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“Granny” Midwife to Nurse-Midwife: The Decline of Southern Black Midwifery in the 20th Century*

Sydney Shead

“No new granny midwives are to be certified after April 1, 1978,” Dr. Robert Goldenburg, the Alabama state health director of maternal and child health, proclaimed in the late 20th century.1 Declarations made by Goldenburg and other health professionals officially ended lay midwifery in the South, outlawing the work of many Black midwives, regardless of experience or certification. In the 1900s, the United States experienced a dramatic shift in birthing practices; from slavery to the early 20th century, Black midwives with informal training predominantly delivered babies in both Black and white communities in southern states. Black women working as midwives were trusted to safely support women in childbirth during a time when Black women were given few rights and little respect. However, the public image and general acceptance of these “granny midwives” began to decline at the turn of the 20th century for a variety of reasons that emerged from what historians have termed “the midwife problem.” While the national debate over “the midwife problem” affected midwifery in the South at a slower rate than the rest of the country, it nonetheless set in motion the eventual decline of Black midwifery.

The effects of the “midwife problem” were slower to impact the South because midwives were needed in rural and poor areas. As regulations and attention to midwives increased, southern midwives saw fewer white women but continued to attend to Black women in the earlier decades of the 20th century. However,

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regulation eventually increased to the point where even southern midwives treating Black women were restricted and excluded from the field. By the 1940s, Black midwives, regardless of experience, were required to attend trainings and maintain licensure in order to continue delivering babies, even for Black families. Increased regulation and licensing enforced on midwives resulted in the elimination of “granny” midwives and the creation of the nurse-midwife. The 1970s saw the end of legal midwifery in the United States, with traditional lay midwives no longer being allowed to renew their permits to practice. The shift from traditional lay midwifery to nurse-midwifery eventually led to the exclusion of Black women in a field in which they used to dominate: today, only 6.7% of nurse-midwives are Black.2 Through exploring the history of Black midwifery in the South, it is evident that in the 20th century, Black midwives faced increasing regulation and exclusion due to the professionalization of both white and Black medical communities, racism and sexism within the medical and social spheres, and the creation of the nurse-midwife.

The role of Black women in the field of midwifery and as healers prior to the 20th century has been well documented by historians Deirdre Cooper Owens and Marie Schwartz. Their works are extremely important for providing context surrounding the work of Black women as midwives beginning on slave plantations and for demonstrating the ways in which Black women’s bodies were used to form the field of gynecology. Litoff’s *American Midwives: 1860 to the Present*, along with Thompson’s and Varney’s *A History of Midwifery in the United States*, link the decline of midwifery to the development of germ theory, the perceived safety and prestige of hospital births, and the fear surrounding mortality rates. The unique experiences of Black midwives and the culture of Black midwifery has been explored by historians Gertrude Fraser, Valerie Lee, Ellen Terrell, and Dominique Tobbell. Other works, including those of Jenny Luke

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2 “Certified Nurse Midwife Demographics and Statistics In The US,” ZIPPIA.
and Debra Anne Susie, analyze the role of Black midwives in the South and the specific choices southern states made in regulating midwives. Their works reveal the 20th century demand for midwives in the South due to the lack of physicians available to rural, poor, Black women. There are very few memoirs and oral histories from 20th century Black midwives themselves, but Onnie Lee Logan’s *Motherwit: An Alabama Midwife’s Story*, Margaret Charles Smith’s *Listen to Me Good: The Story of an Alabama Midwife*, and Claudine Curry Smith’s *Memories of a Black Lay Midwife from Northern Neck Virginia* provide insight into the feelings and practices of Black midwives.

While historians have highlighted the important work of Black midwives prior to and during the 20th century, this essay aims to explore the various factors that resulted in the Black, female-dominated field of midwifery becoming one in which Black women are now the minority. The goal of this research is to explore early 20th century concerns about the legitimacy and safety of midwives in comparison to physicians. I will use the fields of ethnic studies and history, along with their associated theories and perspectives, to analyze and emphasize the role that race and shifting cultural norms played in the regulation of Black midwives. I will focus not only on how the white medical community and public treated Black midwives but also how the Black medical community depicted and reformed Black midwifery. I will center the voices of Black individuals in order to create a complete picture of the history of Black midwifery. My work will acknowledge the ways in which Black midwives became marginalized by white and Black physicians, society, and the government. I will examine how the social and cultural standing of Black midwives in the rural South shifted when Black women were pushed out of the field to make room for white, male physicians, and later, white female nurse-midwives.

Black women have been involved in childbirth in America since the 17th century. During slavery, Black women served as
healers in various ways including assisting with childbirth.³ Oftentimes, doctors could not reach plantations in time for births because of the rural nature of the South, leaving the responsibility of delivering babies to enslaved women. In this way, Black female healers exercised a certain level of autonomy on plantations; they could help fellow slaves give birth without oversight from white doctors.⁴ William E. Breckell, a plantation owner in the 19th century, stated that “on plantations, of course it cannot be expected that the physician is to be called in for every case of natural labor,” demonstrating how common it was for women to give birth with the help of a lay midwife rather than a physician.⁵ In many cases, enslaved women acted as “the sole matron, midwife, nurse, physician, surgeon, and servant” on plantations.⁶ Some midwives were permitted to deliver babies on neighboring plantations, traveling to deliver both white and Black babies, demonstrating how midwifery granted enslaved women some mobility and degree of freedom.⁷

Plantation owners also encouraged enslaved women to act as midwives out of financial interest. It was cheaper for plantation owners to use slaves to deliver enslaved babies for free than to hire a white practitioner. A Mississippi slave owner reflected that his “physician’s bill averaged fifty dollars a year” because he sent his sick and pregnant slaves to an enslaved woman instead of employing a physician.⁸ His bill being only $50 annually is impressive considering that his family and a number of enslaved individuals inhabited his plantation. The use of midwives for

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childbirth rather than physicians was a cost-effective choice during this time period.

