before Gloria sat.

In my doula workshops and readings we learned that having a mother labor while sitting on the toilet could be helpful, it’s a space that laboring women can be by themselves, it’s quiet, and when women sit on the toilet their hips are offered the chance to relax and open, similar to when one squats. The bathroom is an ideal place for a woman in labor. I stood in the doorframe, and watched as with intense coaching from Jane Kate, Gloria gave birth to a daughter, yelling the whole time. As soon as she announced the birth, I could hear Grace cheering behind me, and see the birth photographer’s flash, which had paused after a stern word from Jane Kate, started going off. Jane Kate walked with Gloria to the bedroom where she planned to conduct the postpartum and newborn exam. Blood ran down Gloria’s leg, and onto the floor. This was not particularly alarming—birth is messy, and everything would be cleaned up as soon as Jane Kate had finished

her exams. As Gloria laid in bed holding her new daughter, Jane Kate started the exams. She became alarmed when she gently tugged on the umbilical cord to assist in the expulsion of the placenta and fresh blood appeared. After what was at most 10 minutes of a consistent trickle of bright red, or "new blood," Jane Kate had Gloria's husband call 911 for an ambulance transport to the hospital. While on the phone, the husband forgot his address, to which Gloria promptly chastised him. With an ambulance on the way Jane Kate sprang into action collecting her tools and bag. I looked at the tub, and Jane Kate said," There's nothing we can do about that."

Grace and the birth photographer organized the older siblings and got them ready to be picked up by relatives, Jane Kate continued to collect her tools, and I met the EMTs at the front door. As a stretcher was rolled back to the bedroom an EMT looked around, saw the birth pool, and asked "Did y'all plan this?" "Did we plan for my wife to start bleeding uncontrollably? NO," Gloria's husband shot back. I looked at Jane Kate, who was watching Gloria intently. Grace had called ahead to Gloria's OB, and let him know that they were on their way to the hospital. Jane Kate told Gloria that we would meet her at the hospital as soon as we were done cleaning up the home. As soon as the ambulance left Jane Kate sat down and nursed her own child. Nancy saw that the older children were sent on to stay with relatives. With a bottle of hydrogen peroxide, a washcloth, and gloves, I began to remove blood from the carpet. Jane Kate stripped the bed of its sheets and started restoring order to the bedroom. When finished with our tasks we stood in front of the birth pool. Jane Kate looked at me. "This is the one thing we are leaving." We drove to the hospital, where it was confirmed that Gloria and her daughter were fine. I sat with Harmony in the waiting area, while Jane Kate visited with Gloria, and her OB/GYN. The OB/GYN was not hostile towards Jane Kate. He made it clear to her that he could tell exactly what happened: the baby was born compound presentation with her elbow, and a "sticky" placenta. He assured her

that she had made the correct decisions, and as a result he was able to repair a significant vaginal tear and expel the placenta. As per hospital policy the baby was taken to the nursery and given the newborn exams that Jane Kate had attempted an hour or so before. The baby was fine, and ultimately was able to room in with Gloria. Jane Kate and I left the hospital in the early evening, after a long chat in the parking lot, where she updated me on the postpartum appointment dates. She gave me a hug, and we both ventured off towards our own homes.

The previous births of Alessandra and Harmony had given me a positive impression of homebirth. The birth of Gloria's third child was everything no one could anticipate. Jane Kate and I spent time going over the birth; was there anything that Jane Kate could have done to change the birthing experience? Ultimately the answer was no. In contrast to the previous home births I had attended we had only one caretaker present, no one was watching older children, and there was tension between the midwife and doula. These factors did not and could not have had any impact on the baby's presentation, the "sticky" placenta, or the need to call for transport. Jane Kate indicated that the only telling moment could be when no heartbeat was detected, and that she explained had more to do with going with her gut than anything else. It became clear that as a young midwife she was finding her footing, and that while her multi-year apprenticeship had prepared her for handling emergency situations, the journey of asserting herself as primary care provider, and the person in charge in the birth room would be on going.

Pamela's Birth Story

Midwifery in Alabama was a fairly isolating experience. Most of my time researching was actually spent driving. Occasionally Jane Kate and I would be able to ride together to a birth, but most of the time this was not possible. One of the rare times we were able to travel together was in March. A young, second-time mother had hired Jane Kate in the middle of her second

trimester, and lucky for us she lived fairly close to Jane Kate. For home visits with this particular mom, I would meet Jane Kate at her own home. We would grab a snack or cup of coffee, load the van, and hit the road. It was in these moments that it became clear how isolating the midwifery experience in Alabama could be. Our drives turned into discussion about previous births, her aspirations for a Master's Degree in Midwifery, and what her own journey to become a midwife included. On the rare opportunity that Jane Kate and I got to drive to a birth together, she would utilize the time to ask me how I thought the birth would go. She would ask "what do we need to be prepared for?" Due to the location of Pamela's home, I was able to meet Jane Kate at her home and ride with her to the birth. On the way, Jane Kate discussed Pamela's medical history and prenatal appointments. "Now, she has already gotten in the tub to help with contractions. I need to be prepared to get her out of the tub and on her hands and knees if necessary. I'm not anticipating any huge issues, but if there's a hard time finding heart tones, or if it seems like she's struggling, she'll need to get out of the tub. I will be very strategic about where I have my baby bag, and emergency kit."

We arrived at the home, and we walked in and Jane Kate assessed the situation. After determining that yes, the mom was in labor, we gathered the birth bags and supplies from the car. Pamela's home was swallowed by the birth pool and oldest child's toys. But she labored contently in the water, eyes closed. Pamela's husband alternated between assisting in labor comfort measures and disappearing for 10 minutes at a time. This birth was a challenge because while Pamela had stopped smoking during her pregnancy, her husband had not, and continued to smoke in the home. There was little ventilation, let alone air movement within the home. However, Pamela and her husband were comfortable, and Jane Kate and I alternated going outside every hour to get fresh air for about 15 minutes. When Pamela indicated that she was

ready to push, Jane Kate was inside, charting. She encouraged Pamela to push, and unlike in previous births, I watched her take heart tones every time Pamela did so. After about 20 minutes or so of pushing we watched as the head of the baby began to crown. However, rather than being born, the baby's head moved slightly back into the vaginal canal. This happened with one more push and Jane Kate grabbed Pamela's arm and said, "We need you on your hands and knees out of the tub. Now." Paul helped Jane Kate, as they lifted Pamela up and out of the tub onto towels onto her hands and knees. "Now PUSH," Jane Kate exclaimed. "Again!" The baby was born, but not breathing.

Paul helped Jane Kate get Pamela into a sitting position, as I brought over the necessary items for neonatal resuscitation. Jane Kate looked at me and said "Call 911 and request transport, hand me that towel." As I called, I watched Jane Kate utilize the neonatal resuscitation education I had learned only a month before. Once I got off the phone, I could hear her muttering "come on baby…. come on baby…. come on…." And then a cough and the baby came around. Pamela held her baby to her chest and Jane Kate took vitals and established that both mom and baby were fine. While Jane Kate cared for them, Paul was so amped up from the birth that his adrenaline took over and he was not able to be calm. I told him to breathe, and reached over, grabbed his hand and placed it on Pamela, "Paul, feel that? That is your wife. She is here and she is ok." Next, I placed his hand on their baby, "Do you feel that? That is your child breathing. Breathe with your child. In, out, in, out…." Paul's breathing began to slow down, and he and Pamela were able to share a calm moment with their child.

Jane Kate hovered nearby, but the chaos and emergency were gone. She nodded at me to reassure that everything was fine. EMS arrived and questioned Jane Kate, Paul, and Pamela as to what happened. As they discussed they left the front door open. A paramedic looked at me, and

said “Ma’am, will you please open the back door? We need to increase air flow and ventilation for the baby.” I gladly opened the back door. A paramedic stood in front of Jane Kate and Pamela and Paul. “Are you a midwife?” He asked Jane Kate point blank. “We’re doulas!” She responded. “We help with labor.” The paramedic did not push for information but helped place Pamela and the baby onto a stretcher to be taken to the local hospital, 20 minutes away. “Because of where we are, it’s better to just let this happen,” Jane Kate later explained to me. “If we were in Birmingham things would be different, but we don’t want to risk interfering with her care.” Paul rode in the ambulance to the hospital. Jane Kate and I once again set to cleaning the birth space and collecting her items. Due to the accessibility granted through mechanisms such as Amazon Prime, anyone could have most of the items in Jane Kate’s birth bag, including a fetal Doppler, an ambu bag, stethoscopes, etc. Additionally, the cultural lack of knowledge about the difference between midwives and doulas was to our advantage at every birth that we needed to transport to the hospital.

As we drove to the hospital, we reviewed the birth. “Everything you said might happen did,” I said to Jane Kate. She shrugged. “It’s still scary. Thank you for talking Paul down. That was helpful.” The more that Jane Kate and I attended births together the clearer it became that the midwifery in Alabama was not only isolating due to geography, but that midwifery was isolating due to the lack of support from her own colleagues. Jane Kate had no on-site back-up or collaborating care providers depending on the birthing place of her client. After Gloria’s birth Jane Kate had made every concerted effort to ensure that an additional midwife was either on site, or within the vicinity of the birth we were hired to attend. Due to Pamela’s geographical location this had not been possible. This proved to be a constant issue for Jane Kate, who made necessary adjustments with each family, so that home and hospital care could be transitioned

smoothly if necessary. However, the unnecessary pressure of being the sole care provider was never entirely lifted in our time together.

Christa's Birth Story

The birth of Christa's daughter ended up being the most dramatic birth I've ever been a part of, as an observer or a doula. We were excited for a low-key birth with a mom who had no prenatal issues. No yeast infections, no protein in her urine, everything for all intents and purposes was perfect, and we anticipated a quiet birth. Christa labored quietly with the help of her husband, and every once in a while, a suggestion from Jane Kate: food, water, labor tea (a concoction of honey, lemon, and water), naps, the labor was incredibly peaceful. However, when Jane Kate encouraged Christa to start pushing, something wasn't quite right. Christa expressed that something wasn't quite right. In an atypical moment, Jane Kate asked permission and gave Christa a vaginal exam. I watched Jane Kate remove her gloved hand, there was a black dot on her glove. Jane Kate wiped her glove on the chucks pad she was kneeling on, re-gloved and asked permission to check Christa again. After Jane Kate's gloved hand yet again revealed a black dot, she looked at Christa and her husband and quietly and calmly stated, "Christa, the baby has flipped on us and is breech. We have the following options, we can stay and attempt a breech delivery, or we can transport. I will do what you decide, but I recommend that we transport in." Christa and her partner, Isaac, did not hesitate, and agreed to transport.

