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Birthing, Blackness, and the Body: Black Midwives and Experiential Continuities of Institutional Racism

Keisha La'Nesha Goode
Graduate Center, City University of New York

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Birthing, Blackness, and the Body: Black Midwives and Experiential Continuities of
Institutional Racism

by

Keisha L. Goode

A dissertation submitted to the Graduate Faculty in Sociology in partial fulfillment of the
requirements for the degree of Doctor of Philosophy, The City University of New York

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Barbara Katz Rothman

_____   _____
Date   Chair of Examining Committee

Phillip Kasinitz

_____   _____
Date   Executive Officer

Barbara Katz Rothman _____

Mary Clare Lennon _____

Paul Attewell _____

Supervisory Committee

THE CITY UNIVERSITY OF NEW YORK

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Abstract

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by

Keisha L. Goode

Adviser: Professor Barbara Katz Rothman

Within the last decade, historical and contemporary accounts of midwives, along

with the efficacy of the Midwives Model of Care for pregnancy, childbirth and general

women's health, have become increasing popular in mainstream publications and

documentaries. Yet, very few of these accounts represent historical or contemporary

black midwives (and midwives of color, more generally). Despite a long history of

midwifery in the black community, black women currently represent less than 2% of the

nation's reported 15,000 midwives. Relatedly, black women and infants experience the

worst birth outcomes of any racial-ethnic cohort in the United States.

In the early 20th century, as the obstetrics-gynecology specialty sought to advance and secure professional boundaries and homogenization, physicians of this time began recording the "midwife problem." Publicly labeling the primarily immigrant and midwives of color (the majority of whom were black women) attending approximately 50% of the nation's births at the time as dirty, ignorant, evil and the like had a profound effect in nearly eradicating midwifery. Despite a revival of midwifery during the 1960s and 1970s, 1% of today's United States births are attended by midwives, of which black midwives and black mothers are but a fraction of that 1%.

This qualitative study of 22 contemporary black Certified Midwives, Certified Nurse-Midwives and Certified Professional Midwives, of varying ages, years of experience and U.S. region, seeks to understand how a very racist and classist denigration of black midwives in the early 20th century is still manifesting itself in their experiences and perceptions of predominantly white midwifery education programs and professional organizations. These reported experiences of institutionalized racism and negative, controlling images of blackness is what I have framed as "the contemporary midwife problem." This samples' perceptions of the social operation of racism, and its impact on poor black birth outcomes and black women's relative underutilization of black midwives, is also explored.

Federal and local policy implications are discussed.

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Chapter One

Framing the Contemporary Midwife Problem

The land of life, liberty and the pursuit of happiness. The land of the free and the home of the brave. The land of dreams, opportunity and abundance. Such platitudes are so deeply inscribed in the founding documents and celebratory songs of the United States of America, and are reified in public policy and popular culture. And yet, it is also the land of massive inequalities by income, wealth, quality education access and achievement and health disparities marked by racial-ethnic lines.

In 2000, the United States, along with 188 other United Nations member states, identified eight international development goals-Millennium Development Goals (MDGs)-to be achieved by 2015: (1) eradicate extreme poverty and hunger, (2) achieve universal primary education, (3) promote gender equality and empower women, (4) reduce child mortality, (5) improve maternal health, (6) combat HIV/AIDS, malaria, and other diseases, (7) ensure environmental sustainability and (8) develop a global partnership for development (United Nations Millennium Development Goals, http://www.un.org/millenniumgoals/, n.d.). MDGs four and five-reducing childhood mortality and improving maternal health-are serious areas of concern for all U.S. women and children, especially black women and children.

The U.S. continues to spend large amounts of money on medical care, but is not seeing consistent, long-term positive results on key health outcomes: cesarean rate, preterm birthrate, low birth weight rate[1], very low birth weight rate, infant mortality and maternal mortality rate. The cesarean rate in the United States has experienced a nearly 60% increase from 1996 to 2009 and only a small decline since, and is currently at 32.8% (Hamilton, Martin, & Ventura, 2012, p.

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[1] Low birth weight is measured as infants born at less than 2,500 grams or 5 lb., 8 oz. Very low birth weight is measured as infants born than 1,500 grams or 3 lb., 4 oz.

2). Although at its lowest in more than a decade, the 2011 rate of preterm birth is still higher than rates reported during the 1980s and most of the 1990s at 11.72% (p. 2). After more than a 20% increase from the mid-1980s through 2006, the low birth weight rate has since slowly declined to a current rate of 8.10% and a very low birth weight rate of 1.44% (p. 4). The U.S. infant mortality rate is one of the highest among all developed countries with the most recent statistics charting seven deaths per 1,000 live births (Kliff, 2013). This places the U.S. at the lowest out of 17 peer countries. The U.S. maternal mortality rate is 12.7 deaths out of 100,000 live births, and has changed very little in the last 25 years, exceeding the rates for at least 41 other peer countries (Singh, 2010, p. 2).

The birth outcomes for black women and babies demonstrates a consistent theme: this cohort experiences the worst of those key health outcomes. Of the total number of births in 2011 (3,952,841), 47.4% were born to non-Hispanic black women (Martin, Hamilton, Osterman, Curtin & Mathews, 2013). The preterm birth rate to black women is the highest of any racial group at 16.75%-5% greater than white women (Martin, Hamilton, Osterman, Curtin & Mathews, 2013). The low birth weight rate to black women, following the same pattern, is the highest of any racial group at 13.33%-5% greater than white women-and, still the highest of any racial group, nearly 2% greater than white women in very low birth weight (Martin, Hamilton, Osterman, Curtin & Mathews, 2013). Black women lose their babies at a rate almost 2.3 times greater than non-Hispanic white women (Martin, Hamilton, Osterman, Curtin & Mathews, 2013). The black maternal mortality rate is 34.0 deaths per 100,000 live births, three times higher than the rate for white women (Singh, 2010).

Further, preeclampsia (the development of high blood pressure after the 20th week of pregnancy) is a serious prenatal condition for which black women are at increased risk, when

compared to white women (Bigelow et al., 2014; Larson, Strong & Farley, 2012; Lisonkova & Joseph, 2013). Even prior to giving birth, using data reported in the National Violent Death Reporting System from 2003-2007, Palladino, Singh, Campbell, Flynn and Gold (2001) found that black women account for almost half (44.6%) of pregnancy-associated homicide victims (p. 5).