Former slaves have also discussed the role of Black women as midwives on plantations. While firsthand accounts of Black midwifery before the 20th century are scarce, there are some oral histories of Black women working as midwives during and following slavery. Maria Jackson was born into slavery and lived through the emancipation of slaves in Georgia; when interviewed, she revealed that “I has cotched plenny babies in dis world,” including the children of “the rich, poor, and colored folks to… I has wuked wid dem all,” suggesting that she worked as a midwife for both Black and white women.9 Jennie Gibson divulges that her “grandma was a midwife and doctored all the babies on the place” while enslaved on a plantation in Arkansas.10 Annie Mae Hunt’s grandmother was a midwife in Texas during the 19th century. In her memoir, Hunt states that “every white man or black man born in that country that’s my age, my grandma caught him.”11 Black women dominated childbirth assistance as midwives during slavery as well as in the years following, especially within southern Black communities.

Following slavery, women practicing as midwives in the late 19th century to the mid-20th century in southern states were termed “granny midwives.”12 The term “granny” was used to describe traditional Black midwives specifically. It is worth noting that Black patients used the term “granny” out of respect while the medical elite used it as a derogatory term to degrade Black midwives based on their race. Onnie Lee Logan, an Alabama

9 Maria Jackson, interview by Ed Cune, American Slave Narratives: An Online Anthology, University of Virginia, December 13, 1938.
11 Annie Mae Hunt, I Am Annie Mae: An Extraordinary Black Texas Woman in Her Own Words (University of Texas Press, 1983), 19.
midwife in the 1900s, recalls how her mother and grandmother were called “granny midwives” or “grannies” in the late 1800s-1900s.\(^\text{13}\)

At the turn of the 20th century, physicians began to question the legitimacy of midwifery under the “midwife problem.” One of the contributing factors to the “midwife problem” was the professionalization of the obstetrics field. By the late 19th century, physicians sought to legitimize their profession to increase their salary and prestige. In 1859, the American Medical Association designated practical medicine and obstetrics as one of the four scientific sections of the association.\(^\text{14}\)

The founding of the *American Journal of Obstetrics* in 1868, the American Gynecological Society in 1876\(^\text{15}\), and the American Association of Obstetricians and Gynecologists in 1888\(^\text{16}\) also contributed to the professionalization of the obstetrics field. In 1930, the American Board of Obstetrics and Gynecology was formed “to grant and to insure to physicians, duly licensed by law, certificates or other equivalent recognition of special knowledge of obstetrics and gynecology,” establishing standards for the obstetrics field.\(^\text{17}\)

Despite the legitimization of the field of obstetrics, physicians remained hesitant to specialize in obstetrics because obstetricians were paid and respected less than physicians in other specialties. Obstetricians blamed midwives for the lack of pay and respect they received in the field. Many physicians believed that midwives overcrowded the obstetrics field, reducing the amount physicians could charge for deliveries and creating an oversaturated market. Dr. Joseph B. DeLee wrote in “Progress Toward Ideal Obstetrics” that “as long as the medical profession

\(^\text{17}\) Litoff, *American Midwives*, 72-73.
tolerates that brand of infamy, the midwife, the public will not be brought to realize that… it must pay as well for it as for surgery.”

In this work, he argues that midwives reduce the salary of obstetricians because they provide a cheaper option for patients. Dr. H.J. Garrigues, an obstetrician, stated that there was a “superabundance of medical men” seeking obstetric cases.

Similarly, in 1907, a doctor expressed concern because “it has been estimated that it requires one thousand of the population to insure a physician a decent living, yet in these United States the average is one physician to seven hundred or eight hundred population,” revealing that some physicians believed that there were not enough women requiring obstetricians to keep the profession in demand.

Many doctors accused midwives of taking away potential cases, leaving physicians with few job opportunities. In 1912, physicians Arthur Brewster Emmons and James Lincoln Huntington expressed their concern in “The Midwife: Her Future in the United States” when they wrote that “some 30,000 women have taken enough practice away from the physicians to obtain a livelihood,” accusing midwives of taking away patients and money from obstetricians. These physicians constructed the narrative that midwives were to blame for the perceived lack of patients available for obstetricians. Further, physicians believed that as men, they had a right to patients that female midwives did not. They were specifically concerned with the fact that women were taking away potential patients and money from male physicians.

Obstetricians also worried that midwifery diminished the prestige of obstetrics and that the general public would not respect them because midwives performed similar duties. Dr. B. DeLee

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stated that “the midwife has been a drag on the progress of the science and art of obstetrics… she prevented obstetrics from obtaining any standing at all among the sciences of medicine.”

Here, the physician blames midwives for the public’s lack of respect for obstetricians and the slow progress of the field. He argues that patients are less inclined to respect or hire obstetricians because of the idea that “if an uneducated woman of the lower classes may practice obstetrics… it certainly must require very little knowledge and skill - surely it cannot belong to the science and art of medicine.”

As long as midwives with no formal education nor training continued to safely, and inexpensively, deliver babies, obstetricians could not routinely charge as much nor expect the majority of patients to choose them over midwives. As a result of these fears, physicians sought to improve their own status by convincing the public that they were superior and safer than midwives, emphasizing the ways in which they were more qualified. They highlighted hygiene practices and mortality rates as areas of concern. In the 1880s, Louis Pasteur discovered that women in labor were more susceptible to virulent bacterial infection, including puerperal fever. Based on Pasteur’s research in microbiology, Joseph Lister successfully figured out how to use carbolic acid as an antiseptic, reducing mortality from surgery and childbirth. The rise of Germ Theory, the belief that certain diseases are caused by microorganisms too small to be seen with the naked eye, and the use of antiseptics to sterilize equipment and wounds shaped how doctors approached childbirth. During the 1930s, the discovery of sulfa and penicillin provided treatments for infections developed during childbirth. The reformed hygiene practices of physicians contributed to the professionalization of the obstetrics

22 Lee, “Progress Toward Ideal Obstetrics,” 114-123.
23 Ibid.
25 Ibid., 127.
field as doctors adopted standard aseptic and antiseptic practices for childbirth.