Attempting to keep a sense of calm was difficult as Isaac grabbed the emergency go-to-the-hospital bag, Jane Kate called 911 to acquire an emergency transport, and I gathered our things to prepare for the arrival of EMS. While a first responder team did arrive, an ambulance and full EMS team never did. After about 20 minutes of waiting, the local first responder team arrived with a fire truck, and police car. Christa stood in the foyer, looking at her husband, and

doing her best to keep her baby in. Clutching the side table in the foyer, she followed Jane Kate's instructions on breathing. In between instructions, Jane Kate called 911 again, confirming whether or not an ambulance had been sent. It was clear when the first responder team arrived they did not have a clear grasp of what to do in the current situation. One medic suggested we get Christa on the guest bed, so she could give birth, while another medic's assured us that-an ambulance had been sent, but the closest ambulance dispatch was 40 miles away, so it would be a few minutes. Isaac chatted with the first responders, and he and Christa declined further treatment from the first responders, while Jane Kate confirmed the quickest route to the hospital 15 minutes away. The medic clarified the location of the hospital, and that since they had refused care that they were not able to get a police escort to the hospital. Jane Kate and Christa piled into a car, and Isaac drove. I followed shortly after locking up the house on my way out.

When I arrived at the hospital, I met Jane Kate in the parking lot, resting against the car she had ridden over in, checking in with her own family. As we walked in the hospital, looking for labor and delivery, she took a deep breath and told me about her ride over. "Isaac was going over 80 mph. I had to convince him that the speed he was going was endangering us even more. Oh, and what the medic told us about not getting a police escort. That was wrong. We did get an escort. When we got on the main road a cop pulled up behind us. Isaac wouldn't pull over. At the county line, a cop pulled out in front of us and led us to the hospital. I thought I was gonna be arrested when we got here." When we found labor and delivery in the hospital, Christa was laboring on a hospital bed, and an anesthesiologist was determining whether or not he could administer a spinal block, or if he would have to put Christa under general anesthesia. When the OB/GYN arrived, it was determined, to the frustration of the anesthesiologist, that Christa would be put completely under general anesthesia. Isaac waited outside the operating room door to go

with his daughter to the nursery. The hospital nursery had glass windows, and Jane Kate and I waited anxiously for Isaac to arrive. When Isaac walked into the nursery with his daughter, who was born at 10:30 p.m., we all cried. He sat and rocked his daughter, while a nurse took the baby's vitals.

Jane Kate's youngest daughter was nine months old at this time, and still nursing. This was the first birth that she did not attend a birth with us. Jane Kate began to mention that she needed to express breast milk in order to prevent developing clogged milk ducts. The nursery nurse allowed Jane Kate to utilize a breast pump which gave her some much needed relief. About this time Isaac indicated that his daughter was starting to root on him, expecting to breastfeed. The nurse offered Isaac formula to give his daughter. He hesitated, as he knew Christa planned to exclusively breastfeed their daughter. Jane Kate then offered him the milk she had just pumped, explaining that she did not have a cooler to transport it back to her own daughter, and disclosing that she was not sick or had any communicable diseases. Jane Kate also reassured him that she would not be offended if they did not utilize her milk. Isaac nodded and said that he thought Rebecca would prefer that Faith have milk from Jane Kate. Faith's first meal came from her midwife.

About an hour after Isaac brought Faith into the nursery it was announced that Christa was out of recovery and being wheeled to her room. Jane Kate took the family's things to the room, Isaac stayed with his daughter, and I met Christa in the hallway. She didn't have her glasses, and I told her who I was, and pointed to Isaac and Faith as nurses rolled her past the nursery. Once Christa was in her room, Jane Kate found her glasses, and she was able to see as Isaac and Faith walked in together. Jane Kate and I sat to the side as the new family attempted to take time to regroup from the exciting evening. Nurses came in and out, and the OB/GYN came

in and told Christa that her cesarean was a routine operation with no complications. After the OB/GYN left, Jane Kate helped Christa with breastfeeding, and explained that Faith had had some of her own milk. Christa was very thankful for Jane Kate's kind gesture and stated that the decision to give Faith her milk was the right one. Christa and Faith did not have any breastfeeding issues.

Audre's Birth Story

Audre was by far the healthiest mom we encountered. She and her husband Charlie own a small farm in central Alabama. They eat whatever they grow on their own land, and get eggs, butter, and other items from neighbors and farmers markets where they have booths. Jane Kate and I would walk away from prenatal appointments with bags of vegetables. Additionally, Audre was hands down the funniest mom that I've encountered. Her prenatal appointments were filled with jokes and silliness, and she would push the limits of Southern politeness. While Jane Kate would insist she did not have favorite clients, Audre's appointments were by far the most enjoyable, and we were both looking forward to her birth.

Few people enjoy summer months in the South, but for pregnant women they are a particular nuisance. Hot temperatures and high humidity make it difficult for anyone to remain hydrated to say nothing of pregnant women. The beginning of July and a week within her estimated due date, Audre called to say that her water had broken at about lunch time. Jane Kate and I arrived in time for dinner. Over a dinner of Merrill mushrooms, bagels, and kombucha, I watched as Jane Kate looked from the table to Audre, to the sparse kitchen sink, back to the limited, but delicious, dinner and ask, "so tell me what you've been eating and drinking today. Have you been helping prepare for the market this weekend?" Audre looked a bit sheepish as she explained that she had been working in the vegetables, and that her food and water intake had

been comparatively limited. Jane Kate nodded, and briefly made eye contact with me. A couple of hours later after a walk, an increase in fluids, and monitoring of baby and Audre, we settled in to spend the night. Jane Kate made it clear that while both Audre and baby were fine, a lack of fluid intake could have put stress on Audre's body and caused the amniotic sack to break. Jane Kate shook her head, "ultimately I'm not worried as she's so healthy. But this does put a time limit on us if a contraction pattern doesn't start." I woke up the next morning and was told that while contractions had started, little to no pattern was established. Additionally, Audre was feeling nauseous. All of her and the baby's vital signs were positive, but Jane Kate recommended that they transport. "We're reaching the 24-hour mark of your water being broken with little to no contraction pattern. I think it would be best to go in and receive fluids, and rest. You are still a candidate for a vaginal birth. I think the only real difference will be that it is a hospital birth." Audre and Charlie piled into Jane Kate's car, and I followed them to the hospital, about 30 minutes away. We arrived at the hospital, and I sat with baby Harmony, our ever-present birth companion, in the family waiting room as Jane Kate assisted Audre and Charlie as they checked in and met with their OB. Jane Kate had instructed Audre to request an OB on staff with whom she had previously worked, and with whom she had developed a good rapport. Luckily, he was on call that day and willing to take Audre on as a patient. The OB's assessment of Audre was in line with Jane Kate's, and Audre was given an IV of saline fluids to keep her hydrated.

Jane Kate volleyed back and forth from the waiting room to nurse Harmony and Audre's room to continue to support her and keep her as informed as possible as to what was going on around her. It became my job to insure while Audre was being taken care of by the nurses, that Jane Kate had everything she needed. I became the person who found her a toothbrush, a meal, coffee, etc. It became clear that Jane Kate's priority was taking care of her clients and her child.

Little else mattered in these scenarios, and while that is understandable, it became clear that the quality of care that Jane Kate could provide should not be compromised, and I took actions to prevent any compromising that might have impacted that care. The most heartening part of Audre's birth was the joking that Jane Kate would relay to me. "Emma, listen to what Audre said to this nurse," Jane Kate started each story. Again, even in a supportive environment, Jane Kate encountered isolation.

Audre's baby was born another 24 hours later. With some pharmaceutical intervention after receiving fluids, her body established a consistent contraction pattern and Audre had an uneventful and average labor and vaginal birth for a woman giving birth for the first time. Jane Kate spent three days caring for Audre, both in and out of the hospital. She was the one constant in Audre's care. When Jane Kate and I left Audre's first postpartum visit three days later, we each left with bouquets of garden flowers, a bucket of tomatoes, and a bag of various other vegetables. No amount of protesting could get us out of the gifts. Audre and her husband were elated at the birth of their child and that Jane Kate never left. Upon chatting at her car, Jane Kate looked at me and stated, "Of course I stayed. It's my job, and I take my job seriously."

Midwife Crisis

The lack of legal recognition of out-of-hospital birth midwives in the state of Alabama is not only a denial of women's economic citizenship, but an example of structural violence as it relates to the state's lack of care that it provides to its citizens. To provide the most ethical and quality care, an out-of-hospital-birth midwife ideally works with multiple colleagues such as fellow midwives, midwife assistants, business managers et al. In 2015, The American College of

Obstetricians and Gynecologists (ACOG) released the Obstetric Care Consensus.[100] ACOG concedes that out-of-hospital midwives, designated as Certified Professional Midwives, may be utilized in birth centers, and Level I Basic Care facilities.[101] While this is a fantastic opportunity for women's economic citizenship, and increasing access to maternal healthcare, states must already have the infrastructure of birth centers and hospitals in place to follow through with such a care plan.

The lack of infrastructure in Alabama creates a lack of care for all women, a void which midwives try to fill. However, the lack of infrastructure impacts the midwifery community more than they and their supporters care to admit. Out-of-hospital-birth midwives cannot ethically provide birth care to birthing women when access to basic healthcare is limited. When the average Alabamian drives an hour or more to the hospital the assumed risk of a rural or suburban home birth increases exponentially. The risk is greatly reduced for women in urban settings, however, when a hospital is 20 minutes away. This is clearly mapped in the previous chapter. Through the active repression of out-of-hospital birth midwifery, no solid professional support network was able to form for those midwives who live in the state and practice regardless of legal status. The non-nurse-midwives are spread throughout the state, and that aids in their suppression. Likewise, reaching out to non-nurse-midwives in neighboring states is not always a solution to supplementing that lack of network, as they also risk prosecution if attending births in Alabama.

The conclusion of my own participant observation with a compassionate and quality care provider was incredibly bittersweet. Jane Kate worked hard to provide her clients with woman

[100] Obstetric Care Consensus. https://www.acog.org/Clinical-Guidance-and-Publications/Obstetric-Care-Consensus-Series/Levels-of-Maternal-Care.
[101] Ibid.

centered care informed by the most up-to-date information, built relationships with OB/GYNs who had practiced a client centered approach to care, and ultimately created a community of families who could share experiences and learn from one another. Yet, she could not sustain a single midwife practice which lacked support from other midwives, and whose closest supporter was an OB/GYN located an hour and a half from her home. From our own discussions to and from prenatal appointments and births, I know that Jane Kate also felt frustrated with the Midwifery advocacy groups in the state. I remember her telling me at one point, "We can't say that home-birth is the answer to all women's birth experiences. It's not. It's the midwife's model of care that is the answer. Women and families should all have access to *that*." When a job opportunity presented itself, Jane Kate made the difficult decision to move her family across the country. In the fall of 2015 she began working at a birth center in a western state, where she and her fellow midwives provide home-birth care, birth center care, and are able to exist within the recommended ACOG Obstetric Care recommendations.

CHAPTER 4. STILLBORN POLITICS: NON-NURSE MIDWIFERY'S CURRENT MOMENT IN ALABAMA

Over the last ten years, the midwifery advocacy organizations in Alabama have attempted to pass legislation to legally recognize non-nurse midwives. Some years were more successful than others. In 2014, the natural birth community was thrilled when Governor Robert Bentley said "that he was not opposed to some north Alabama lawmakers' efforts to legalize the practice of [non-nurse] midwifery in Alabama, as long as there are a few rules in place."[102] The greatest political adversary to the non-nurse midwifery movement has been, and continues to be, the Medical Association of the State of Alabama (MASA). MASA regularly speaks out against bills proposed by the Alabama Birth Coalition (ABC) during the legislative session, in public hearings or in written letters to the editor or in public statements.