It turns out that socioeconomic status-income, education, occupation and wealth[2]-and genetic makeup are not explanatory factors. Prenatal care, too, has shown to have no impact on improving outcomes. Race, alongside reported experiences of racism, has shown to be a powerful independent variable.

The Inadequacies of Socioeconomic Status as an Explanatory Variable for Black Birth Outcomes

Socioeconomic status is typically measured by highest level of education earned, income and occupation. Women who are poorest and least educated are those whose babies are at greatest risk in any racial group. But the babies of black mothers with higher education are still at greater risk than expected. In fact, black mothers with a college degree have worse birth outcomes than white mothers without a high school education (Gennaro, 2005; Schoendorf, Jogue, Kleinman & Rowley, 1997).

Susan Gennaro (2005) explains this further:

> College-educated black women continue to experience higher rates of low birth weight than college-educated white women. If a black infant is born at normal weight, there is no difference in the infant mortality rate, including the number of sudden infant death syndrome deaths between black and white children of

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[2] Though income is generally the primary variable by which economic status is measured, a measurement of wealth is likely a better measure because it can buffer the effects of temporarily low-income. Yet, there is a massively wide racial wealth gap. Shapiro, Meschede and Osoro (2013) traced the same households from 1984 to 2009 and found that the total wealth gap between white and black families nearly tripled, from $85,000 to $236, 500 (p. 1). Some of the greatest contributing factors to the racial wealth gap are years of homeownership, unemployment (more prominent among black families), a college education and generational wealth. Such an increasingly wide gap leaves black families at a considerable disadvantage in reaping the benefits of wealth as a buffer for temporarily low income.

college-educated parents. The rate of low birth weight remains twice as high in black infants of college-educated parents as in white infants of college-educated parents. These disparities again underscore the need to examine factors other than socioeconomic status in an explanation of health disparities. (pp. S5-S6)

Income, too, is not an explanatory factor. Researchers Colen, Geronimus, Bound, and James (2006) investigated the extent to which upward socioeconomic mobility, focusing specifically on income, may or may not improve birth outcomes of poor black and white women who spent their childhoods in or near poverty. They found that an increase in family income for poor white women resulted in a decrease in the probability of having a low birth weight baby (48% for 1 unit increase). For poor black women with similar increases in family income, however, the same benefit was not statistically significant. This is further evidence that for black women, improved socioeconomic status (here income) does not reduce the risk for some adverse birth outcomes.

Take, for instance, the story of Kim Anderson, a black Atlanta, Georgia, Ivy League educated business executive and lawyer featured in the 2008 documentary *Unnatural Causes: Is Inequality Making Us Sick?*. Describing herself, she says, "People would think I'm living the American Dream: a lawyer with two cars, two and a half kids, the dog, the porch, a good husband, great family. I've always been lucky to have good health. Always ate well. Exercised. Never smoked" (Unnatural Causes, "When the Bough Breaks Transcript," 2008). And yet, her baby was born two and a half months early, weighing only two pounds thirteen ounces:

> As a mother you're thinking: I did all the right things. They told me to take vitamins; I took vitamins. They told me to walk. They told me to eat vegetables. They told me not to drink. I didn't do all that, and why is my kid sitting here with these needles and, you know, so you feel real helpless. You really feel helpless. (p. 4)

Because socioeconomic status is not a great explanatory factors, researchers are investigating other variables.

Inadequacies of Genetics as an Explanatory Factor for Black Birth Outcomes

Neonatologists Richard David and James Collins (2007) investigated if prematurity and low birth weight may be genetic. That is, is it possible that the issue is not something that Kim Anderson, and the thousands of other U.S. black women like her, did or did not do during pregnancy and rather a devastating manifestation of a genetic predisposition? Comparing newborn African immigrants to the U.S., African American women, and U.S. born white women, they found that Africans and whites have similar birth outcomes. African-Americans, on the other hand, had babies that weighed almost eight or nine ounces less than the other two groups (David & Collins, 2007). Astonishingly, they found that when African women immigrate to the US, it takes only one generation before their daughters are at risk of having premature babies at a significantly higher rate and with poorer birth outcomes[3]. Prior studies have demonstrated the same patterns (Cabral, Fried, Levenson, Amaro & Zuckerman, 1990; Valanis & Rush, 1979).

Prenatal Care and Black Birth Outcomes

Prenatal care-the series of screening tests, checkups and general prenatal health advisement during pregnancy-has long been thought to be an important and effective intervention for reducing racial disparities, specifically on key measure of infant mortality, low birth weight and prematurity. Around 1990, major expansions of Medicaid maternity care reduced the black-white disparities in underutilization of prenatal care. Unfortunately, however, increased access has not resulted in marked improved birth outcomes. Independent of race, the data are inconclusive in

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[3] It is interesting to note that, in contrast, rates of low birth among the infants of first-generation Mexican women are comparable to white women of high socioeconomic background. When compared with black women, the same cohort of first-generation Mexican women are at a lower risk of giving birth to babies both prematurely and with low birth weights. Called the "Hispanic Paradox," researchers present this data to challenge the argument that poverty is the main explanatory factor for poor birth outcomes (Galvez, 2011; Zambrana, Scrimshaw, Collins & Dunkel, 1997).

determining the effectiveness of prenatal care in improving birth outcomes, even post the national efforts to increase access. When factoring in race, black women who begin prenatal care within the first trimester still have higher rates of infant mortality than white women with late or no prenatal care (Coley & Aronson, 2013; Dubay, Joyce, Kaestner & Kenney, 2001; Lu & Halfron, 2003).[4]

Like increases in income, education or occupational prestige, the fact that the introduction of this nine-month or shorter intervention does not dramatically reverse disparities in birth outcomes is not surprising. It is terribly unrealistic to think that a lifetime of social disadvantage could be reversed in such a short period of time.

Understanding the Interrelationships among Racism, Stress and Black Birth Outcomes

Dr. Camara Jones, Research Director on Social Determinants of Health and Equity within the Division of Adult and Community Health at the Centers for Disease Control and Prevention (CDC), theorizes three forms of racism: internalized racism (internalization of negative stereotypes of images), personally-mediated racism (experiences of prejudice or "differential assumptions" and discrimination or "differential actions" by individuals and/or groups[5]) and institutional racism (differential access to goods, opportunities and/or resources) (Jones, 2000). Collectively, exposure to internalized, personally-mediated and/or institutionalized racism is directly related to incidences of stress and is statistically associated with poor birth outcomes. Some researchers are focusing on the relationship between pregnant women's reported experiences of personally-mediated racism, stress and its impact on birth outcomes (Collins & David, 2009; David & Collins, 1991; Lu & Halfron, 2003; Lu, 2007). Black women are

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[4]Centering Pregnancy, an innovative, collaborative prenatal care model, has demonstrated positive effects. This prenatal care model is discussed further in chapter 5 of this manuscript.
[5] Psychology's microaggression theory is a useful counterpart to Jones's conceptualization of personally-mediated racism. See Sue (2010).

challenged with the simultaneous, intersecting oppressions of race and gender, ultimately having tremendous impacts on birth outcomes and maternal, infant and child health (Jackson, 2003).