At the root of many arguments made by physicians against “granny” midwives was racism against Black women. While midwifery was being questioned nationally, the medical community specifically targeted Black midwives for their race. Racism informed physicians’ assertions about the lack of hygiene and intelligence that midwives possessed. Dr. O.R. Thompson of Macon, Georgia wrote in “Midwife Problem” that southern midwives were more difficult to train than northern midwives because they were “primarily ‘ignorant’ and ‘superstitious’ Negroes.”

His sentiments expose how racial prejudice contributed to his negative perception of Black midwives. Dr. Hardin stated that “typical of the midwife of the rural south. She is far below the European midwife in intelligence and no training under the sun could make her a competent obstetric.”

He implies that there is a difference in ability between white, European midwives, and Black, southern midwives, linking race and intelligence. In “The Development of Midwifery in Mississippi,” Dr. Felix J. Underwood, director of the Bureau of Child Hygiene for Mississippi, wrote:

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 an accoucheur, filthy and ignorant, and not far removed from the jungles of Africa, laden with its atmosphere of weird superstition and voodooism.

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He stated in the same article that “4,209 midwives were actively engaged in the work, that 97 percent were of African descent, all of them untrained, unlettered, and fettered by the grossest superstition, without any idea of what constitutes physical cleanliness.” Dr. Henry Borst published an article in *The Pensacola Journal* in which he recommended that Florida “handle the Ignorant negro midwife question in a sensible manner, by requiring them to go through hospital training before being allowed to do ‘granny’ malpractice.” Here, he suggests that Black midwives are ignorant because of their race and that traditional Black midwifery is illegitimate.

Logan recalls her experiences with racism as a midwife when a doctor told her “you uncompetent nigra woman. You don’t know what you’re doin. If you want to deliver any mo’ babies go back to Africa where you come from.” The physician refers to Logan as a “nigra woman,” explicitly using racist language to criticize her. When he tells her to return to Africa, he makes it clear that he disapproves of her because she is Black, not solely because she is a midwife. Paul Coughlin, surgeon and director of the Leon County Health Department, suggested that the medical profession should have “respect for the ‘Grannys’ but caution not to be contaminated by them.” By using the term “contaminated,” Coughlin implies that he believes that by interacting with Black women, white doctors can be tainted. He also suggests that Black midwives are dirty and untrained and that physicians should not attempt to learn from the midwife or engage with her in collaborative work. The racism and sexism present in the obstetrics field cannot be ignored when discussing the “midwife problem” because it largely rested

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29 Ibid.
31 Logan, *Motherwit*, 166.
upon arguments made against the southern, typically Black, female midwife.

Racism also motivated physicians to accuse “granny” midwives of being responsible for deaths during childbirth. Published mortality rates placed an emphasis on the safety of women and children during childbirth. In 1917, the federal Children’s Bureau published the *Maternal Mortality from All Conditions Connected with Childbirth*, which stated that “in 1913, at least 15,000 women, it is estimated, died from conditions caused by childbirth; about 7,000 of these died from childbed fever… remaining 8,000 from diseases now known to be to a great extent preventable or curable.”

In this publication, the Children’s Bureau expresses concern over the United States childbirth mortality rate and the idea that many of these deaths are, in their opinion, preventable. In “The Midwife Problem,” physician E.R. Hardin wrote that midwives are “ignorant, untrained, incompetent women, and some of the results of their incompetence are unnecessary deaths and blindness of infants, avoidable invalidism, suffering and death of mothers.”

Carolyn Conant Van Blarcom, a nurse and midwife who graduated from Johns Hopkins University in 1901, stated that “it is due in great measure to the ignorance and neglect on the part of midwives that many babies become blind from what is commonly known as babies’ sore eyes.” Obstetricians cited their standardized hygiene practices as evidence that hiring a physician was safer and used perceived high maternal and infant mortality rates to condemn midwives as dangerous and unhygienic.

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Organizations such as the American Association for the Study and Prevention of Infant Mortality (AASPIM) also analyzed the infant mortality rate in the United States and were concerned by the idea that midwives played a role in causing infant and maternal deaths. In 1912, the AASPIM conducted numerous investigations and debated the role of the midwife, contributing to the belief that midwives increased the maternal and infant mortality rate. The organization did not investigate the role of physicians in these mortality rates, suggesting that midwives were the sole cause of high mortality rates during childbirth.\(^{36}\) The work of these organizations demonstrates how the midwife problem spanned beyond the medical community; governmental organizations and the general public were involved in questioning the competency of midwives in childbirth in the 20th century.