Despite the constant pushback from MASA, non-nurse midwives and their supporters continue to pursue legalization or decriminalization. There are two non-nurse midwifery advocacy groups in Alabama. The Alabama Birth Coalition (ABC) is a consumer advocacy organization. ABC has two goals: the first, to educate consumers on their choices in childbirth, and second, to raise funds to hire a lobbyist, to find legislative sponsors, and ultimately pass a pro Non-nurse midwifery bill. The second group, the Alabama Midwives Alliance (ALMA), is a group of current and aspiring Non-nurse midwives.[103] ALMA membership includes Non-nurse

[102] The Time Daily, Florence, AL. http://www.timesdaily.com/news/state-capital/article_c8776ab0-7b3f-11e3-9fd5-0019bb30f31a.html, January 11, 2014

[103] As a part of participant observation methodology, I was a dues paying member of ALMA since 2013. I attended tele-con meetings, but remained an active listener, as this is one of the few safe spaces for non-nurse midwives to come together in Alabama. Post fieldwork, at the end of January 2016, I was nominated and elected vice president of ALMA. No one else was nominated for the position. As a result, I ran unopposed and won the position of Vice President. As the participant observation fieldwork for the dissertation was completed, I chose to accept and fulfill the position. However, upon the realization of the legal status, or lack there-of, I have since resigned from this position. My letter of resignation is included in Appendix 4.

midwives in surrounding states that legally recognize Non-nurse midwives who serve Alabama women. ALMA consistently works with ABC to write the year's bill that will be presented to the state legislature.

Since the creation of ABC and ALMA in 2007, and the grass roots organizing that occurred prior to these organizations, pro Non-nurse midwifery legislation has failed to pass in the Alabama Legislature. The failure to successfully pass a bill is most often attributed to MASA and its political capital; to be sure this is a key component. However, I believe that the failure to successfully pass a bill lies within the two advocacy groups, ABC and ALMA. While both groups are working towards admirable goals, they reflect larger issues of disorganization and divided attention within the organizations. The disorganization and divided attention is a direct result of non-nurse midwives being forced to work outside of their scope of practice: organizing, lobbying, writing bills, etc., all things these women were not trained to do. It is important to note that most Non-nurse midwives who are involved in legislative efforts on any level, are doing so alongside maintaining their midwifery practice. In effect Non-nurse midwives are placed between a rock and a hard place: do they practice illegally, risking their well-being, or do they cease to practice, unable to support themselves and any legalization efforts?

In the first half of this chapter I examine the advocacy organizations ABC and ALMA. I explore the problems that arise from utilizing a neoliberal rhetoric within advocacy efforts, and the impact of being forced to work outside one's scope of practice. I will utilize my own field notes, and public record, or lack thereof, to support the argument that these organizations are in fact their own worst enemies. The Non-nurse midwifery criminalization that occurred in 1976, and the continued insistence by MASA to perpetuate misinformation regarding Non-nurse midwives alongside the State of Alabama's refusal to invest in (women's) healthcare, are driving

factors in ABC and ALMA's advocacy and decision making process. However, with the legal status of Non-nurse midwives unlikely to change in the near future, and the general disorganization in the two groups, I suggest that advocacy efforts be focused on supplementary health care groups that include: doula organizations, breastfeeding support groups, birth educators, etc.

In the second-half of this chapter I focus specifically on these supplementary health care groups and how they serve Alabama women. While these groups do not replace the holistic care of midwives, they do enable women to challenge the authoritative knowledge that exists in our current medical system and to seek support for "alternative" care similar to that provided by a midwife. I refer to these groups as supplementary healthcare networks, as they complete or enhance our existing healthcare networks. Such networks allow for the practice of medical pluralism, or the use of both conventional and complementary and alternative medicine. As a result, these networks are more likely to be conscious of intersectionality within their work. In the US complementary and alternative medicine is not widely accepted, and generally anything that deviates from conventional medicine is suspicious, as indicated by the legal status of non-nurse midwives in Alabama. Ultimately focusing advocacy efforts on strengthening the supplementary health care groups, which will result in bridging the mainstream and alternative medical communities, and will, in the long term, build a friendlier atmosphere for non-nurse midwives and create a greater possibility of becoming part of the care provider community in Alabama.

Midwife Crisis: Working Outside Scope of Practice

In 1976, Alabama redefined "midwifery" as "nurse midwifery," and as a result all Non-nurse midwifery has since been criminalized. However, despite the lack of legal recognition,

Non-nurse midwives continued to practice with little if any interference from the state. Despite the criminalization of their profession, Non-nurse midwives practiced without interference until 1992, when a Non-nurse midwife was charged with five class c misdemeanor counts of practicing Nurse Midwifery without a license. The charges were thrown out, and midwives continued to practice, although in dwindling numbers. In 2002 when another Non-nurse midwife was charged and prosecuted on five counts of practicing nurse midwifery without a license.[104] As a result of the trial, two advocacy organizations were formed; The Alabama Birth Coalition (ABC), and the Alabama Midwives Alliance (ALMA). ABC is the consumer advocacy group. ALMA is the Non-nurse midwives professional organization.

With the formation of these groups, particularly ALMA, Non-nurse midwives became, and remain, activists. As activists and advocates, ABC utilizes a consumer choice/neoliberal discourse in order to convince those within the state legislature that midwifery should be legally recognized. Such an approach has yielded successful results in various other states most recently in Virginia, and Indiana. However, when the ABC and its supporters are denied the legal recognition of Non-nurse midwifery care, the group's discourse shifts from that of consumer choice to that of human rights. The sudden shift in discourse begs the questions: is the legal recognition of midwifery then a consumer choice issue or is it a human rights issue?

The human rights discourse allows for intersectionality, in this case as it relates specifically to midwifery advocacy and legalization, to be made visible. The members of ABC are predominantly white middle-class women. The lack of racial and class diversity is strikingly noticeable at public events, particularly legislative hearings, and fundraisers, etc. Yet despite

[104] Appendix 8, no longer available at the ALMA website, http://www.alabamamidwivesalliance.org/,

this lack of racial and class diversity the group regularly holds up African American midwives who once practiced in Alabama as examples of the quality of midwifery care. They routinely cite Margaret Charles Smith's *Listen to Me Good* and Onnie Lee Logan's *MotherWit* for the good care offered by midwives of color. I once commented on the lack of racial diversity at a public event, and the reaction from an ABC member was "we're here and we've been here for 10 years. This movement has always been the white women advocating. Where are they? We're open to everyone."[105] This comment is not only inherently racist, but classist, and anti-gender-inclusive. Thus, the question emerges: who are we advocating midwifery care for? What kind of mother does the ABC want to have access to midwifery care? And is this sentiment reflected in the work of ABC or ALMA or both? ABC and ALMA actively exploit the history of Black non-nurse midwifery in the pursuit of legal recognition, while simultaneously excluding Black women from the opportunity to work with the organizations. In short, ABC and ALMA are working for cisgender, white, middle- and upper-class women, not the Black women whose history they showcase upon convince.

With the current lack of legal status in Alabama, midwives are very much ostracized both by mainstream and medical culture. Upon the creation of a legally hostile environment in 2002, women who had previously or would otherwise choose midwifery care began "to birth unassisted rather than ask their midwife to take such a costly legal risk."[106] Unassisted birth is exactly what it sounds like: birth unassisted by any kind of trained birth attendant be they an OB, a CNM, a CPM, etc. Here we come to the realization that many of the women who are members of the ABC, advocating for the utilization of midwives and evidence-based care practices, are in

[105] Public Event, hosted by ICAN Huntsville, conversation with attendant, December of 2013

[106] Appendix 8. ALMA position paper, no longer available on their website, http://www.alabamamidwivesalliance.org/,

fact taking great medical risk and are not engaging in the evidence-based practices they advocate for. I do not mean that we should cast judgement upon an individual woman's choice of birth attendant, or lack thereof, but rather what can be made of a midwifery advocacy group that inherently does not support the midwives they advocate for?

Due to the lack of legal status of Non-nurse midwives in Alabama, it makes sense that these women act as both midwives and activists. However, this means that in addition to providing prenatal care, catching babies, and providing postpartum care for women and families, midwives must also be accountants, lobbyists, event planners/organizers, public speakers, politicians, etc. In other words**,** to achieve legal recognition, midwives must not only practice illegally, but they must also work outside their scope of practice. To offset Non-nurse midwives practicing outside their scope, ALMA represents itself as a 501c (6), a not-for-profit educational/professional organization for midwives and student/aspiring midwives. ABC is a 501c (4), also a not for profit, but a consumer advocacy organization with the ability to lobby for legislation. There is a Legislative Writing Group that is made up of board members from both ABC and ALMA, and which is responsible for drafting the year's legislation, deciding on non-negotiables for bill amendments (i.e. whether or not Non-nurse midwives should carry malpractice insurance, whether or not Non-nurse midwives can attend Vaginal Births After Cesareans, planned breech births, multiples, or provide abortions), and developing an action plan regarding lobbying and education. However, due to the classification of each organization, it is not the midwives, but the consumers who ultimately control whether or not legal recognition is afforded. To clarify: what is previously stated is what is publicly presented as "the movement for midwifery" in Alabama. Yet, this is not the reality of the "movement for midwifery."

Certificates of formation exist for both ALMA and ABC, and both organizations are listed as "exists" on the Alabama Secretary of State's website. However, if one digs deeper, public record that while ALMA may exist as an organization (a "midwives club," if you will), it no longer exists as a tax-exempt organization. ALMA, which was created in December of 2007, has a Revocation Posting Date of September 11, 2012. An organization's tax-exempt status is automatically revoked for "its failure to file a Form 990-series return or notice for three consecutive years." ALMA was only a tax-exempt entity for two full years. It is possible that ALMA has applied for and been granted reinstatement.[107] ABC has consistently filed its 990-series return since its formation, and all of the basic documentation is available via the IRS. The lack of transparency within ALMA, alongside the organization's inability to file paperwork, results in a Stillborn Politics within midwifery advocacy in Alabama. In effect the non-nurse midwives have prevented themselves from being activists.

To be sure, ALMA is a very small organization, and meeting minutes indicate that the financial holdings of the group have been, and are, fairly small. The issue of losing a tax-exempt status for such a small organization at first glance appears to be of little or no consequence. However, ALMA has been misrepresenting itself to its supporters, consumers, the Alabama Birth Coalition, and most significantly its own membership. In doing so, ALMA members have misrepresented themselves and the organization in fundraising and speaking events. If ALMA were to be audited by the IRS, the governing board would be held responsible, and open to litigation. Due to the organization's small size, and financial holdings, such an audit or litigation

[107] I must note that as a general ALMA member, I was not notified of the organization's lack of tax exempt status until December 6th, 2015, where meeting minutes reveal: "filing 990-n e-Postcards annually in order to maintain good standing EIN status... had not been done for several years..." E-mail correspondence from the ALMA president to the general membership states that she filed a reinstatement application, however, when speaking with an IRS representative, no paperwork was found. ABC has filed it's 990-series return, all of the basic documentation is available via the IRS.

is unlikely, but it is a possibility. The most significant fact remains that for seven of its nine years of existence, ALMA has misrepresented itself to its consumers, fellow midwifery advocates in ABC, and most importantly: its membership at large. Due to the negligence of the ALMA board, it is riskier to be a non-nurse midwife practicing illegally and a member of ALMA, than it is to be non-nurse midwife practicing illegally.