This research again supports the observation that socioeconomic status is not an explanatory factor. Dominquez, Dunkel-Schetter, Glynn, Hobel and Sandman (2008) compared black and white women of similar education and income levels who reported experiences of racism throughout their life course. For black women, such experiences of racism, especially during childhood, were strong predictors of low birth weight for their infants. This is consistent with other research in this area (Collins et al., 2000; Dominquez, Dunkel-Schetter, Glynn, Hobel & Sandman, 2008; Mustillo et al., 2004; Nuru-Jeter et al., 2009; Rosenberg, Palmer, Wise, Horton & Corwin, 2002). When white women reported racial discrimination, Dominquez, Dunkel-Schetter, Glynn, Hobel and Sandman (2008), however, did not find a similar predictor of low birth weight among the white women who had experienced the discrimination. Dole et al. (2004) observed the same relationship among reported experiences of racial discrimination among black women and rates of preterm birth.

In a sample of black women alone, Collins, David, Handler, Wall and Andes (2004) found that those who reportedly experienced racial discrimination during pregnancy in five domains-school, medical care facilities, a commercial retailer, housing agent or agency or work-were more than three times as likely to give birth to a very low birth weight infant, compared to those who did not. Experiences of racial discrimination has devastating effects for pregnant black women, independent of socioeconomic status.

Understanding the physiological impact of stress on birth outcomes begins with Brian McEwen's (1998) seminal work on allostasis, allostatic load and the weathering effect. Allostatis is the body's attempts to maintain stability during and after exposure to stressful experiences. We

depend on the systems in our bodies to regulate and protect us by responding to internal and external stress. If the body consistently and continuously is exposed to prolonged periods of allostasis, it reaches a limit or allostatic load. This load represents the body's inability to recover from the effects of prolonged wear and tear on the system. This load ultimately has a "weathering effect" and gradually increases the risk of developing a chronic disease, declines reproductive health, and increases the likelihood of experiencing poor birth outcomes. Research suggests that preterm birth is initiated by imbalances in the hypothalamic-pituitary-adrenal encrodine (HPA) axis, systematic inflammation, challenges of placenta blood flow and/or uterine overdistention (Buss et al., 2009; Challis, Matthews, Gibb & Lye, 2000; Glynn, Schetter, Chicz-DeMet, Hobel, & Sandman, 2007; Hobel, Dunkel-Schetter & Roesch, 1998; Kivlighan, DiPietro, Costigan, & Laudenslager, 2008; Wadhwa et al., 2001).

The intricacies and impact of the HPA axis has received considerable attention, especially the differential impact of imbalances of the HPA axis by race. During pregnancy, the endocrine system is of extreme importance. This system is a collection of glands responsible for secreting hormones into the blood stream for a safe, balanced hormonal environment for mother and baby. The hypothalamic, pituitary and adrenal endocrine glands comprise the important HPA axis. Consistent with other research on black birth outcomes, black women and babies are particularly vulnerable to chronic imbalances in the HPA axis.

In 2010, Suglia et al. measured the cumulative stress-comprised of reported exposures to interpersonal violence, community violence, racial discrimination, negative life events-of 68 urban black and 132 urban Hispanic women. They focused specifically on cortisol production. In the span of a day, cortisol typically peaks shortly after awakening to get us energized and falls throughout the day. Exposure to acute stress generally triggers cortisol production, indicative of

a healthy HPA axis, as it is a demonstration of the body's efforts to regulate internal hormones and protect the nervous system's flexibility and adaptability. Chronic stress, however, results in little to no cortisol production, leaving the HPA axis and nervous system particularly vulnerable. This is consistent with McEwen's (1998) discussion of allostatic load and the subsequent weathering effect, i.e. the body has difficulty recovering from the effects of prolonged wear and tear on the system and, over time, increases the risk of developing chronic disease, a decline in reproductive health, and the likelihood of experiencing poor birth outcomes.

Suglia et al. (2010) collected salivary cortisol samples five times per day over three days. Controlling for education level, age, smoking status, body mass index and weeks pregnant at time of cortisol sampling, they found that the majority of Hispanic women had low cumulative stress exposure (57%), while the majority of black women had intermediate (35%) or high (41%) cumulative stress exposure. Relatedly, results showed that among black but *not* Hispanic women, cumulative stress was associated with lower morning cortisol levels and a flatter waking to bedtime rhythm-a finding consistent with women diagnosed with posttraumatic stress disorder (Meewisse, Reitsma, de Vries, Gersons, & Olff, 2007; Miller, Chen, & Zhou, 2007). These analyses suggest that the combined effects of cumulative stressful experiences are associated with disrupted HPA functioning among pregnant women. Further, grouping all minority women together fails to elucidate the specific experience of blackness in the United States.

Relatedly, researchers Glynn, Schetter, Chicz-DeMet, Hobel and Sandman (2007) conducted a longitudinal analysis of the levels of cortisol along with ACTH and CRH (two additional hormones that, like cortisol, regulate stress) in 310 African American, Hispanic and non-Hispanic White women at 18–20, 24–26 and 30–32 weeks' gestation. Even adjusting for

socioeconomic status and biomedical factors, African-American women suffered the greatest imbalances in the HPA axis above Hispanic and white women.

Neighborhood stressors can have an equally devastating effect for black women as it is a form of the institutional racism that Jones (2000) describes. Bell, Zimmerman, Almgren, Mayer and Huebner (2006), Grady (2006), Grady and Ramirez (2008), LaVeist (1993) and Polednak (1996), for example, found greater black-white disparities in infant mortality and birth weight in cities and neighborhoods that are more racially segregated. That is, places with a low concentration of affordable and healthy goods, services and opportunities leaves blacks at a tremendous disadvantage. Yet, interestingly, other studies indicate that racial integration is not a magic solution. For example, Pickett, Collins, Masi and Wilkinson (2005) found the risk of low birth weight and preterm delivery among black women in high socioeconomic areas was higher for those whose neighborhoods were predominately white. This suggests that an increase in socioeconomic status does not mitigate the stressful effects of racial discrimination and stigma within neighborhoods and communities. Further, in an earlier study, the risk of preterm birth for black women increased as the proportion of black residents in their neighborhood decreased (Pickett, Ahern, Selvin, & Abrams, 2002). Bell, Zimmerman, Almgren, Mayer and Huebner (2006) found the same pattern not only in preterm birth among black women, but also in birth weight. Being in close proximity to other blacks was associated with better outcomes. This may be largely the effect of increased social support, which has been found to be a crucial intervention for black women (Lu & Lu, 2007).