While physicians and organizations blamed midwifery for high mortality rates, there was no evidence to support the idea that maternal and infant deaths were due primarily to the work of midwives. In fact, several studies, mainly conducted by public health professionals concerned with discovering the true causes of the high mortality rates, show that the mortality rates of mothers and newborns did not decrease when physicians assisted with childbirth. The 1930 White House Conference on Child Health and Protection published two volumes investigating maternal and infant health care and found that “the midwife was not the determining factor in the high maternal mortality of any particular area in the United States.”\(^{37}\) The Committee on the Costs of Medical Care disclosed “that untrained midwives approach, and trained midwives surpass, the record [of successful births] of physicians in normal deliveries,” arguing that midwives delivered healthy babies at similar rates as physicians.\(^{38}\) Studies conducted in the 1930s found that “uneducated midwives of New York had


\(^{38}\) Ibid., 110.
septicemia rates no worse than those of doctors in home and hospital deliveries”\textsuperscript{39} and that “maternal mortality had not declined between 1915 and 1930 despite the increase in hospital delivery.”\textsuperscript{40} A graph mapping puerperal fever deaths as percent of total maternal mortality demonstrates that mortality rates did not decline during the 1920s, even though hospital births increased.\textsuperscript{41} In conclusion, while physicians blamed midwives for the high maternal and infant mortality rates, physicians were no more effective than their midwife counterparts at decreasing these rates. In some cases, it was even found that midwife-attended births had a lower rate of maternal and infant mortality. Julius Levy published an article titled “Maternal Mortality and Mortality in the First Month of Life in Relation to Attendant at Birth” in which he reported that midwifery and mortality rates were inversely related. In Newark, New Jersey, “the percentage [of midwives] has decreased from 48 in 1917 to 38 in 1921, while in the same five year period the maternal mortality has risen from 4.1 to 6.5.”\textsuperscript{42} In Pittsburgh, the percentage of cases delivered by midwives increased from 1920 to 1921 while the maternal mortality rates decreased from 10.0 to 7.6; in Cleveland, cases attended by midwives decreased from 28% to 25% while maternal mortality increased from 5.9 to 6.9.\textsuperscript{43} Levy also reported that “the lowest maternal mortality rate is in the city with the highest percentage of births delivered by midwives... the highest maternal mortality rate is in the city with the second lowest percentage of births attended by midwives,” suggesting a connection between midwives and lower maternal mortality rates.\textsuperscript{44}

\textsuperscript{39} Wertz, \textit{Lying-in}, 127.  
\textsuperscript{40} Ibid., 161.  
\textsuperscript{43} Ibid.  
\textsuperscript{44} Ibid.
In 1933, New York Academy of Medicine’s Committee on Public Health Relations estimated that physicians were present for 61.1% of preventable deaths while midwives attended only 2.2% of these deaths; additionally, midwives had the lowest maternal death rate of any birth attendant at a rate of 1.4% compared to 5.4% for physicians and 9.9% for surgeons. One physician found that “statistics show that 26% to 31% of maternal deaths from puerperal sepsis were attended by midwives; 59% to 71% were attended by physicians” and a Philadelphia doctor observed that “our statistics in Philadelphia show that patients are as well off, if not better, in the hands of our midwives than they are in the hands of doctors,” revealing how in some cities, mortality rates were actually higher among physician attended births. In 1933, it was found that “the number of infant deaths from birth injuries had actually increased by 40 to 50 percent from 1915 to 1929,” correlating with an increase in hospital-based and physician attended births.

Not only were midwives not solely responsible for the high mortality rates, but in some cases, they were found safer than physicians, suggesting that these rates were being unfairly attributed to the work of midwives to deflect blame from physicians. Doctors worked to establish the image that midwives were unhygienic, unsafe, and more likely to cause complications or death during childbirth. Evidence supporting the safety and competence of Black midwifery suggests that physicians looked for statistics to support their arguments against midwifery and demonstrates that the fear concerning midwifery was based largely on myths about midwives. The way in which physicians attacked

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Black midwives for being unhygienic, dangerous, and incompetent was rooted in racism and contributed to the marginalization of Black midwives.

The choice of physicians to blame “granny” midwives for mortality rates and accuse them of being unhygienic and dangerous spread from the medical community to the general public. Negative stories about midwives spread through newspapers, reaching a wider audience than the anti-midwife sentiments expressed in medical journals. *The Prescott Daily News* published a story in 1911 titled “Coroner to Investigate Cause of Demise of Mother Following Visit of Midwife,” in which a midwife is blamed for causing the death of patient Julia Muhr during childbirth.\(^{49}\) The fact that this story was reported in a newspaper suggests that the public, outside of the medical community, was beginning to question the competence of midwives. A *Society and Home Topics for Women* article titled the “Midwife Should Be Eliminated” stated that “the midwife should be eliminated and her work should be taken over by physicians and nurses… the speaker blamed the public for the midwife's existence.”\(^{50}\) This article reveals that anti-midwife sentiments appeared in newspapers geared towards middle to upper class white women. The author emphasizes the power that women have to end the practice of midwifery by employing a doctor instead of a midwife. In an article titled “Health and Wealth,” the author stated that “one in every 29 deaths among white women between 10 and 20 were due to puerperal septicemia, or childbed fever, in Georgia last year. The filthy midwife or a dirty nurse is to blame for a majority of these deaths.”\(^{51}\) Similarly, *The Atlanta Georgian And News* stated that “in the United States in 1910 there were 154,373 babies who


died before they were one year old... 50 percent of all the births are attended by a class of untaught and untrained women, who, as a rule, are densely ignorant and unspeakably dirty,” implying that the unhygienic nature of midwives results in higher rates of infant mortality.\textsuperscript{52} The fact that newspaper articles criticized midwives and pushed for their elimination suggests that the “midwife problem” had become a public discussion rather than one existing solely in the medical community.

The public perception of “granny” midwives within white communities shifted as a result of biased, racist, sexist ideology expressed by physicians against midwives and later, anti-midwife sentiments found in local newspapers. The use of midwives declined among many southern white, well-off families as a result of racist ideology and the belief that white physicians were superior, safer, and of higher status than Black midwives. These families began to believe that midwives were dirty, untrained, and for the lower classes. Logan remembers how “my patients have come and told me what the doctors said. Said we didn’t know what we was doin. We was black. We was ignorant. Because we’re black we’re ignorant,” revealing not only the racism of the white medical community but how these sentiments reached patients.\textsuperscript{53}

In 1925, a survey was conducted across different counties in Texas to examine how many births were being attended by midwives. The study shows that the rate of midwifery among white families had declined by the mid-1920s, with Black midwives in Smith County, Texas delivering 31 white babies and 276 Black babies. In Cameron County, Black midwives attended 28 white births opposed to 198 Black births, and in Bastrop County, midwives delivered 53 white babies and 213 Black babies, demonstrating a dramatic difference in the use of midwives among

\textsuperscript{52} “Importance of Midwife,” \textit{Atlanta Georgian}, 30 September 1912, \textit{Chronicling America: Historic American Newspapers}, Lib. of Congress.