With the current state of ALMA, and an ABC board that does NOT include non-nurse midwives to advise, the likelihood of obtaining legal recognition in the foreseeable future is unlikely. This is extremely unfortunate in a state where access to maternal healthcare is scarce, particularly for women of color. However, the midwifery movement in Alabama is majority white, and there is little if any recognition of privilege, or critical reflection on the impact of whiteness on the midwives' ability to practice illegally. Luckily Alabama women and families are utilizing supplementary healthcare networks that stand in place of midwifery care. These networks include, but are not limited to local chapters of La Leche League, BabyWearing International, International Cesarean Awareness Networks, and doulas and doula co ops/collectives. It is a piecemeal system for sure, which ultimately has many of the same intersectional issues as the midwifery movement and community. Still, while support networks exist for women and families, it does not take away from the irresponsible behavior, and the birth of a stillborn politics where the movement dies and the so-called activists are unable to create effective change for themselves, and the women they claim to serve.

Creating Our Own Care

In the fall of 2013 a doula client, Mary, met with her OB and discussed her reservations regarding undergoing various medical testing while pregnant. She explained to her OB that she would prefer not to undergo testing for gestational diabetes, as the test is at least a three-hour

time commitment and seemed to cause unnecessary stress on both herself and the baby. Mary did express a willingness to participate in alternatives to the tests, such as meeting with a nutritionist, or participating in diet counseling. The OB acknowledged that while such alternatives did exist, the preferred method in Alabama is the "orange drink test," stating that "if only everyone looked and ate like you, Mary, and we lived in someplace like Colorado, the test would be optional." This statement led to a discussion between physician and patient regarding the various testing throughout the pregnancy and birth process. The OB expressed her frustration at the "cohort of educated women, willing to challenge necessary and routine procedures." Ultimately Mary agreed to take the "orange drink test." The OB's assertion, and frustration, that "educated women" are willing to challenge her position of authority as a medical practitioner, reveals that practitioners are not invested in a patient centered approach to care. Practitioners are more invested in maintaining their authoritative knowledge. Anthropologist Brigitte Jordan explains that "frequently, one kind of knowledge gains ascendance. To legitimize one way of knowing as authoritative, devalues, often totally dismisses all other ways of knowing."[108] Most importantly, Jordan articulates that: "*The power of authoritative knowledge is not that it is correct, but that it counts.*"[109] Mary's OB readily admits that meeting with a dietitian or nutrition counseling can achieve the same outcome as the orange drink test, it is the care provider's preference, in this case the OB, that should be respected.

To be fair, Mary's OB has a point; within the grand scheme of life, what long-term harm does a gestational diabetes test cause a healthy pregnant woman and a developing fetus? However, what is concerning is that it is a problem to challenge authoritative knowledge.

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[108] Davis-Floyd, Robbie E. and Carolyn F. Sargent ed. 1997. *Childbirth and Authoritative Knowledge.* Los Angeles: University of California Press. 152

[109] Ibid., 154.

Additionally, when is being educated a negative quality? Mary's willingness and ability to confidently challenge her OB does speak to a certain level of education, and privilege; Mary is a cisgender, straight, white female, with a PhD who works at the local University. Another issue that presents itself in the conversation between Mary and her OB, that is illustrative of many women and their care providers, is that those wielding authoritative knowledge are not necessarily aggressive or openly hostile. As a result, many women, regardless of their educational background are confident in their upcoming birth experience, simply because they appeased their care provider until that moment. Most often those wielding authoritative knowledge, OBs and nurses, are simply matter of fact. Most providers do not become explicitly manipulative or openly hostile until they are challenged within the birthing room. Unlike Mary's OB who voiced a frustration, Caroline, another doula client, experienced out and out hostility from her OB during her labor. Caroline, a first time mother in her late 30s and so labeled a "geriatric pregnancy,' labored with the assistance of an epidural. Her labor lasted beyond 12 hours, and the on call OB noticeably frustrated and impatient, advised a cesarean section. Caroline asked why she should consider a cesarean section as she was continuing to progress, albeit slowly, the baby's heart rate was ideal, and she was maintaining healthy vital signs. The on-call OB declared that Caroline was not progressing fast enough due to her advanced maternal age, and "old uterus." Caroline, a member of the "cohort of educated women" maintained a calm demeanor and continued to question the on-call OB, quoting research from ACOG in her defense. A tense conversation ensued, but the on-call OB finally declared that he would allow her to continue to labor for a few more hours. Authoritative knowledge can appear as frustration as with Mary's OB, or hostility as with Caroline's OB.

Both Mary and Caroline were able to confront and challenge authoritative knowledge in part because of their educational background and white privilege. However, if Mary and Caroline are meeting resistance within the medical system, what of women who are not cisgender**,** straight, white, and highly educated? Where does one go to find support for "alternative," or "holistic" methods? Where does one go to acquire the knowledge to challenge authoritative knowledge? Where does one go where they are guaranteed respect in the labor and birth room? As previously indicated, the non-nurse midwifery community in Alabama is currently in disarray, and not accessible to all. In spite of this disarray, women across the state of Alabama have created a variety of care organizations or networks that aim to hold the place of non-nurse midwifery care until it is legally recognized.

Caroline and Mary both found support via supplementary healthcare networks within their community, which resulted in each woman hiring a doula. Supplementary healthcare networks complete or enhance our existing healthcare networks. Such networks allow for the practice of medical pluralism, or the use of both conventional and complementary and alternative medicine. In the US complementary and alternative medicine is not widely accepted, and generally anything that deviates from conventional medicine is regarded with suspicion. This attitude is heightened in Alabama, thus, we have the previously mentioned OB who is critical of her patients and their resistance to varying medical procedures.

In Alabama there are several groups within the supplementary networks specific to reproductive and maternal health. These networks include local chapters of larger national groups, including La Leche League and BabyWearing International.[110] One local organization of particular importance to maternal health outcomes in Alabama is BirthWell Partners Community

[110] It should be noted that all of these particular networks are independent, privately run, not for profit, organizations which rely on volunteers to function.

doula project. Why are these networks needed? Tuscaloosa County has two hospitals which attend to the reproductive and maternal health needs of not only its own residents, but several surrounding counties including, but not limited to Hale, Greene, Bibb, Perry, Fayette, Lamar, and Pickens. In serving such a large area, the supplementary networks can take some pressure off the conventional medical system, which in the context of western Alabama, is clearly overworked. To be clear, pregnant women in west Alabama recognize the need to utilize those in authoritative positions: OB/GYNs, Nurses, Certified Nurse Midwives, etc. However, with the support of supplementary healthcare networks, women and families are more comfortable in challenging the norms set by the medical authorities, and asserting their own bodily knowledge.

The most accessible supplemental network is found in that of a doula and/or doula organizations. A doula is a pregnancy and labor support person, staying with birthing families throughout active labor and the birth of their child. Doulas make the historical idea of social birth[111] possible in our current moment of high tech, hospital birth; and while doulas work in a variety of birth settings, including home birth and birth centers, they are most often found in the hospital. Certifying organizations, such as Doulas of North America, International (DONA International), have a formal scope of practice which outlines the doulas specific role, and highlights how doula care is intended to complement or supplement the primary care provider.[112] For example, doulas certified, and representative of DONA are limited to only the emotional and physical support of the laboring and birthing mother and family. DONA International includes the following "Limits to Practice," which solidifies doulas as supplementary care providers:

[111] Defined in Chapter 1.

[112] http://www.dona.org/PDF/Standards%20of%20Practice_Birth.pdf

> DONA International Standards and Certification apply to emotional, physical and informational support only. The DONA certified or member doula does not perform clinical or medical tasks, such as taking blood pressure or temperature, fetal heart tone checks, vaginal examinations or postpartum clinical care. The DONA certified or member doula will not diagnose or treat in any modality.[113]

To be clear, doulas are not midwives, but midwives can be doulas. For many, the first step to becoming a midwife, regardless of nurse or non-nurse, is becoming and practicing as a doula.[114] And while doulas have a specific scope of practice, that scope does fall within the larger midwifery model of care by "Providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support."[115] In their literature review of the impact of doulas on birthing women and families, the Cochrane Review finds: "Continuous support during labour has clinically meaningful benefits for women and infants and no known harm. All women should have support throughout labour and birth."[116] Additionally, studies have shown that working with a doula reduces unnecessary intervention, and also reduces the chance of a cesarean section. Parents who utilize doulas are more informed regarding the experience of birth, and the possible interventions that are available to them. Most notable is the observation that:

> Doula practice highlights the changing relationship between healthcare practitioner and patient with regard to informed consent and shared decision making... doula practice demonstrates the critical importance of clear

[113] http://www.dona.org/PDF/Standards%20of%20Practice_Birth.pdf

[114] Most MEAC schools require that incoming students have attended a birth doula training, or be trained as a birth doula. Schools include: Florida School of Traditional Midwifery, Birthwise Midwifery School, Birthingway College of Midwifery, etc. http://meacschools.org/member-school-directory/

[115] Midwifery Model of Care, http://cfmidwifery.org/mmoc/define.aspx

[116] Hodnett ED, Gates S, Hofmeyr GJ, Sakala C. Continuous support for women during childbirth. Cochrane Database of Systematic Reviews 2012, Issue 10. Art. No.: CD003766. DOI: 10.1002/14651858.CD003766.pub4.

> communication and information exchange in order for women to make informed decisions prenatally and in the course of labor.[117]

And yet, while doulas can be a positive force in the labor and birth room, doulas face two significant challenges: gatekeeping which is done via the wielding of authoritative knowledge from the mainstream medical community, and being economically accessible to all women.

BirthWell Partners Community Doula Project

At large, doulas are a privilege utilized by those who can afford their services. In Alabama, doulas serve a population of women that is predominately cisgender, straight, white, educated, and middle/upper class. However, there are several organizations working to make doula services more accessible. There are doula organizations and cooperative's that offer scholarships for women who might not otherwise be able to afford the rising cost of doula care, as well as doula cooperatives that work with specific populations, including but not limited to incarcerated women, women utilizing Medicaid, and women experiencing pregnancy loss. Of particular importance to Alabama is BirthWell Community Doula Project. A not for profit, 501c3 in Birmingham, the organization offers volunteer doula services for women lacking the socioeconomic status to otherwise hire a doula. Eligibility for services is based on whether an applicant is eligible for Medicaid and/or WIC. BirthWell Partners' official mission is: "to improve the health of low-resource mothers and infants in central Alabama by offering free and reduced-cost childbirth education, breastfeeding assistance, and non-medical labor support provided by birth doulas."[118]

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[117] Hodnett, E. D., Gates, S., Hofmeyr, G. J., and Sakala. C. 2012. Continuous support for women during childbirth. Cochrane Database of Systematic Reviews 2012, Issue 10. Art. No.: CD003766. DOI: 10.1002/14651858.CD003766.pub4.