Yet, there is some promise in this story. The midwife-an Old English word meaning "with woman"-has been a primary birth worker from the beginning of time. Those countries for whom midwives are the primary maternity care providers (most other countries in the word) and

for whom obstetricians attend primarily high-risk women, women and infants experience far

greater outcomes (Goode, Rothman, Chen & Stone, 2014). Because the United States is

experiencing a maternity care crisis in terms of quality, access and cost, midwives and the

Midwives Model of Care ™ may be a valuable resource.

An Introduction to Historical and Contemporary Birth Work

Today, The International Confederation of Midwives (ICM), supporting and representing

professional midwifery associations around the world, defines the midwife as follows:

> 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 counselling 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.
>
> > (International Confederation of Midwives,
> > http://www.internationalmidwives.org/assets/uploads/documents/D
> > efinition%20of%20the%20Midwife%20-%202011.pdf, 2011).

The drastic shifts in birthing patterns in United States history have been well documented

(Block, 2007; Ehrenreich, 2010; Lake, 2008; Leavitt, 1986; Litoff, 1982; Litoff, 1990; Mitford,

1992; Rooks, 1997; Simonds & Rothman, 2007; Wertz & Wertz, 1989). Midwifery has deep

roots in the black community, from the arrival of slave ships in the 17th century to the grand

midwives of the south attending births well into the 1950s (Haynes, 2003; Lee, 1996; Mongeou,

1961; Robinson, 1984; Schwartz, 2006; Smith & Holmes, 1996; Stoney, 1952). In 1900, almost

all U.S. births occurred outside a hospital, the vast majority of which occurred at home under the attention of midwives. Yet, the early to mid 20th century brought drastic changes to this tradition. In the early 20th century, obstetrics-gynecology was a relatively weak specialty. Midwives presented a barrier to the professionalization and advance of the specialty. Articles appearing in the *American Journal of Obstetrics and Diseases in Women and Children*, illustrate what came to be known as "the midwife problem."[6] Take, for instance, the words of Dr. Thomas Darlington (1911), Commissioner of Health for New York City:

> We know in general that the midwife is commonly employed in this country by the *negro and alien populations* as well as by many native born of foreign parentage....Reports upon midwifery investigations made in several of our large cities, together with observations from those who confront the problem in the rural districts, prove conclusively that the midwife, with very few exceptions the country over, is *dirty, ignorant, and totally unfit* to discharge the duties for which she assumes. And these women attend approximately 50 percent. (pp. 870-871, my emphasis)

Dr. J. Clifton Edgar (1911), extends further, saying "….midwives who, except in some rare instances, are *dark , dirty, ignorant, untrained, incompetent women*….she is *evil,* though a *necessary evil*, and must be *controlled*. We must save *our* women." (p. 881).

It is interesting that despite being labeled as dark, dirty, evil, ignorant, unfit, untrained and incompetent, the value of early black and immigrant midwives, specifically to the burgeoning obstetrics profession, is that they worked with 50% of the nation's population at the time. The midwife, at this time, may have been evil, but she was a necessary one. Early obstetricians reportedly observed and learned about birth from midwives, yet their offering and marketing of analgesic drugs and surgical interventions slowly reconceptualized American birth as equivalent with risk, obstetricians and the hospital (Kobrin, 1966; Litoff, 1982; Wertz &

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[6] The *American Journal of Obstetrics and Diseases of Women and Children* began publishing in 1868, and ran until 1919. The next year, it was succeeded by the American Journal of Obstetrics and Gynecology, still published today (and listed separately).

Wertz, 1989). By 1940, then, 44% of births occurred in the hospital and 99% by 1969

(MacDorman, Matthews & DeClerq, 2012). I elaborate much further on this history in the next

chapter.

The contemporary world of birth work in the United States is very complex[7]. The vast

majority of births in the U.S., independent of race, are delivered in hospitals. In 2012, 98.6% of

all U.S births occurred in the hospital (Martin, Hamilton, Osterman, Curtin & Matthews)[8]. Of

those hospital births, 92% were attended by physicians, primarily obstetricians. Obstetricians

complete four years of medical school, pass the United States Medical Licensing Examination

(USMLE), participate in an obstetrics-gynecology residency program and become board

certified. Obstetricians primarily practice in hospitals and medical clinics. Founded in 1951, the

American Congress of Obstetrics and Gynecology is the nation's leading professional

organization for obstetricians and gynecologists.

It is noteworthy here that the American Congress of Obstetrics and Gynecology has, in

recent years, been reporting workforce challenges in the United States. A 2011 report indicates

that the obstetrics and gynecology specialty is in crisis for three main reasons: (1) the workforce

is aging, (2) the specialty is one of the most stressful and time-demanding and (3) U.S. medical

students are demonstrating decreased interest in entering the specialty. I recently attended the

second annual U.S. Midwifery Education, Regulation and Association (US MERA) Workgroup

meeting where Dr. John Jennings, President of the American Congress of Obstetricians and

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[7] In this section, I detail the professional pathway and current practice statistics of obstetricians and the three main types of midwives in the United States. Doulas (an ancient Greek word meaning "a woman who serves") are noteworthy here, too, though they are not primary birth workers. Doulas provide continuous physical, emotional and informational support to mothers before, during and after birth. The main requirement for becoming a doula in the United States is to complete a birth doula workshop or 16 or more hours in length. See DONA International (http://www.dona.org/PDF/Birth+Doula_steps+to+cert_website_07-13.pdf) for further details. I discuss the prevalence and importance of doulas in the last chapter.

[8] All national birth data reported in this section of the chapter, unless otherwise cited, comes from Martin, Hamilton, Osterman, Curtin & Matthews (2013).

Gynecologists, presented this research and urged for more "collaborative care"[9] between physicians and midwives. Waldman and Kennedy (2011), along with Farrow, Lawrence & Schulkin (2012) have found such collaborations between obstetricians and women's healthcare providers, including midwives, to be associated with improved outcomes, greater efficiency and enhanced patient and provider satisfaction.