\textsuperscript{53} Logan, \textit{Motherwit}, 167.
white and Black southern families. The survey also reveals that many white patients hired doctors because they believed them to be safer than midwives. When asked why she chose a doctor to attend her birth, one woman stated that “I was young and wanted best care” while another woman said that “lives safer in hands of doctor,” suggesting that it had become a common belief that doctors were superior to, and safer than, midwives. Another woman surveyed said that she chose a doctor because “I know midwives are uneducated and dangerous,” revealing how the arguments made by the white medical community negatively affected how patients saw midwives.

Fears over the safety and hygiene practices of midwives combined with racist and sexist beliefs about Black women called the practice of midwifery into question. Physicians were seen as more qualified, safer, and superior because of required training, standard hygiene practices, and status. Middle to upper class white families began to choose physicians as birth attendants over midwives, and hospital births increased in the early 20th century. However, it is important to note that white patients’ preference for obstetricians over midwives was not mirrored amongst Black families. One Black woman surveyed said that she “had to have midwife. All we colored folks need,” while another said “Mother is a granny that’s why I like grannies,” demonstrating the continued use of midwives within southern Black families in the mid-1920s. The Texas survey reveals that Black midwives continued to practice care in the South during the 1920s, but mainly for Black families. The white community had begun to view Black midwives as inferior to, and less safe than, white physicians.

Black midwifery was accepted among Black families in the South even following the arguments made against “granny” midwives. During the initial debates surrounding midwifery in the early 20th century, midwives and physicians attended about an

55 Ibid.
equal number of births, demonstrating that midwives were still used widely by women of all races.\textsuperscript{56} In 1918, 87.9 percent of all Black births in Mississippi were still attended by midwives\textsuperscript{57} and as late as 1940, while the widespread use of midwives had declined, the Children's Bureau published that “midwives attend more than two-thirds of the negro births in Mississippi, South Carolina, Arkansas, Georgia, Florida, Alabama, and Louisiana. They attend from one-third to two-thirds of Negro births in North Carolina, Virginia, Delaware, Texas, and Oklahoma.”\textsuperscript{58} It is evident that midwifery thrived in the South well into the 20th century, specifically among Black communities.

Black midwifery survived in the South for a variety of reasons. Southern physicians usually lived in towns and cities, far from many rural families. Margaret Smith, a Black midwife in the 1940s, stated that “poor rural counties with large black populations typically had few physicians,” including where she lived in Green County, Alabama.\textsuperscript{59} In contrast, midwives were more prominent throughout rural areas; in rural Mississippi, “no family lived more than 2 or 3 miles” from a midwife.\textsuperscript{60} For many poor women, it was financially impossible to afford a physician, especially if they lived in a rural area. In 1916 rural Mississippi, fees for midwives ranged from $5 to $10 while physicians charged anywhere from $10 to $15 plus additional travel fees.\textsuperscript{61} In many cases, midwives accepted informal payments for their labor such as “chickens, pigs, grain, or a neighborly give-and-take-basis,” making midwives much more affordable than physicians.\textsuperscript{62} Logan writes that her

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\textsuperscript{57} Helen M. Dart, \textit{Maternity and Child Care in Selected Rural Areas of Mississippi}, United States Department of Labor, Children’s Bureau Publication, No. 88 (Washington, D.C., 1921), 27.

\textsuperscript{58} Thompson, \textit{A History of Midwifery in the United States}, 10.

\textsuperscript{59} Smith, \textit{Listen to Me Good}, 85.

\textsuperscript{60} Dart, \textit{Maternity and Child Care in Selected Rural Areas of Mississippi}, 27.

\textsuperscript{61} Litoff, \textit{American Midwives}, 28.

\textsuperscript{62} Ibid.
\end{footnotesize}
mother was rarely paid for her work as a midwife, and when she was, it was in the form of “co’n, chicken, greens.” Smith remembers that there were many times when “Mama ain’t never paid me, Daddy ain’t never paid me” after her work as a midwife for families. Claudine Smith, a midwife in Virginia in the mid-1900s, explains “I didn’t keep a billing system… most of them that did owe they would kind of stop by,” again demonstrating the ways in which midwives served poor, Black women in the South.

“Grannies” were not only cheaper than physicians, but performed more services for pregnant women as well. Black midwives often cared for mothers and newborn babies, cleaned houses, prepared meals, and looked after other children in the family in addition to delivering babies. Logan recalls that her mother and grandmother did more than deliver babies; “they do the cookin and the washin” as well. Black women also preferred to employ Black midwives rather than white doctors because of the racism they experienced from white physicians. Before desegregation, many doctors refused to deliver babies for Black women, leaving these women with few birthing options. Professor Valerie Lee writes that while hospitals became desirable birthing locations for wealthier white women in the 20th century, Black women were placed in basement wards or segregated wings with inferior treatment. Logan writes that “black people would always prefer a midwife… black people was afraid of white doctors…they knew how they was gonna be treated…like they wasn’t a human bein.”