[118] http://www.birthwellpartners.org/programs-and-services/birth-doula-services/

The motivation to start BirthWell Partners came out of volunteering with the ABC and members of ALMA. The cofounders, Dalia and Susan, note that they "went to rallies... [and] we lobbied together."[119] While advocating for non-nurse midwives was an educational experience, the co-founders decided that they wanted to shift their efforts. They started an informal group, Birth Stories & More, in 2008. Birth Stories was, and continues to be, a space for women to share their own birth stories, recommend care providers, and find other support networks such as La Leche League, ICAN, Babywearing International, etc. From there they decided to create a network of doulas and postpartum care support people, including lactation consultants and postpartum doulas, Dalia explains that she and her cofounder Susan, in addition to providing care to women, wanted to "create a doula community." Building off her cofounder, Susan insists on other goals: "Increasing the number of doulas. Increasing access to doulas."[120] In effect, BirthWell Partners is doing two things at once: providing care to women, and providing a supportive network for their statewide community.

By offering care and support to birthing women and care providers, BirthWell Partners is challenging the authoritative knowledge of the larger medical community head on, and their outcomes over the last five years are impressive. BirthWell Partners offers partial and full scholarships to women who wish to become doulas but are in financial need. "The value of this scholarship, covering the cost of training, certification, client assignment and mentoring support is over $1200."[121] According to annual report data, BirthWell Partners has trained 113 doulas, 45 of whom received a scholarship between 2011 and 2015. Being able to provide a scholarship opportunity is key to BirthWell Partners, be it full or partial, because "this approach allows us to

[119] Interview 3:02.
[120] Interview 3:06.
[121] Appendix 5, and BirthWell Partners website

spread our limited scholarship money to as many applicants as possible. As one of our goals is increasing access to doula care, the more scholarships we can provide, the further we go toward meeting that goal."[122] Dalia is a BirthWell Partners doula trainer. The training is intense, several days of labor, birth, and breastfeeding education from 8:30 in the morning to 5:00 in the afternoon.[123] Once training is complete women are informationally equipped to attend births and can begin taking private clients and/or attending volunteer births. Dalia and Susan make an effort to provide mentorship to new doulas, particularly those who are attending volunteer births. Dalia explains, form her own experience why it's so important to mentor and offer support to fellow doulas.

> D: When everyone works well together it's fabulous... It's not that you need a doula if you have a horrible doctor. A doula adds, everyone adds benefit together, and that's the best situation.... But doulas do really need to be trained in how to negotiate that environment when it's hostile. Because sometimes it's hostile. And sometimes there's a hostile person in the room. Or two or three. So, you need to know how to deal with that... [voice changes, and Dalia becomes very quiet] One of the first births I ever went to, I didn't have enough experience, and this mom, she was having a strong urge to push at like 7 cm. And I didn't know enough at that point to help her... And then she got an epidural, and then they had her push, and she couldn't push anymore. And I wanted to ask her to change positions, and her mom said, 'She's done enough already!' And she went in for a c-section. I didn't know what to do with that, I didn't know how to handle it, and the mother was so, she was like 'she's already had a horrible time, she's already worked too hard.' And she has no clue what she has just sent her child to do, right? Like, um... but I didn't know enough. I still always wonder: why was she having such a strong urge to push at 7 and then she had no urge to push and couldn't push afterwards. And you know those first ones, ***they stay with you.*** I'll never forget that woman saying, 'she's done enough already!' She was so mad. And she never let me come do a postpartum. So it was sad. It happens.[124]

[122] Appendix 6, also available on BirthWell Partner Website

[123] Appendix 6

[124] Interview 31:00, my emphasis

Many newly trained doulas often ask if they can shadow more experienced doulas prior to attending their first birth. However, this is not always possible, as it adds an additional person in the birth room, and not all mothers and families wish to increase the number of attendees at their birth. When new doulas have a similar situation to the one mentioned above, they are encouraged to contact Dalia, Susan, or another more experienced doula. At continuing education opportunities it is not unusual to see Susan listening intently to a new doula relate a recent birth experience. Susan has joked more than once, that while Dalia trains the new doulas, her specific role is to "doula the doulas." As a result of the trainings and support, there is a strong network of doulas able to provide care for women in Central Alabama.

BirthWell Partner clients are a diverse group of people. In order to qualify for low or no cost doula services women must qualify for Medicaid and/or WIC. The organization's impact is significant. From June 2014 to June 2015, BirthWell Partners provided prenatal, birth, and postpartum support to 55 women, and 37 women had prenatal and or postpartum support.[125] While not an overwhelmingly large number of women, BirthWell Partners statistics reveal that their clientele is incredibly diverse: 51% of these women are African American, 66% are single, and 7.7% are teen mothers.[126] And when BirthWell Partners compares its data to the local county Medicaid office, it is revealed that women with a doula benefit enormously. For 2014-2015, BirthWell Partners clients had-an average pregnancy length of 39.4 weeks,, baby birth weight averaged at 7 lb. 6.2 oz, only 9% of births were preterm, and 20% of births were cesarean sections. The most recent available data from the local county health department (2013) reveals that women on Medicaid the average pregnancy length is 38 weeks, baby birth weight

[125] Appendix 7, BWP Annual Report 2014/2015, http://www.birthwellpartners.org/wp-content/uploads/2014/07/BWP-Annual-Report-14-15.pdf

[126] Ibid.

averages at 6 lb. 12.2 oz, with a preterm birth rate of 13.4%, and a cesarean section rate of 34.6%.[127] BirthWell Partners' not only directly challenges authoritative knowledge with outstanding results, but it is deliberate in acknowledging intersectionality, and serving their community. Over the five years of BWP's existence volunteers have begun teaching childbirth classes for the expectant mothers who rely on the following organizations: Alethia House,[128] CAS Project Independence,[129] JCCEO Early Head Start,[130] and Tarrant High School.[131]

BirthWell Partners intentionally works to address and reduce the disparities in birth outcomes across race and class in Birmingham, AL. This is in direct contrast to both ABC and ALMA, which are organizations made up of almost exclusively upper middle class, white women for exclusively upper middle class, white women. This is not say that the overall mission of BirthWell Partners, ABC, and ALMA are all that different, but that each group serves a particular community. As Susan notes:

> if CPMs [non-nurse midwives] become legal in AL, they're not going to be serving low income, African American families, because birth workers don't make a very high income. They can't then turn around and volunteer all of their time even with--with their limited income. So somebody needs to serve that population. Um, and that population in Alabama has to go to the hospital so doulas are what can help.[132]

Beyond conducting doula trainings, and informing women of their choices in childbirth, the direct challenge of authoritative knowledge is difficult. Dalia notes that "The service we're providing is very valuable to the people were providing it to. It's just sometimes, it's very hard to

[127] Appendix7 BWP Annual Report 2014/2015, http://www.birthwellpartners.org/wp-content/uploads/2014/07/BWP-Annual-Report-14-15.pdf

[128] https://www.specialkindofcaring.org/services/

[129] http://www.childrensaid.org/what_we_do/programs/project_independence.html

[130] https://www.jcceo.org/early-head-start

[131] http://www.tarrant.k12.al.us/1/Home; a community directly outside of Birmingham, AL, the local high school offers childbirth classes to expectant teenagers

[132] Interview 44:10.

be there [in the hospital]."[133] A few minutes later Dalia expands on why it's difficult to be in the hospital: "more care is better care. But what about good care?"[134] Dalia's question is an important question within the larger context of birth culture. The authoritative institutions that directly impact women's everyday birthing experience, the American College of Obstetricians and Gynecologists, call for routine interventions of a varying degree. In some moments it's simply a glucose test, as with the previously mentioned Mary, but other times, depending on the patient and her care provider, it could be an episiotomy, artificially rupturing membranes, or having a cesarean section. Insuring that a woman is informed of her choices in childbirth and feels confident that she is receiving individualized care is difficult.

Conceiving a New Movement

In the larger context of birth culture in the state of Alabama, doulas have the greatest opportunity to create effective change. They are not burdened by regulation or criminalization and the pressures that come with these burdens, like the non-nurse midwife community. Susan observes:

> ...I think families who are working for change in midwifery are burning out... when you don't have a walk in Birmingham now...I think now we're trying to change the things that we can change, so in the large context of midwifery in the state I think people are changing their focus to what they can do, right now... I'm just seeing, and maybe it's because of where I am, the larger picture of midwifery is falling to the side.[135]

[133] Interview 45:00
[134] Interview 27:29
[135] Interview 34:49

In this particular moment, 2015, although the idea that "midwifery is falling to the side" is not ideal, perhaps that is fine. Doulas are in a particular sweet spot to create effective change as they are not medical professionals, and not subject to regulation at the local, state, or national level. Additionally, and most importantly, doulas are most likely to work and develop relationships with the individuals most likely to have an impact on Alabama birth culture: the hospitals and OB/GYNs and nurses. Dalia notes that even though she no longer works closely with midwifery advocacy: "...We are all working towards the same thing. Trying to raise awareness [about birth options]."[136]

There are organizations throughout the state that are increasing access to informed birth experiences. Doula cooperatives exist throughout the state from Huntsville to Mobile. Of particular note is The East Alabama Birth Village, a cooperative of doulas and birth educators, several of whom were trained by Dalia and Susan through BWP, have started the Alabama Prison Birth Project.[137] The Alabama Prison Birth Project operates in much the same way that BWP does, with volunteer doulas serving women who wish to have the support of a doula. The Alabama Prison Birth Project is new, but is working with the Alabama Department of Corrections, Corizon Health, and the Minnesota Prison Doula Project to insure a successful program.

Supplementary networks such as BirthWell Partners are more impactful than non-nurse midwives in our current moment in Alabama. Simply by being reflexive and recognizing that not all women have the resources to utilize a network of underground midwives, but deserve a positive birth experience, BirthWell Partners has proved its worth. The group is deliberate in its

[136] Interview 34:00

[137] Alabama Birth Prison Project, https://www.prisonbirth.org/

attempts to recognize the intersectionality of its fellow doulas and clients. By encouraging the growth of a doula community additional supplementary groups such as the Prison Birth Project, local chapters of International Cesarean Awareness Network (ICAN), La Leche League, Baby Wearing International (BWI) are strengthened. At this particular moment non-nurse midwives are not in a position to organize or be legally recognized as primary birth attendants. Those that represent ALMA lack the reflexivity to address and be mindful of intersectionality, despite arguing at public bill hearings that lack of access to non-nurse midwives is a human rights violation. Likewise, as Susan mentions, and as is mentioned in previous chapters, most of the non-nurse midwives would not necessarily be addressing the main issue that faces mothers in Alabama: access to quality maternal healthcare. While the inability to access a non-nurse-midwife for a homebirth is frustrating to be sure and prevents non-nurse midwives from pursuing their full economic citizenship, the larger picture should be considered. Supplementary healthcare networks encourage positive change within the current system for both care providers, and birthing families. From what I have learned in my research there would be distinct advantages to eventual legalization of non-nurse midwifery, so that home births could be provided with quality care without fear of reprisals when transports are needed and so that a range of clients can get quality care and have choices. In the meantime, however, and as of the completion of this research in 2016, the piecemeal system that has emerged is proving more effective for addressing not only birth options, but the disparities of birth outcomes across race and class. The piecemeal system overall gives greater access to quality maternal healthcare in the state due to their recognition of the importance of intersectionality, and its impact on one's lived experience in Alabama.