Midwives practice in private homes, clinics, birth centers, physician offices and hospitals. The most commonly practicing U.S. midwives are Certified Nurse Midwives (CNMs), Certified Midwives (CMs) and Certified Professional Midwives (CPMs).

Certified Nurse Midwives (CNMs) and Certified Midwives (CMs) have met standards for certification set by the American Midwifery Certification Board (AMCB). CMs complete a midwifery education program in an independent midwifery school or a program within a college or university; CNMs are Registered Nurses (RNs) with additional training in midwifery. A Bachelor's degree from an accredited college or university with completion of specified science courses is required for admission into a midwifery education program leading to the CM credential; A Bachelor's degree from an accredited college or university *and* a RN license is generally required for admission into a nurse-midwifery program leading to the CNM credential. Upon completion of the respective programs, CMs earn a Master's degree and CNMs earn a Master's or doctoral degree. A Master's degree is the minimum requirement to take the AMCB certifying exam for the CM and CNM credentials. CMs and CNMs primarily practice in hospitals. CMs are licensed in New Jersey, New York and Rhode Island. CNMs are licensed in all 50 states, the District of Columbia and all U.S. territories. CMs have prescriptive authority in New York; CNMs have prescriptive authority in all U.S. jurisdictions. CMs are eligible for

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[9] I qualify collaborative care in quotations because the actual nature of the collaboration, i.e. midwives operating as true primary care providers alongside physicians as opposed to their subordinates, is unclear and remains to be seen.

reimbursement from private insurance companies and Medicaid in New York, New Jersey and Rhode Island; CNMs are eligible for reimbursement from private insurance companies, Medicare, Tricare and reimbursement for Medicaid reimbursements in all states. Founded in 1955, The American College of Nurse Midwives represents and advances the CM and CNM credentials.

In 2012, Certified Nurse Midwives attended 7.9% of all U.S. births. Of that 7.9%, 94.8% of those births took place in the hospital; the remainder took place outside of the hospital, primarily in freestanding birth centers (2.5%) and residences (2.5%). CMNs primarily attended the births of white women (57%). 23% of CNM-attended births were to Hispanic women and 13% to black women. Of those CNM attended black births, the vase majority (98.7%) occurred in hospitals. In 2012, Eugene Declereq analyzed trends in midwife-attended birth from 1989-2009. Interestingly, he found that in 1990, CNMs attended a disproportionately high number of births to non-white mothers, whereas in 2009, the profile of CNM births mirrors the national distribution in race/ethnicity.

A Certified Professional Midwife (CPM) is an independent midwifery practitioner who has specialized knowledge and training in out-of-hospital birth. CPMs have met standards for certification set by the North American Registry of Midwives (NARM) by completing a midwifery education program, a state licensure program or an apprenticeship pathway. A high school diploma is required for admission into a midwifery education program or state licensure program leading to the CPM credential; no degree or diploma is required for an apprenticeship pathway. Most graduates of midwifery education programs toward the CPM credential earn a certificate or Associates degree; no degree or diploma is granted through the apprenticeship pathway. There is no minimum degree requirement to take the NARM certifying exam for the

CPM credential. CPMs primarily practice in private homes and birthing centers. CPMs are

legally eligible to practice in 28 states. CPMs have no prescriptive authority though they may

obtain and administer certain medications in some states. They are eligible for reimbursement

from private insurance companies in some states and Medicaid reimbursement in 12 states.

Founded in 1992, The National Association of Certified Professional Midwives represents and

advances the CPM credential.

 The Centers for Disease Control (CDC) does not report data specific to Certified

Professional Midwives. Instead, data are grouped as "other midwife" which includes CPMs,

CMs or direct-entry midwives[10]. The majority of those in the CDC's "other midwife," category,

however, are CPMs. That said, in 2012, less than 0.7% of all U.S. births were attended by other

midwives. Of that 0.7% of midwife-attended birth, the vast majority (80.9%) of those births took

place outside of the hospitals, primarily in private residences (70%).

 Like CNMs, "other" midwives primarily attend births (80.3%) to white women. Unlike

CNMs, however, the vast majority of other midwife-attended births (61%) take place inside of

private residences (Martin, Osterman, Hamilton, Curtin & Matthews, 2013). Since 1990, 90% of

the increase in home birth is attributable to white women (MacDorman, Mathews & Declerq,

2012). Other midwives are attending the births of just 4% of black women, but, interestingly and

in stark contrast to white women, the majority of these births (58.9%) are still taking place inside

of hospitals, likely by CMs because they are the only type of midwife in the "other midwife"

category that is legally sanctioned to practice in hospitals. Only 21.5% of black births occurred

outside of the hospital in private residences (a stark contrast to 61% for white women) and only

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[10] Direct-entry" is an umbrella term to refer to non-nurse midwives who are specialists in birth outside of the hospital, particularly in private homes and at freestanding birth centers. The majority of direct-entry midwives in this country are CPMs and only CPMs are represented in this study. Licensed Midwives (LMs) and Registered Midwives (RMs) are legally recognized and regulated in their respective states. See www.mana.org for further information.

19% in freestanding birth centers.

Here it is important to highlight the Midwives Alliance of North America (MANA). Birthed from a grassroots coalition, MANA was founded in 1982 to support and represent *all* midwives-regardless of their educational route into midwifery. They seek to advance access to midwifery-CMs, CNMS, CPMs and direct-entry-for all North American women. This organization is unique because it is inclusively designed, though the majority of its members are CPMs and direct-entry midwives.

Sociology of Professions

The sociology of professions investigates the social processes by which trades or occupations specialize knowledge, form professional boundaries and secure social dominance (Friedson, 1970; Parsons, 1939). Andrew Abbott's *The System of Professions* (1979), specifically his discussion of jurisdictional disputes, is important to understanding the historical and contemporary complexities of birth work. Abbot explains that professions make jurisdictional claims via three mechanisms. First, the legal system formally controls and validates their work. In the world of birth, those operating within the medical model-physicians, CNMs and CMs-are privileged with legal authorization to practice in more state territories; receive third-party reimbursement, including Medicaid, which is a huge advantage given the fact that an astounding 48% of all births were paid for by Medicaid in 2010, an increase of 19% in the proportion of all births covered by Medicaid in 2008; and, have prescriptive authority (Markus, Andres, West, Garro & Pellegrini, 2013). CPMs and other midwives, unfortunately, are at a great disadvantage without consistent legal support to practice in all state territories; inconsistent,

state-specific challenges to receiving third-party reimbursement, *especially* for Medicaid; and, no prescriptive authority.