63 Logan, Motherwit, 52.
64 Smith, Listen to Me Good, 76.
66 Litoff, American Midwives, 28.
67 Logan, Motherwit, 52.
68 Smith, Listen to Me Good, 88.
70 Logan, Motherwit, 52.
women chose to employ midwives in order to avoid the racism they experienced from white doctors and the healthcare system. As midwives, Black women had the unique power to positively impact the treatment of Black women during childbirth and shield them from the racism present in healthcare. For Black women in the South, calling a midwife was safer, cheaper, and more comfortable than being faced with racism and expensive fees at the hands of white doctors during childbirth.

However, changes in the Black medical community during the 1930s-1940s resulted in Black physicians echoing the arguments made against “granny” midwives by the white medical community. As Black medical professionals sought respect and validation, they sided with the white medical community over the “midwife problem,” criticizing “granny” midwives so that the Black medical community would gain approval from white society. While previous arguments made by white physicians did not largely affect how Black patients saw midwives, the criticism of “granny” midwives by Black physicians decreased the Black community’s support of midwives. Black physicians played an important role in the eventual diminishment of Black midwifery within Black communities by shunning them from the medical field. In order to understand the motivation of Black physicians to attack “granny” midwives, it is imperative to recognize the unique struggles of Black doctors in the preceding decades.

Black physicians struggled to establish legitimate careers in the 19th and 20th centuries. In order to practice in hospitals, doctors had to be members of the American Medical Association (AMA), an organization founded in 1847 to establish standards for medical education. Membership decisions were left up to local chapters, and many southern chapters rejected Black doctors, preventing them from practicing in the field. Black physicians also struggled to establish practices because patients saw white physicians as more professional, choosing to employ white doctors instead. Additionally, many Black patients were unable to pay for doctor visits, leaving Black physicians with few patients.
doctors also often struggled to obtain office spaces due to racism, poverty, segregation, and debt.\textsuperscript{71}

In response to this discrimination, Black doctors founded the National Medical Association (NMA) in 1895 and some Black physicians, including surgeon Daniel Hale Williams, opened hospitals in their own homes.\textsuperscript{72} Unfortunately for Black physicians, the Flexner Report was issued in 1910. This report imposed new standards on medical colleges that the majority of Black medical schools could not meet. For example, the report required all medical schools to be affiliated with both a university and a hospital, have adequate clinical training, and retain full time faculty. These new standards resulted in the closure of at least four Black medical schools, reducing the number of Black doctors in the early 20th century. In 1900, only 1.3\% of doctors in the U.S were Black.\textsuperscript{73}

In the 1940s, southern medical schools began to desegregate, opening up new opportunities for Black physicians. The desire to be accepted by the white medical community influenced the way Black physicians viewed the “midwife problem.” Black doctors knew that in order to establish themselves as respected practitioners in the eyes of the white community, they needed to adhere to the medical beliefs of white physicians. One Black physician who spoke about the role of midwives was John A. Kenney Sr., a Black surgeon who served as the medical director of the John A. Andrew Memorial Hospital at the Tuskegee Institute in Alabama. He agreed with many white physicians about the fact that midwives were often the cause of high mortality rates and birth complications. As editor-in-chief of the \textit{Journal of the National Medical Association}, he published an article in 1932

\textsuperscript{71} Thomas J. Ward, \textit{Black Physicians in the Jim Crow South} (University of Arkansas Press, 2003), 110-124.
stating that “it is unfortunate but true that ‘meddlesome midwives’ are the cause of disorders.”\(^\text{74}\) In the same article, he argues that while statistics show that physicians cause more maternal and infant deaths than midwives, it is only because midwives attend simpler births while physicians treat more complicated deliveries.\(^\text{75}\)

This argument reveals both Kenney’s bias as a male physician and his opposition to Black midwives, even as a Black doctor. Ten years later, Kenney had more forceful things to say about midwives who still practiced in the South. He wrote that mortality rates are higher in “rural areas where ignorant, I won’t say untrained, but at least unlettered midwives” are responsible and that “much damage has been done by meddlesome midwifery, by grannies, by midwives.”\(^\text{76}\)

Kenney, along with other Black physicians, sought to adhere to the standards of white physicians to elevate their own status in the medical field. By agreeing that midwives were ignorant, dangerous, and incompetent, Black doctors were able to establish more legitimacy. They desired for the Black medical community as a whole to be seen as professional and congruent with the standards of the white medical community. In order for this to happen, Black midwives had to be accepted by white doctors. To accomplish this goal, Black physicians pushed for the reform of midwifery to better standardize the Black medical community. The opposition of Black midwifery from both white and Black medical communities increased licensing requirements for midwives. The racialization of midwifery contributed to increased regulations for midwives, even for southern midwives that were deemed necessary in rural areas. States that previously had no licensing requirements for midwives began establishing standards


\(^{75}\) Ibid.

\(^{76}\) J. A. Kenney, “The First Graduating Class of the Tuskegee School of Midwifery,” *Journal of the National Medical Association* 34, no. 3 (1942): 108.
for midwifery. In the early 20th century, midwives could freely practice with no formal training or education. A 1912 *Birmingham Age Herald* article complained that there were no laws restricting midwifery in 31 states and that in Georgia, Alabama, and Mississippi, midwives were legally allowed to practice without regulation, allowing midwives to “follow their calling unsupervised and unrestricted…midwives are actually allowed by law to practice unrestricted.” However, a couple of years later, a Mississippi Health Bulletin stated that “it is imperative that a state law be passed requiring each midwife to stand an examination and hold a license,” illustrating that even in the South, demand for the regulation of midwifery was developing. The *Southern Herald* stated that the Mississippi State Board of Health required the Midwife Association to meet to go over hygiene and safety practices. The 1921 Sheppard-Towner Maternity and Infancy Protection Act provided federal funding with the purpose of “promoting the care of maternity and infancy in rural districts,” increasing the amount of education and training available to midwives in southern, rural areas. The meetings and funds directed solely for the development of midwifery meant that southern midwives were encouraged to attend trainings about hygiene and birthing practices. While midwives were not legally restricted if they did not attend these meetings, the existence of such opportunities suggests that the medical community was focusing its attention on standardizing midwifery.