Afterword

In the summer of 2016 Kay Ivey, the current Governor of Alabama signed a bill into law legally recognizing out-of-hospital midwifery in Alabama. Ten years of organizing, lobbying, and advocacy finally came to fruition. However, one of the contingencies of the bill is that a midwifery regulatory board be established prior to non-nurse midwives beginning to practice.[138] Members of the Alabama Birth Coalition are working to have the regulatory board in place and able to issue licenses for midwives before the end of 2018.

While the legal recognition of out-of-hospital birth midwives in Alabama means that women in are one step closer to economic, and thus full, citizenship, it must be remembered that this does not correct the lack of healthcare infrastructure in the state, or the continued structural violence against most of the state's residents. As more midwives move to Alabama some of the structural violence will lessen, as access to midwifery care will increase. However, this does not mean that access to non-nurse midwifery care will increase in areas that are not urban. This also does not mean that nurse or non-nurse midwifery education will be accessible to those who wish to pursue the profession and serve those who most need assistance.[139] Both nurse and non-nurse midwives must meet certain parameters to become a preceptor or be in charge of a student's clinical experience. Ultimately, even with the legal recognition of midwifery in the state of Alabama, the impact of structural violence and the undoing of a community of women of color which has been co-opted by white women still only enables women of a particular race and class to pursue midwifery as a vocation. Ultimately until a network of midwives is in place that

[138] https://www.al.com/news/birmingham/index.ssf/2017/05/bill_to_allow_midwives_to_prac.html

[139] A list of accredited Master's in Midwifery programs can be found here: https://portal.midwife.org/education/accredited-programs

prioritizes reproductive justice,[140] and includes women of color and student midwives (of color), the supplementary healthcare networks of doulas around the state are the most beneficial to Alabama residents and birthing women.

Throughout my research experience it became more and more clear that I would like to be a midwife. As Jane Kate moved out of state to work where midwifery is legally recognized I could not transition into being her assistant or student. Due to the reasons I outline in the final chapter it is not possible to work with the majority of midwives currently residing in the state. However, returning to the local community college and pursuing an RN degree, while subsequently pursuing a Master of Science in Nurse Midwifery through Frontier University is an option. Albeit, I am in a unique position to pursue this vocation, as geographically I reside where I can readily access not only the local community college to pursue an Associate's Degree in Nursing, but I know a nurse midwife willing to be a preceptor. Yet again though, I am a white woman, from a very educated family, who has benefitted from a network of highly educated individuals. I do not encounter structural violence anywhere near my peers and neighbors of color.

I had such a positive experience with Jane Kate, despite the emergent birth scenarios. Before she moved, she shared that she was confident I wouldn't return after Gloria's birth, our first birth together. I was surprised when she shared this with me. I asked her why, and she responded with something that we talked about often: "Look. Every doula I have ever met wants

[140] Jennifer Nelson defines reproductive justice as: "Rather than building a movement around demands for personal reproductive control, reproductive justice activists' inclusive demands foster a coalitional politics across common interests. Maintaining abortion legality, ensuring abortion access, protecting and strengthening women's access to various forms of birth control, educating and protecting women from reproductive abuses and population control, as well as fighting for an environment in which women can bear and raise healthy wanted children are at the center of coalitional struggles of the reproductive justice movement." (*More Than Medicine*, pg 10)

to be a midwife. Then they have to boil water, or clean out the puke bucket, and they're done. Think about Gloria's birth. We had to call EMS, clean up all that blood, and go to the hospital. That was not a home-birth experience anyone wants. I was floored when you kept coming back." Jane Kate often commented that my experience with her differed greatly from her own experience as an apprentice from the simple fact that I saw more transfers, and scarier situations than she did. She also expressed frustration that more than half the births we attended together resulted in a transport for one reason or another. Yet I believe it is the most significant aspect of our time together. Our high number of transports affirms that non-nurse midwives are competent, recognizing when a situation is progressing past their skill level and that they need to seek assistance. Additionally, these births showcased not merely the lack of access to a certain kind of care, but how the lack of healthcare infrastructure impacts maternal healthcare providers as well as birthing families. The participant observation with Jane Kate juxtaposed with my work as a doula gave me considerable exposure to births in Alabama. Supplementary healthcare networks offer some relief to the structural violence that is the lack of infrastructure, but they are by no means a perfect solution. These networks do directly address the crisis of care, and many attempts to address the racial bias within the larger medical system at the local level. However, the supplemental systems cannot address the larger structural crisis that is a lack of infrastructure both within the state's medical system and the state's economy. A huge significance of supplementary healthcare networks is that for many women this is their introduction to the midwifery model of care, and the possibility of pursuing their economic citizenship via the vocation of midwifery.

About six months ago I attended my annual well woman exam at Simon-Williamson Clinic, in Birmingham. I spent the first thirty minutes of my appointment chatting with my nurse

midwife about my mental health, my research, and births we had attended together. I mentioned that I had begun the process of completing prerequisite courses in order to apply to nursing school. “Really?! I’ll put you on our list!” I looked at her, concerned. “We have a list of patients and doulas who are pursuing their RN or PA or CPM. We’re trying to keep up to date on folks that have worked with us, and who are actively invested in the midwifery model of care. I believe you’ll be the ninth person we add to the list.” I was, and am, encouraged by this information. Women are actively working to pursue their economic citizenship via a career of their choice within maternal health. I’m most encouraged that all of these women have expressed a desire to work with this particular practice, which utilizes the midwifery model of care, is a practice made up of women with diverse backgrounds and works with an on-call doula program. The practice actively engages in reproductive justice, identifying and reflecting on the community they serve, encouraging women to make the choices that are best for them.

Pursuing an Associate’s Degree in Nursing (RN), and a Master of Science in Midwifery to become a Certified Nurse Midwife is a concrete way to challenge authoritative knowledge and fulfill my own economic citizenship. The experience of participant observation with Jane Kate was not only an exercise in Anthropological methods, but an opportunity to participate in reproductive justice in real time. Women deserve the opportunity to become midwives, be it an in-hospital or out-of-hospital, and actively participate in intersectional reproductive justice.

APPENDIX 1. GLOSSARY OF TERMS:

Emergent: utilized with Mary Kate in practice to describe a situation that could become, but is not yet an emergency.

Midwife:

The American College of Nurse Midwives defines midwives as "primary health care providers to women throughout the lifespan. This means that midwives perform physical exams, prescribe medications including contraceptive methods, order laboratory tests as needed, provide prenatal care, gynecological care, labor and birth care, as well as health education and counseling to women of all ages.

The International confederation of Midwives utilizes the following definition:

"A midwife is a person who has successfully completed a midwifery education program that is duly recognized in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery.

The midwife is recognized as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of

normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.

The midwife has an important task in health counseling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care.

A midwife may practice in any setting including the home, community, hospitals, clinics or health units. (Adopted June 15, 2011, due for review 2017.)"

A hierarchy of midwives:

Certified Nurse Midwife: "is an individual educated in the two disciplines of nursing and midwifery, who possesses evidence of certification according to the requirements of the American College of Nurse-Midwives."

Certified Midwife: "is an individual educated in the discipline of midwifery, who possesses evidence of certification according to the requirements of the American College of Nurse-Midwives."

Certified Professional Midwife: "is a knowledgeable, skilled and professional independent midwifery practitioner who has met the standards for certification set by the North American Registry of Midwives (NARM) and is qualified to provide the midwifery model of care. The CPM is the only midwifery credential that requires knowledge about and experience in out-of-hospital settings." Currently, only twenty eight of fifty states legally recognize the practice and care of CPMs.

Direct-Entry Midwife: is an independent practitioner educated in the discipline of midwifery through self-study, apprenticeship, a midwifery school, or a college- or university-based program distinct from the discipline of nursing. A direct-entry midwife is trained to provide the Midwives Model of Care to healthy women and newborns throughout the childbearing cycle primarily in out-of-hospital settings.

Traditional midwives: is someone "who—for religious, personal, and philosophical reasons—choose not to become certified or licensed. Typically, they are called traditional or community-based midwives. They believe that they are ultimately accountable to the communities they serve; or that midwifery is a social contract between the midwife and client/patient, and should not be legislated at all; or that women have a right to choose qualified care providers regardless of their legal status." This definition also applies to midwives who are referred to as "lay/granny/Grand" etc.

APPENDIX 2. THE MIDWIVES MODEL OF CARE:

The Midwives Model of Care is based on the fact that pregnancy and birth are normal life processes.

The Midwives Model of Care includes:

- Monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle
- Providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support
- Minimizing technological interventions
- Identifying and referring women who require obstetrical attention

The application of this woman-centered model of care has been proven to reduce the incidence of birth injury, trauma, and cesarean section.

APPENDIX 3. POLICY FOR INCREASED COLLABORATION BETWEEN DIRECT ENTRY MIDWIVES (DEMS) AND OBSTETRICIANS FOR HOME-BIRTH CLIENTS:

Goals

1. To improve communication and collaboration between direct-entry midwives and physicians.
2. To help create a climate of mutual respect and understanding between practitioners of a midwifery and medical models of care.
3. To design and implement protocols to facilitate transports, transfers of care, and co-care consolations between direct-entry midwives and physicians.

Context

- Homebirth is a safe alternative to hospital birth for most women particularly when attended by a skilled, experienced direct-entry midwives with access to physician back -up.
- Research clearly supports homebirth as a viable option for low risk women, though many physicians remain skeptical or explicitly opposed to this option either due to lack of awareness of the literature or because they have been influenced by their own or their colleagues' experiences with transport (i.e., anecdotal data).
- Obstetricians and hospital care represent a "safety net" that often allows for positive outcomes even when a client develops complications.
- Better cooperation between direct-entry midwives and obstetricians will improve outcomes in these complicated situations by facilitating continuity of care through keeping the midwife involved in the care of her client, enhancing communication between providers, and allowing

for interventions available only in the hospital under obstetric or certified nurse midwife (CNM) care.

- Research has identified two areas where morbidity and mortality are increased in a homebirth sample: breech and twins. For example, the Johnson and Davis (2005) study showed a doubling of mortality rate when twins and breeches were included. In addition, given the elevated risk associated with some Vaginal Birth After Cesarean (VBAC) scenarios, postdates beyond 42 weeks, gestational diabetes, pre-eclampsia, and other conditions, homebirth midwives may find themselves in need of a consulting physician.
- In some areas of Oregon, direct-entry midwives, and especially new direct-entry midwives, find access to physician backup difficult or impossible.
- Direct-entry midwives may benefit from a more formalized protocol allowing them access to physician consultation. However, it is clear under Oregon law that direct-entry midwives remain autonomous practitioners and that the ultimate decision to consult or transfer care lies with our birthing families. However, the decision to seek consultation may benefit both families and practitioners when higher risk conditions are present.
- Additionally, following research conducted by the Oregon Health Licensing Agency in 2009 that examined complaints brought against licensed direct-entry midwives (LDMs), complications associated with breech, twins, VBAC, and postdates are overrepresented in the last 15 years of complaints. Hostility between home and hospital providers and a resulting lack of options for the mother and family played a role in most, if not all, of these cases.
- Because no information provided to a client is ever completely value free, there may be some benefit to homebirth clientele to hearing multiple perspectives on risks associated with breech, twins, VBACs, postdates, etc. If mothers still choose to pursue a homebirth after

consulting with a physician for a higher-risk birth, the midwife may be protected from the accusation that true informed consent was not obtained. Accusations against the midwife regarding lack of informed consent also predominate in the complaints filed against direct entry midwives in the last 15 years.