Second, professions build images in public opinion that support the legal system. Such imagery, beginning with Darlington (1911) and Edgar (1911), is fundamental to understanding the historical shifts from predominantly midwife-attended birth to predominantly physician-attended birth in this country. Abbott, in fact, contends that "In America it is ultimately through public opinion that professions establish the power that enables them to achieve legal protection" (p. 60) The medical model's power rests on what Abbott calls abstract knowledge: "But only a knowledge system governed by abstractions can redefine its problems and tasks, defend them from interlopers, and seize new problems…" (p. 9). This body of knowledge, firmly rooted in discourses of risk, is operationalized in diagnoses, treatment and the continued production of academic knowledge to shape the professional jurisdiction of physician-attended birth. This grants them the monopoly of practice (the dominance of physician-attended childbirth in hospitals is evidence of this), public payments (disparities in Medicaid reimbursement is evidence of this) and control of professional training. The American Medical Association and the American Congress of Obstetricians and Gynecologists have considerably influence in the training and jurisdictional boundaries of midwives.

Third, professions make jurisdictional claims in the workplace but it is here, though, that the jurisdictional lines-who controls and supervises the work-become distorted. This could not be truer in birth work. In hospitals and clinics, physicians still occupy a supervisory role over midwives, even though they may have been attending to women throughout the length of their pregnancy or, day of birth, are fully trained to attend a non-cesarean birth. Outside of the hospital, those "other midwives," too, are supervised by physicians, usually by way of a

supervisory physician of record at the local hospital in the event that a woman experiences distress requiring surgical or prescriptive intervention and/or needs to be transferred to the hospital. I want to be clear here that supervision, as in all other professions, may be top-down, micromanaged supervision; "call me if you need me" type of supervision or true collaborative practice.

Ultimately, U.S. birth work professionals operate within an interactive and intersecting system. There are two important conclusions to draw from this discussion. First, the more medical, the more jurisdictional claims, i.e. more power in the legislature, public opinion and in the workforce. This applies to professional organizations and the respective birth workers and credentials they represent and advance. That is, the American Congress of Obstetricians and Gynecologists and the obstetricians they represent have more power to make jurisdictional claims than The American College of Nurse Midwives and the Certified Midwives and Certified Nurse Midwives they represent who, in term, have more power jurisdictional claims than The National Association of Certified Professional Midwives and the Certified Professional Midwives they represent. This is not, I want to be clear, a statement about hierarchy of skill; instead, it is a statement about hierarchy of jurisdictional claims-making.

Second, physician-attended birth inside of the hospital is the standard in the United States. Further, national statistics demonstrate that when we refer to midwife-attended birth in the present day, this primarily is CNM or CM attended birth inside of hospitals. This is true for women of all races. Less than 1% of national births occur outside of the hospital with CPMs or direct-entry midwives (Martin, Hamilton, Osterman, Curtin & Matthews, 2012).

The Safety, Efficacy and Cost-Effectiveness of the Midwives Model of Care

Despite varying educational pathways and differences in power to make jurisdictional

claims, all midwives practice the Midwives Model of Care™. In 1982, sociologist Barbara Katz-

Rothman was the first to define the differences between a medical and midwifery model of care

in *In Labor: Women and Power in the Birthplace*.[11] Since then, the model has been finalized as

follows:

- 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

(Midwives Alliance of North America, "Midwives Model of Care",
http://cfmidwifery.org/mmoc/define.aspx, n.d.)

In contrast, the dominant medical model of pregnancy and childbirth tends to be risk-

oriented, being charted on a range from low to high risk, which inherently excludes the definition

of a healthy pregnancy or birth (Lupton, 2000; Rothman, 1987; Sakala & Corry, 2008). Thus, the

question is not actually whether or not a woman is on the risk continuum, but *which* risks require

physician monitoring and control (Lupton, 1993). Applying this model of risk to all pregnant

women increases the risk of mortality, injury, and unnecessary technological intervention, more

commonly called the "cascade of intervention" or "snowball effect of intervention"[12] whereby

labor induction with the commonly used drug Pitocin increases the frequency and pain of

contractions, causing more women to request an epidural which effectively alleviates pain but

also slows down the labor process, therefore more Pitocin, more pain, negatively impacting

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[11] See Davis-Floyd (1994) for similar models she termed technocratic and holistic.
[12] Though I am unable to locate a specific citation for these phrases, I am told they originated with Doris Haire, former president of the International Childbirth Education Association and the American Foundation of Maternal and Child Health.

women's natural ability to push (especially if laying in a hospital bed), causing fetal distress and voila-cesarean section (The Childbirth Connection, http://www.childbirthconnection.org/article.asp?ck=10182, n.d.; Lake, 2008). The pervasiveness of this cascade or snowball effect is not only dangerous, but also costly.

Studies consistently demonstrate the safety, efficacy and evidenced-based nature of the Midwives Model of Care both in and out-of-hospital (Fullerton, Navarro & Young, 2007; Hutton, Reitsma & Kaufman 2009; Janssen et al., 2009; Jonge et al., 2009; Sakala & Corry, 2008). Special attention should be paid to the work of Cheyney et al. (2014a) and (2014b). In the largest ever examination of planned home births in the United States- nearly 17,000 women and their babies- it was found that among low-risk women, planned home births resulted in low rates of birth interventions without an increase in adverse outcomes for mothers and newborns, and resulted in health benefits to mothers and their babies. Some of the key data points include: over 93% women had a normal physiologic birth; the cesarean rate was 5%; only 2.5% of babies were admitted to the NICU in the first six weeks of life; 87% of women with previous cesareans had their babies vaginally; and of the 10.9% of women who transferred from home to hospital during labor, the majority moved for non-emergent reasons, like a slow, non-progressing labor, or maternal exhaustion (Cheyney et al., 2014, p. 18). A similar study by Johnson and Daviss (2005), "Outcomes of Planned Home Births with Certified Professional Midwives: A Large Prospective Study in North America," found that of 5,148 women, 12% of women who intended to deliver at home when labor began were transferred to the hospital (p. 1). Of those women, rates of medical intervention-epidural, episiotomy, forceps, vacuum extraction and cesarean section-were substantially lower than for low risk U.S. women having hospital births. Rates of intrapartum and neonatal mortality were similar to that of low risk hospital births.