By the 1930s and 40s, midwives in most southern states were required to obtain licensure in order to practice. In 1937, a midwife meeting in Key West taught midwives new techniques in order to

80 H.R. 12634, *A Bill to Encourage Instruction in the Hygiene of Maternity and Infancy*, 1 July 1918.
reduce the maternal and infant mortality rate.\(^81\) *The Skyland Post* published an article stating that “all practicing midwives, as well as those wishing to secure permits to practice, are required to attend” at least one of the classes being offered in North Carolina.\(^82\) Similarly, *The Roanoke Rapids Herald* revealed that the Halifax County Health Department was holding its annual midwife meeting; all midwives were required to “attend this meeting to obtain license to practice midwifery during 1947,” demonstrating that licensure was necessary by the mid-20th century, even for southern midwives.\(^83\) During the 20th century, midwifery transitioned from a largely unregulated practice to one that required licensing. Different counties and states in the South varied in terms of licensing requirements, but in general, requirements for midwives increased throughout the 20th century through classes, programs, meetings, and permits.

Southern midwives responded to the increased regulations imposed on them by state and local governments, along with pressure from both white and Black medical communities to standardize the field of midwifery, with compliance. Before formal training was required of midwives, many joined associations that emphasized hygiene and safety practices, demonstrating a willingness to meet the rising standards of the medical community. A 1919 copy of *The Advertiser* included a notice for a meeting of the Tehula Midwife Association, where members were required, and other midwives were invited, to listen to Dr. Rosamond’s lecture.\(^84\) This requirement for Tehula Midwife Association members suggests that midwives were acting in accordance with the increasing standards placed on them, seeking adequate training.


and collaboration with physicians to continue to practice with the approval of the larger medical community. Once licenses were required of midwives, midwife institutions were held regionally across the South with the goal of educating practicing midwives on up-to-date hygiene and medical practices. A certificate of fitness was awarded to midwives who completed the course, allowing midwives to continue practicing. The images below depict classes of midwives:

*Class of Midwives in Bainbridge, Georgia in 1934.*

*Midwife Institute in St. Augustine in 1934.*

*Midwife Institute in Tampa in 1935.*
Many of the women pictured had practiced as traditional lay midwives, or “grannies,” for decades before being required to obtain licensure. The fact that these women attended midwife institutes shows how Black women fought to remain in the field of midwifery. These women, many of whom were from poor and rural areas of the South, dedicated their time and energy to these programs in order to continue to practice as midwives. Midwife institutes played a large role in the professionalization of midwifery. Within these institutes, there were standardized uniforms, including the midwife bags pictured. In order to successfully graduate, students had to meet requirements such as witnessing live births under the supervision of physicians. Midwife institutes altered the field of midwifery in the 1930s and 1940s as midwifery education transitioned from informal training to regulated educational programs.

Despite the willingness of midwives to comply with licensure, attending lectures and training courses organized by midwives themselves were soon no longer seen as adequate midwifery preparation. Public health officials turned to nurses to train and oversee the work of midwives and to elevate the field. For example, in Indiana, the Public Health Nursing Association provided training courses for midwives in rural areas. In *A Manual of Public Health Nursing* in 1949, the Texas State Department of Health instructed that:

> Each public health nurse should plan to visit regularly the active midwives who reside in her district…the nurse should endeavor to see that the midwife understands the principles of good hygiene, both in her own living, and in the instructions she gives to her patients…the nurse may also assist the midwife to understand the importance of eye prophylaxis for the newborn infant, and of birth

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registration...the nurse should examine closely the superstitious practices of midwives.\textsuperscript{86}

Nurses were expected to critique, oversee, and instruct midwives. Nurses were seen as superior in terms of education and hygiene while midwives occupied the lowest rung of the healthcare field. Many of the nurses placed in charge of regulating “granny” midwives were white, and they were instructed to monitor the “superstitious practices” of Black midwives. This illustrates the role that racism played in the regulation of “granny” midwives; white nurses were seen as superior, cleaner, and more competent than Black midwives. Many health professionals wanted nurses to replace midwives as birth attendants altogether. In the South Carolina \textit{Hospital Herald}, doctors wrote that “we hope to see some reform...but we cannot hope for this until we have competent nurses to take the places of those now holding in their possession authority to practice midwifery and kill as many babies as they please.”\textsuperscript{87} This preference for nurses over midwives soon resulted in the creation of the nurse-midwife, a nursing graduate specializing in obstetrics. New programs were created for nurses wishing to practice as nurse-midwives, marking the beginning of the end for traditional lay midwives.

Black health professionals also supported the creation of the nurse-midwife. Kenney wrote that “with the passing of the granny, intelligent, competent, young women, trained according to modern methods, must take their places.”\textsuperscript{88} Aline Vance, a Black nurse, reported in the \textit{Jackson Advocate}, a Black newspaper, that “the work of Negro nurses in the city and county during the last 40 years has wiped out the midwifery trade among Negros... the chief accomplishments of the Negro public health nurses has been their participation in the elimination of the ignorant Negro

\textsuperscript{87} A. C. McClennan, \textit{Hospital Herald} 2, no. 2 (January 1899).
\textsuperscript{88} Kenney, “The First Graduating Class of the Tuskegee School of Midwifery,” 109.
midwife,” suggesting that the replacement of traditional midwives with nurses was supported by Black health professionals. By elevating Black nurses over “granny” midwives, the Black medical community mirrored the medical standards of the white medical community that valued nurses over midwives. Additionally, the Tuskegee School of Nurse-Midwifery, the first Black nurse-midwifery program, opened in 1943, suggesting that Black physicians supported the creation of the nurse-midwife and the replacement of “granny” midwives. The program was created with funds provided by organizations including the Children’s Bureau and the Maternity Center Association. The opening of a Black nurse-midwifery school in the South demonstrated that Black midwives were being regulated by both the white and Black medical communities. Black physicians, in addition to white doctors, believed that southern Black midwives needed to be regulated and reformed. Traditional lay midwives were being replaced by nurses trained as nurse-midwives.