- Physicians may benefit from prenatal consultation with homebirth clients who are higher risk because they have the opportunity to meet the woman and her family prior to a possible intrapartum transport. This will also allow physicians to understand the extent to which homebirth practice is directed by the worldviews of the minority if families who choose an out-of-hospital birth, reducing accusations that midwives misrepresent risks to their clients.
- Acknowledging that smooth articulations between home and hospital providers remain a utopian ideal, we have collaborated on this proposal in an effort to at least begin a dialogue.

Proposal:

We recommend that:

1. Obstetricians acknowledge that there are over 30 studies that now clearly indicate homebirth as a safe and viable option for low-risk women.
2. Direct-Entry midwives acknowledge that their views of hospital and their models of care are disproportionately affected by those clients who have had negative experiences in the hospital and are therefore seeking homebirth care as an alternative. This would entail the acknowledgement that many hospital -based providers are working diligently to humanize birth.
3. Providers already familiar with and supportive of the the larger worldviews that inform the midwifery model of care take responsibility for initiating a cultural shift in the hospital environment that promotes mutual respect between obstetricians and direct-entry midwives.

4. All home and hospital-based providers suspend judgement and stereotypes and work to have a better understanding of the worldviews, cultural values, institutional barriers, and the needs of various patient/client populations that affect the provision of care under each model.
5. Direct-entry midwives and obstetricians acknowledge the choices surrounding place of birth constitute cultural differences. The same respect and cultural sensitivity offered to women with cultural, language, or religious differences should be extended to practitioners and their clients/patients who hold potentially opposing perspectives on childbirth.
6. Direct-entry midwives seek outpatient consultation with an obstetrician of their choice when faced with higher risk circumstances that include, but are not limited to, breech, twins, VBAC, and postdates (remembering that the ultimate decision to consult lies with our birthing families). Direct-entry midwives also require access to collaborating physicians for mundane complications of pregnancy such as bladder infections and resistant yeast infections. We recommend that willing obstetricians work to make prenatal consultation and collaboration more readily available.
7. The goal of consultation will depend on the circumstances, but will in many cases an offer from the obstetrician to transfer care for the birth to a hospital setting. Whenever this occurs, every effort should be made to honor the maternal-midwife connection and to maintain continuity of care (i.e. keeping the midwife involved as a colleague throughout the intrapartum).
8. If the homebirth client accepts the counseling of the physician, the physician's group will become jointly responsible for that client provided she continues within the care plan as outlined together.

9. If the homebirth client does not develop a jointly agreed-on a care plan with the obstetricians, then that obstetrician and group are not responsible for that client if she should require emergent transfer to the hospital during or after birth. Should transport result in this scenario, the patients do not lose any rights to access to care that they would have held before consult, i.e., access to physician on call for the undoctored. Practitioners will work to maintain mutual respect respect and communication even during this potentially contentious scenario.
10. If a transport from home to hospital is required during labor or in the immediate postpartum period for women who have not consulted previously because of their low risk status, the midwife should be able to call the hospital and be told who the physician on call is. Whenever possible, we also recommend that the midwife be given contact information for the on-call doctor so that the reasons for transport can be discussed before the client arrives at the hospital. Further, if the physician and midwife can meet and discuss the reasons for transport in the hall prior to entering the room, an agreed upon plan of action can be offered to the client in a way that communicates midwife and obstruction collaboration rather than opposition. Because transport is almost always difficult for the family, a positive and mutually respectful working relationship between midwife and obstetrician can help to mitigate the stress and disappointment of a transport and increase the likelihood of a positive outcome/birth experience for the family.
11. On a quarterly basis, physicians and midwives meet to discuss transports and transfers of care so that remaining questions or concerns may be addressed openly. This may provide an opportunity for both physicians and midwife to learn about and come to respect alternative viewpoints or approaches. This may also improve collaboration in subsequent cases.

12. Opportunities be made available for physicians to observe home births and for direct entry midwives to observe low-risk hospital deliveries. This may also help to overturn outdated stereotypes of the midwifery and medical models of care, respectively.
13. Finally, a work group be established to continue to dialogue, create and implement an experimental protocol for collaboration across midwifery and medical models of care.

APPENDIX 4. ALMA RESIGNATION LETTER

To the Board Members of the Alabama Midwives Alliance (ALMA),

I am writing to resign from my position as Vice President of the Alabama Midwives Alliance. My resignation is motivated by the lack of opportunity to fulfill my elected role as Vice President, the organization's lack of compliance with their own purpose and goals, and a general lack of transparency within the general membership of the organization, particularly as it relates to ALMA's non profit status.

In the bylaws dated February 28, 2011, the following responsibilities have been outlined for the role of Vice President:

- Assuming the duties of President if she is absent or unavailable to complete her term of office or is removed from office.
- Acting as a liaison to the Alabama Birth Coalition (ABC), Midwives Alliance of North America (MANA), National Association of Certified Professional Midwives (NACPM), and any and all groups interdependent upon our common purpose and intentions.
- Working in cooperation with the President in preparing meeting agendas

Upon taking the role of Vice President in February, I have yet to be formally connected to any of the state or national organizations mentioned above. This lack of connection is particularly troubling within the context of my supposed role as a liaison with the Alabama Birth Coalition (ABC), and it's role of lobbying pro midwifery legislation in our state. Without the introduction to the ABC board members I am unable to fulfill my role as liaison.

It has been made clear since her nomination, that our current president may need extra assistance in fulfilling her role. As a result, and as the bylaws outline above, this is when the Vice President should make herself available, and take on increased responsibilities within the organization. However, upon the nomination of our current president, who ran unopposed, the member at large and founder of the organization, in no doubt a generous act of support, nominated herself as co president with the nominated. She states: “If you gals don't mind, this will be a joint presidency, with me backing up...” While no doubt a supportive and selfless act, and one supported by the nominated and elected president, it is an act in direct opposition to the role of the elected Vice President, and her own role as member at large as outlined in the by laws. As indicated by the By Laws: The Member at Large shall be responsible for:

- Serving as a de-facto member of the Review Board.
- Conducting annual elections for officers each year.

Let me be clear, I am not critiquing the act of support showed by the member at large, but the lack of compliance with the ALMA bylaws. What is the role of Vice President if there is a co presidency with the member at large?

By undermining its own bylaws, ALMA is no longer in compliance with its purpose to “act as a self-governing body for those interested in midwifery.” It is an organization run by a few key members who feel at liberty to override the bylaws. The lack of compliance also actively works against the organization's goals of “facilitating communication with one other.”

In December of 2015 it was brought to the attention of ALMA membership that the organization’s IRS tax information had not been filed. ALMA tele-con meeting minutes from December 6th reveal the first mention of not having filed information, a 990 n e-Postcard, and

that ALMA may have lost its 501c6 tax exempt status. Meeting minutes state that "filing 990-n e-Postcards annually in order to maintain good standing EIN status... had not been done for several years..." There has been no mention of the Revocation Posting Date for the reinstatement of ALMA's tax exempt status. According to the public records certificates of formation, ALMA, was created in December of 2007, and has a tax Revocation Posting Date of September 11, 2012. According to the IRS, an organization's tax exempt status is automatically revoked for "its failure to file a Form 990-series return or notice for three consecutive years." ALMA was only a tax exempt entity for two full years. According to January telecom meetings, ALMA has applied for tax exempt reinstatement.

To be sure, ALMA is a very small organization, and meeting minutes indicate that the financial holdings of the group has been, and are, fairly small. The issue of losing a tax exempt status for such a small organization at first glance appears to be of little or no consequence. However, ALMA has been misrepresenting itself to its supporters, consumers, the Alabama Birth Coalition, and most significantly it's own membership. In doing so, ALMA members have have misrepresented themselves and the organization in fundraising and speaking events. Additionally, no one can claim a tax exempt donation to ALMA, as it does not have tax exempt status. If ALMA were to be audited by the IRS, the governing board would be held responsible, and open to litigation. Due to the organizations small size, and financial holdings, such an audit or litigation is unlikely, but is a possibility. The most significant fact remains that for seven of its nine years of existence, ALMA has misrepresented itself to its consumers, fellow midwifery advocates, and most importantly: its membership at large.

It is due to the lack of transparency within ALMA that I resign as Vice President. There are serious ramifications for misrepresenting tax information, and it is unfair to the membership of ALMA to unknowingly put us at risk.

Sincerely,

Emma Bertolaet

APPENDIX 5. BIRTHWELL PARTNERS DOULA TRAINING SCHOLARSHIP DETAILS

Scholarship Details

The BirthWell Partners FULL scholarship includes:

- A one year DONA membership
- Birth Doula Certification Packet
- Introduction to Childbirth Education for Doulas (8 hours of instruction)
- Birth Doula Workshop (over 18 hours of instruction)
- Breastfeeding Class (3.5 hours of instruction)
- Perinatal Health Advocate Training (3.5 hours of instruction)
- Volunteer Doula Orientation (3 hours of instruction)
- Additional Training on Topics Relevant to Community Doulas (12 hours of instruction)
- Birth Doula Certification Application Fee
- One of the required books for certification
- Mentoring and Support from Experienced Doulas
- Background Screening

Scholarship recipients agree to:

- Submit to background screening
- Attend the Introduction to Childbirth Education for Doulas course
- Attend the Breastfeeding Class
- Attend the Doula Training Workshop
- Attend the Perinatal Health Advocate Training
- Attend the Volunteer Orientation
- Attend supplemental trainings and meetings throughout the 18 month period (at least 4 per year)
- Follow the DONA Code of Ethics and Standards of Practice for Birth Doulas
- Provide birth doula services to BirthWell Partners clients in Birmingham, Anniston or Tuscaloosa, within 18 months of attending the Birth Doula Workshop. (The number of births is dependent on the amount of the scholarship awarded; full scholarship recipients agree to provide services to 6 clients.) Services per doula client include a minimum of 2 prenatal visits, attendance at the birth and 2 postpartum visits.
- Check and respond to messages (email, phone, or text) within a reasonable period of time, and stay in regular communication with program staff
- Complete and submit documentation for each client in a timely manner

- Attempt to follow up with clients by phone at designated intervals for 12 months

If unforeseen circumstances arise and a recipient is unable to completely fulfill this commitment, scholarship recipients agree to repay the cost of their training at a prorated amount based on the number of births attended. The value of this scholarship, covering the cost of training, certification, client assignment and mentoring support is over $1200.