Analyses of Midwifery Care's Cost Effectiveness & The Possibilities of Collaborative Care

In 2007, the State of Washington Department of Health (DOH) commissioned a report on the economic benefits of midwife-attended out-of-hospital births in the health care system and the economic benefits to the consumers who elect to have out-of-hospital births, including any reduced use of procedures that increase the cost of childbirth. The report concluded that midwifery care results in cost savings to Medicaid of nearly half a million dollars biennially and, when private insurance companies were included in the analysis, the savings to the federal healthcare system was over $2.7 million (Health Management Associates, 2007, p. 9).

In looking at differences in birth setting costs alone from January 2001-December 2004, the costs for midwives attending birth in the home was a reported $1,000 and in the birth center a reported $1,635 as compared with physician-attended, vaginal hospital birth at $3,171 and $5,798 for cesarean section (Health Management Associates, 2007, p. 8). Further, the report indicates that prenatal care provided by midwives saves the state $5,426,143 with the total cost of care provided by midwives in the home, birth center and at home $15,521, 835 and the same cost for physicians at $20,947,978 (Health Management Associates, 2007, p. 8). The cost implications of midwifery care are remarkable and are valuable information for policymakers.

It is also important to note that much research tends to distinguish solely between home and hospital birth. Freestanding birth centers, too, should be an important component of any comparative birth analysis. The second National Birth Center Study, published in 2013, found that because payments for care are nearly 50 percent greater for women who have cesareans versus those who gave birth vaginally, the use of birth centers decreased direct and indirect costs to the U.S. health care system (Stapleton, 2013, p. 9). Given lower costs in the birth center

setting, as well as low rates of cesarean section birth, the 15, 574 births investigated in the study

are estimated to have saved more than $30 million in facility costs alone based on

Medicare/Medicaid rates, not including additional savings in costs of additional providers,

anesthesia and newborn care in hospital settings (Stapleton, 2013, p. 9).

The Importance of Concordant Care

Such studies, however, do not disaggregate the data by race of midwife and patient; these

data are important to understanding the benefits of midwifery specific to women of color and the

need to increase and diversity the nation's corp of midwives. Noteworthy here, though, is

research on physician-provided concordant care. Comparing patient-physician communication in

race-concordant (African-American patient with African-American physician) and race-

discordant (African-American patient with white physician) visits to investigate whether

communication behaviors explain difference in patient ratings of satisfaction and participatory

decision making, Cooper et al. (2003) found that race-concordant visits were reportedly longer

and had higher ratings of "patient positive affect" as compared with race-discordant visits.

Furthermore, patients in race-concordant visits rated their physicians as more satisfactory. Data

in this area are consistent with Malat and Hamilton (2006) and LaVeist, Nuru-Jeter and Jones

(2003). Research specific to race-concordant midwifery care would be beneficial.

In general, greater attention to race and contemporary midwives is imperative. There is an

absence of literature on contemporary black midwives. Much of the great works existing on

black midwives are centered on the grand midwives practicing during slavery well into the 1950s

but who have since passed on (Bovard & Milton, 1993; Haynes, 2003; Lee, 1996; Logan &

Clark, 1991; Smith & Holmes, 1996; Smith & Robinson, 1995; Wilkie, 2003). These works

focusing on historical black midwives must be contextualized within a boom of recent, mainstream publications and documentaries primarily focusing on the experiences of historical and contemporary white midwives (Armstrong & Feldman, 1986; Bohjalian, 1998; Courter, 1981 & 1992; Holloway, 2007; Lake, 2008; McKay, 2006; Turlington, 2010; Ulrich, 1990; Vincent, 2002; Worth, 2009). Work representing the experiences of contemporary black midwives is essential as they are operating within a different set of social, political, economic and legal circumstances than their white counterparts, grand counterparts, particularly on the heels of The Patient Protection and Affordable Care Act of 2010 ("Obamacare"). Further, the efforts of the contemporary midwifery movement in the United States must draw attention to cancerous issues of white privilege and racism in order to make collective gains (Craven & Glatzel, 2010).

Given the consistently poor birth outcomes for black women and children in this country, I focus herein on blackness. Like all U.S. women, black women are primarily birthing in hospitals with physicians (92%) but, interestingly, most of black midwife-attended birth takes place in the hospital. Black women are nearly four times less likely than white women to have a home birth. The value of midwifery-midwives of all credentials and practicing in various settings- for this cohort demands further investigation. At the same time, the nation's corp of midwives is primarily white women with less than 2% of them reportedly black women. This means that of the black women birthing with midwives, they are more likely to be attended by a white midwife than a midwife of color or black midwife. Given the value of concordant care, why are there not more black midwives attending black women? This qualitative study of 22 contemporary black midwives-12 CNMs and 10 CPMs- conducted via in-depth, semi-structured interviews seeks to

make a contribution to midwifery, sociological and public health research literature but

addressing this question and the following research questions:

- How do contemporary black midwives interpret the increasing medicalization[13] and credentialism of midwifery and its impact on their work?
- How do contemporary black midwives interpret the relatively high black maternal and infant mortality rate in the United States?
- How do contemporary black midwives interpret the relatively low percentage of black midwives and black women's underutilization of midwifery services in the United States?
- How do black midwives perceive and experience national midwifery professional organizations?
- How do contemporary black midwives understand their role, its possibilities and challenges, in addressing issues of cost, quality and access in the current health care crisis?
- What are the differences in black midwives' experiences and perceptions by age cohort, years of experience and type of midwife, i.e. CNM, CM or CPM?

This study is the first to address these questions. Consistent with the national data, all of

the CNMs represented in this study primarily practice inside of the hospital or clinic except for

three. Of those three, one practices both in the hospital and at home (very rare) and the other two

in freestanding birth centers. All of the CPMs primarily practice in the home, with the exception

of two who practice in birth centers. They all practice in relatively urban environments.

Collectively, they are attending births of low-risk women, high-risk women, teenage girls,

homeless women, women with disabilities and imprisoned women. In addition to providing

prenatal, natal and post-natal care, they are well-woman care[14] providers, fertility specialists,

childbirth educators, breastfeeding educators, midwifery educators, nursing educators, national

and international maternal and child health policy makers, activists and leaders. They together

hold Master's degrees, professional degrees, doctoral degrees and two of them are doctoral

students and/or candidates. As Angela, a midwife represented herein, took great care to let me

know of my responsibility in producing this work, "Let the world know we love catchin' babies

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[13] See Armstrong (2000), Conrad (1992, 2007) and Zola (1972) for key works in this area.
[14] Well-woman care refers to preventative care such as annual pap smear examinations or mammograms.

but do we more than that, too."