The development of nurse-midwifery, while intended to give Black nurses the opportunity to take over the midwifery field, actually resulted in the eventual exclusion of Black women from obstetrics. The new nurse-midwifery schools came with stricter requirements for potential applicants. Even the Tuskegee School of Nurse-Midwifery, while specifically for Black students, created additional barriers that made it difficult for many Black women to enter the field of nurse-midwifery. In order to gain acceptance into the nurse-midwifery program, applicants had to meet specific standards. According to the “Bulletin of The Tuskegee School of Nurse-Midwifery,” the requirements for admission into the nurse-midwifery program included that “applicants must be graduates of an accredited nursing school…should be between 25 and 40 years of age, and in good health.” In the late 1930s, Florida A&M was

the only Black college that offered a bachelor’s nursing program, making it unlikely that many Black women were nursing college graduates.\(^{91}\) It was also a requirement that applicants be graduates of an accredited nursing program, yet there were only 26 accredited nursing training programs offered to Black nurses in the United States.\(^{92}\) Additionally, the page below, taken from the bulletin, lists the tuition and fees for the Tuskegee School of Nurse-Midwifery:

![Bulletin of the Tuskegee School of Nurse-Midwifery](image)

The listed cost of the program, not including clothing, travel, and other expenses, is equivalent to around $10,000 today.\(^{93}\) Many women, including those already practicing as “granny” midwives before the creation of nurse-midwifery, would have been unable to afford the program. The requirements and tuition for this program excluded many older, poor, rural Black women who had been working as midwives for most of their lives. These standards also lessened the number of Black women qualified to enter the field of nurse-midwifery. Black women had to be college educated, young, and wealthy enough to afford the program.

Even Black women who successfully gained entry and graduated from nurse-midwifery programs faced exclusion based on their race. In the 1940s, the American Association of Nurse-Midwives did not permit Black nurse-midwives to join.\(^ {94}\) The

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\(^{92}\) Ibid., 76.

\(^{93}\) “Calculate the Value of $700 in 1946,” *DollarTimes*.

Tuskegee School of Nurse-Midwifery closed in 1946 after only 5 years due to a lack of funding. In 1943, the state of Alabama withdrew its funding and in 1946, the Children’s Bureau program did the same.\textsuperscript{95} Even though traditional midwifery decreased nationally, white women were still able to enter the new field of nurse-midwifery through educational programs. The closure of the only nurse-midwifery program for Black women marked a shift in the field of midwifery from a predominantly Black profession to a white woman’s domain. White women dominate the smaller field of nurse-midwifery while Black women make up the minority.

Midwives who were not eligible for nurse-midwifery programs were directly excluded from the field. In \textit{Talk to Me Good}, it is revealed that in 1976, “more than 150 Alabama midwives, all black, abruptly received letters and visits from physicians and nurses informing them that they could no longer work.”\textsuperscript{96} Licensed midwife Mary Beth Chambers, when interviewed in 1983, recalls that she did not choose to retire; instead, one day the public health nurse asked her “you about ready to retire?” and when it came time for her midwife license to be renewed, it simply was not.\textsuperscript{97} Even though she had complied with licensing and regulations, Chambers was still pushed out of the field because she was not a nurse-midwife. In Alabama, no county health department issued permits to lay midwives after 1977.\textsuperscript{98} Similarly, in Florida, a public health nurse stated that she “couldn’t sign another license. Wouldn’t be capable for her to sign another license” for any midwife, reflecting the changes made in state health departments in the late 20th century.\textsuperscript{99} Traditional southern lay midwives were unable to resist exclusion from the field. These women, typically Black, older, and rural, had no organization to

\textsuperscript{95} Ibid., 92.
\textsuperscript{96} Smith, \textit{Listen to Me Good}, 135.
\textsuperscript{97} Susie, \textit{In the Way of Our Grandmothers}, 139.
\textsuperscript{98} Smith, \textit{Listen to Me Good}, 135.
\textsuperscript{99} Susie, \textit{In the Way of Our Grandmothers}, 144-145.
advocate for their rights.\textsuperscript{100} They were quietly dismissed from midwifery without being given the opportunity to fight for their profession.

Through the professionalization of white obstetricians, the struggles of Black health professionals to standardize the Black medical community, and the intersectionality of racism, sexism, and poverty, Black women were excluded from the field of midwifery during the 20th century. Midwives were oftentimes unfairly blamed for maternal and infant mortality rates and accused of being unhygienic. The intelligence and abilities of midwives were questioned, especially due to their race and gender. Many midwives were left without access to the necessary training and education required to practice in the later 20th century.

The effects of the exclusion of Black, southern midwives are continually felt, with Black women making up a minority of nurse-midwives today. The work of “granny” midwives in earlier centuries is important to remember and honor because they provided childbirth services to many Black, rural, and poor southern families that did not have alternative access to medical care or the desire to experience racism during childbirth. Many Black patients benefited from the work of “granny” midwives that was rooted in trust, respect, community, and support. With the decline of traditional lay midwives, Black communities in the South lost valuable members of the healthcare field that served their needs. Today, Black women going into labor are still faced with the difficult fact that most obstetricians and nurse-midwives are white, reflecting how Black women were pushed out of obstetrics in the 20th century.

\textsuperscript{100} Ibid.