APPENDIX 6. SCHOLARSHIP GUIDELINES FOR APPLICANTS

Applicants for BirthWell Partners' birth doula scholarships must:

- be at least 21 years of age
- live within the greater Birmingham area, Tuscaloosa or Anniston
- have their own transportation
- have a valid driver's license and automobile liability insurance
- have financial need

We Look at a Range of Applicants: We know that some of our applicants will move on to missionary work outside the country, some will use doula training as a stepping stone to midwifery training, some are public health professionals who will use this experience to enhance their careers and create better policies for maternal and child health, some will become professional doulas in affluent communities, and some will become professional doulas and serve mothers in low-income communities.

We Look at a Range of Financial Need: Some applicants will be offered full scholarships and others will be offered partial scholarships, based on their ability to pay some of the training costs.

This approach allows us to spread our limited scholarship money to as many applicants as possible. As one of our goals is increasing access to doula care, the more scholarships we can provide, the further we go toward meeting that goal.

If we offer you a partial scholarship, any money you can pay helps us cover our costs, and you lower the number of births you commit to attending, while still getting all of the benefits of supplemental training and mentoring.

APPENDIX 7. OUTCOME DATA

Outcome Data: Measurable Results

Measure	National (ref)	State of Alabama	Jefferson County (3)	Jefferson County Medicaid	BWP 2011-2016 (n=246)	BWP 2015-2016 (n=48)
C-Section Rate	32.2% (2)	35.4 (1a)	33.4% (3)	31% (3)	31.01%	34.04%
Epidural Rate	62 (4)		84.2% (3)	82.6% (3)	56.27%	59.09%
Average Gestational Age (weeks)			38.4 (3)	38.3 (3)	38.92	39.12%
Average Birth Weight lbs			6.98 (3)	6.77 (3)	6.98	7.23%
PTB <37 wks gestation	9.57 (1a)	11.66 (1a)	10.9% (3)	12.3% (3)	12.84%	8.33%
Low Birth Weight Infants (all ages)	8.0 (1a)	10.1 (1a)	11.3% (3)	14.1% (3)	11.31%	6.82%
Breastfeeding Initiation	79.2 (5)	67.3 (5)			91.70%	93.33%
BF at discharge			68.1 (3)	57.1 (3)	93.83%	88.89%

APPENDIX 8. THE HISTORY AND LEGALITIES OF MIDWIFERY IN ALABAMA

This Position Paper is provided to clarify legal issues surrounding the practice of independent midwives who render care to Alabama families. As efforts are being made to protect and advance independent midwifery as a profession within its own right in our state, it is vital that parents choosing out-of-hospital birth, childbirth advocates, doulas, midwifery students, and practicing midwives understand the political atmosphere in which Alabama midwives practice.

History of Midwifery in Alabama

Historically, "lay" or "granny" midwives in Alabama were predominantly African-American women who served mostly poor populations. Race, segregation, and economics contributed to the development of an inequitable system. Segregated care was an attempt to keep African-Americans and poor Caucasians out of hospitals. Beginning in 1931, Alabama's "lay" midwives became better trained and strictly regulated. A rigorous screening program reduced the number of midwives by half. Those who remained, attended a 9-month training course, passed a written examination, wore white uniforms, submitted to monthly inspections of their equipment bags and homes, and attended monthly meetings run by their local public health nurse. Despite obstacles, these "lay" midwives served indigent mothers with vigilance and skill, quietly rising above their undeserved reputation as "ignorant, filthy and crude."

After World War II, changing American demographics caused by the civil rights movement and population growth gave rise to a health care shortage. The availability of Medicaid reimbursement gave hospitals and doctors a new source of income from a group of women who were traditionally served by "lay" midwives. In 1976, with the passage of Title 34, Chapter 19 of the Code of Alabama, the legislature sought to eradicate "lay" midwives. The purpose of this act was to legislatively redefine midwifery to include only the practice of nurse-midwives. Simultaneously, it placed stringent regulations on the practice of nurse-midwifery, preventing autonomous practice. Currently Alabama CNMs practice in the most restrictive environment in the nation, according to a 2004 Health and Human Services study, while "lay" midwives referenced in the law are unable to obtain permits to practice in out-of-hospital settings.

Independent Midwifery as a Profession in the United States

Meanwhile, Alabama, like the rest of the nation, was experiencing a renaissance of out-of-hospital birth. Mothers were seeking health care alternatives. These mothers were largely Caucasian, middle class and educated. They wanted birth to be safer and more comfortable than what was being offered in hospitals at the time. A Mobile woman was representative of these mothers. Toni Kimpel sought out the care of Onie Lee Logan, a permitted "granny" midwife, for her first pregnancy. As midwives like Onie Lee Logan neared retirement, the clients they had lost to Medicaid-funded hospital births were partially replaced with mothers like Toni Kimpel. After enjoying midwifery care for her birth, Toni Kimpel picked up the torch by becoming a midwife herself.

To meet the renewed demand for midwives and fill the void left by retiring midwives, women around the country began to study pregnancy and childbirth, seeking knowledge and training from a variety of sources. Some women chose to obtain a nursing education and subsequent training in a formal nurse-midwifery program; others elected to pursue midwifery education directly. Some organized themselves into professional groups and formulated standards of practice. The Midwives Alliance of North America (MANA) was founded in 1982, and the North American Registry of Midwives (NARM) in 1987. Some midwives sought to legalize their practice in various states across the nation. Seeing the need for a national standard and a psychometrically sound testing process, NARM created the Certified Professional Midwife (CPM) credential in 1994 and Toni Kimpel became one of Alabama's first Certified Professional Midwives.

A Grim Precedent in Alabama

Under the 1976 law, county health departments were charged with terminating the practice of "lay" midwifery. Their enforcement was inconsistent. While some county health departments actively revoked permits, others allowed existing permits to expire. Still others began referring mothers to midwives who lacked permits, unintentionally endorsing the continued practice of out-of-hospital midwifery. Some midwives tried to apply for permits with their local health departments. They were told the department no longer issued permits, but no official clearly explained the intent of the law. The ambiguities in how the law was enforced and interpreted contributed to a false sense of security for parents and midwives. Independent midwives in the state practiced openly in the 80's and 90's, unaware of the legal implications of the redefinition of midwifery.

In the early 90's, an appeals court ruling set a grim precedent for midwives and the mothers they served. Toni Kimpel was charged with 5 misdemeanor counts of practicing nurse-midwifery without a license. The trial judge threw out the charges on the grounds that the law regarding "lay" midwives was unconstitutionally vague. The state appealed, and the higher court overturned the trial judge's dismissal of the charges, finding further that Toni Kimpel had, in fact, violated the nurse-midwifery statute. Toni Kimpel's appeal to the Alabama Supreme Court was denied. Within a year she moved to Texas, where she is able to practice legally.

By 2002, the number of midwives attending out-of-hospital births had dwindled. A Cullman midwife, Karen Brock, found herself forced to stop attending out-of-hospital births in Alabama when the state prosecuted her for the same charge faced by Toni Kimpel. In an effort to continue serving mothers, she obtained her license in Tennessee. Mothers who had once birthed with Karen Brock in their homes across north Alabama now drove across the state line to birth with a legal midwife. Other families contracted with midwives who supported their choice to birth at home. A few of her previous clients chose to birth unassisted rather than ask their midwife to take such a costly legal risk.

An Unacceptable Reality

Despite efforts by the medical establishment to eliminate or control the practice of midwives, some parents continue to choose midwifery care in an out-of-hospital setting. Parents make this choice based upon their religious, cultural and/or philosophical beliefs. In a country that prides itself upon protecting individual rights, it is unacceptable that women's healthcare alternatives are restricted. Alabama parents have formed a consumer group, the Alabama Birth Coalition (ABC), to advocate for legalization of midwives with the CPM credential, who are trained specifically to meet the needs of families seeking to birth in out-of-hospital settings.

Independent Alabama midwives have formed a professional midwifery organization, the Alabama Midwives Alliance (ALMA), to preserve the art and the craft of midwifery and to act as a self-governing body for those interested in the practice of midwifery. ALMA is proud that our midwives have continued to educate themselves and find ways to serve families who seek out-of-hospital birth, despite legal concerns. Some of our midwives have undertaken the NARM process to validate their education and experiences to obtain the CPM credential. Others have not decided to do so. Some feel there is little reason to justify spending time and resources to obtain their credential when legal recognition is not available to them. ALMA acknowledges that CPMs are independent practitioners who have met the standards of certification set by the North American Registry of Midwives. In addition, ALMA recognizes and supports the skilled and experienced midwives in Alabama who choose not to become certified. ALMA recognizes that ultimately it is the right and the responsibility of parents to educate themselves, to interview prospective maternity caregivers, to choose their birth setting, and to hire the caregiver whom they feel is most appropriate for their individual circumstances.

Since 2007, ALMA has formulated practice guidelines for out-of-hospital midwifery, facilitated ongoing educational opportunities, and provided accountability through regular peer review for practicing midwives. ALMA recognizes the need for independent midwives to be able to serve their local communities without the risk of criminal prosecution. We also support current legislative efforts that would create a state midwifery board to license our members, who possess the CPM credential, to provide primary care for out-of-hospital births.

Choices for Caregivers and Clients

There is no question that parents may legally birth their children in their home in Alabama. However, if an independent midwife attends a family at their birth, she is at risk of being charged with practicing nurse-midwifery without a license due to the judicial precedent that was established in Toni Kimpel's case and reaffirmed against Karen Brock. Conviction carries with it a C-class misdemeanor, including a fine and possible jail time. According to judicial precedent, it does not matter if the midwife is compensated for her services; if she is performing actions that are within the legal scope of nurse-midwifery according to the Code of Alabama, it is possible that she could be prosecuted.

The reality in Alabama is that a midwife is usually only prosecuted if she provides continuity-of-care when a transfer to a hospital is required, or if there is a difficult outcome involving the well-being of mother or infant. Due to medico-legal concerns, it is difficult for most physicians to form collaborative relationships with out-of-hospital care providers. Infrequently, a midwife has been able to secure a positive relationship with a physician within her community. It is because midwives value continuity-of-care that ALMA is actively seeking legalization for midwifery in Alabama.

Each midwife in Alabama must decide the scope of her midwifery practice in light of the current legal situation. Some midwives choose to obtain out-of-state licensure and their clients plan to birth across state lines. Other midwives choose to continue attending births in their communities within Alabama. ALMA respects each midwife's choice while encouraging all midwives to be open and accountable to both the families they serve and to one another.

Because Alabama does not provide licensed caregivers to assist home birth families, our culture does not recognize out-of-hospital birth as a valid choice. Insurance policies refuse to cover unlicensed caregivers, and often will not even pay for licensed caregivers practicing in legal states. Authorities hostile to alternative care often perceive this choice as parental irresponsibility. Many times, hospital staff members are not receptive to home birth transfers and families are treated poorly.

Parents seeking home birth are the only ones who can evaluate their circumstances and choose the best option for the birth of their child. Some feel compelled to travel out-of-state to birth with a licensed midwife. For others, the trek out-of-state may not be practical. Some parents consciously secure the services of an independent midwife and choose to birth in their homes. Still, other families in Alabama find that there are simply no midwives available in their area. A few choose to birth unassisted. Some families who make this choice would prefer to have a midwife in attendance, but after much consideration and research on all legal perspectives, they chose unassisted birth rather than contract with a midwife and place her in legal jeopardy.

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