Those primarily practicing in the home and birth centers identified their clients as predominantly at least college-educated, middle class white women. This is consistent with the national data on out-of-hospital births reported above. The CNMs or CMs practicing inside of the hospital or clinics identified their clients as predominantly women of color, the majority of who were clients with Medicaid.[15] This means that the black CNM and CM client data reported in my study is inconsistent with national trends as they are primarily attending births to women of color as opposed to white women. This may be due to the fact that the 22 black midwives represented in this study practice in relatively urban environments. Also, the 22 represented may not be generalizable to the entire U.S. black midwifery community though the exact number of practicing U.S. black midwives remains unknown.[16]

All interviews took place in person except for four. Of those four, three were conducted via phone and one via Skype. Also of those four, three of them I later met in person at various midwifery conferences, events or meetings. All born in the United States except for three, they are all currently practicing in the United States and are representative of the northeast, southeast, northwest, southwest and northern Midwest regions of the United States. They range in age from early 30s to 80 years old and range in experience from five to forty years of experience.

Initial contacts were made at the 2010 Midwives Alliance of North America conference and the American College of Nurse-Midwives of Color email list. I used snowball sampling whereby research subjects assisted me in the recruitment of other potential subjects. Thankfully, all of my requests for interviews were granted.

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[15] This finding supports the urgent need for the amendment of the Social Security Act of 1935 to grant CPMs mandated provider status for Medicaid reimbursement eligibility. Both Medicare and state Medicaid plans are mandated by federal law to include the services of CNMs and most state plans have done so since 1988.

[16] The exact number of practicing black midwives in the U.S., however, remains unknown because of non-affiliation with professional organizations who maintain demographic data. Non-affiliation may be the result of feelings of dissatisfaction, disengagement or mistrust midwives reported in chapter two, feelings of risk or danger if practicing illegally or some midwives' desire to not report their race or identity as black.

I have taken great care to protect the anonymity of my sample. I have not identified specific midwives' age or region, for example, because with a small black midwifery community, those details may be easily identifiable. I have identified them by type of midwife, numbers of years of experience and a pseudonym of black female authors who have been inspirational to me at one point or another in my life[17].

I anticipated differences in experience and perception by type of midwife, age and/or years of experience. However, a major finding here, is there are few reported differences. This indicates excellent opportunities for collaboration and political action among the U.S. black midwifery community and equally the recurring challenges to actively address in order to positively impact birth and birth work in this country.

Framing the Contemporary Midwife Problem

As it turns out, this research is not only important, but also timely. I began in 2010 focusing on five of the six identified research questions. One question- How do black midwives perceive and experience national midwifery professional organizations?-was actually not a part of the original research design. However, my very first research participant, Patricia, urged me to investigate the organizations saying, "You really have to ask sisters how they are feeling about the organizations. A lot of us are not a part of them for a number of reasons….not feeling welcome, not feeling like attention to midwives of color is a priority. Ask." So, I did ask.

Anna (CNM, 40-45 years of experience), the oldest in my sample, reflected her early experiences with MANA and ACNM:

> In general, when I used to go to the meetings…and I went to MANA and
> ACNM…the very few of us banned together. But, over the years, less and less of
> us stopped going even though we kind of created our own network but outside of

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[17] See Appendix C for a Chart of Research Participants by Type, Years of Experience and Age.

the organizations. We got fed up because there was not a lot of attention to race and, to be honest, it was racist. [Another black midwife] even tried to get involved, you know in leadership, but she had some horrible experiences. She felt kind of silenced, you know? So most of us don't even go to those meetings anymore.

Strikingly, when I spoke with Alice, a CPM, and bell, a CNM, both with 05-10 years of

experience (practicing 35 years later than Anna, eerily report similar experiences. Here are

Alice's words:

So even when I was a student I went to both MANA and NACPM and, you know, it's a real expense. I was really struck by the lack of people of color, especially black people. The black midwives I met have been so wonderful to me and have helped me so much along the way but outside of the organziations. At one point….and I don't even know when this happened…but I realized why am I a part of an organization that doesn't seem to put money and people behind diversifying midwives of color. Don't get me wrong MANA's MoC [Midwives of Color Section] does great work and I have relationships with the women active in there but, in general I found the organizations a bit racist to be honest.

bell, speaking of ACNM, is nearly on conversation with Alice:

So there are a lot of benefits to being a member of ACNM. That I am not going to deny. But the race stuff is terrible. It's the big issues of really needing more financial support for recruiting and keeping midwives but it is also the smaller stuff….those acts of privilege. You can't keep talking about wanting and needing more midwives in this country without talking about race. And that is, unfortunately, what's happening. I have chosen to stay active and remain a part of it but a lot of sisters have left. Talk to them.

Reported experiences like these were consistent.

Then, in May of 2012, after I had completed over half of my interviews, my research

took an interesting and important shift when six members of the Midwives Alliance of North

America (MANA) Midwives of Color Section resigned from the organization citing experiences

of institutional racism. I more clearly understood their reported experiences and Patricia's

insistence to investigate the professional organizations. MANA, you remember, is the national

professional organization uniquely positioned to support and advance *all* midwives: CPMs,

CNMs, CMs and direct-entry. MANA works in collaboration with the American College of

Nurse-Midwives, National Association of Certified Professional Midwives and other midwifery

professional organizations and accreditation agencies but is unique because of its inclusive

nature, seeking to advance midwifery and all midwifery credentials on a national scale.

In the morning of May 26, 2012, I was forwarded this email disseminated written by

MANA's administration to their member listerv:

Date: May 26, 2012. Email Subject Line: READ THIS!!!!!

With an intriguing email subject line like this, from a well-respected and trusted colleague, I read
on. Below is some of its content:[18]

To the MANA Community

On Monday morning, May 21, MANA's Midwives of Color (MOC) Section Chair
Darynée Blount publicly and unexpectedly presented a letter of formal resignation to the
MANA Board of Directors. Her signature was accompanied by those of five midwives
and students who have comprised her Inner Council leadership team.

The resignation letter identified multiple areas of distress, including the difficulty MOC
section chairs have had with the position, pointing to the fact that the last three section
chairs have resigned prior to the completion of their terms. It is their belief that these
situations, and other concerns expressed in the letter, are the direct result of institutional
racism in MANA's ethos, priorities, structure, and decision-making processes.

In essence, it was stated by the signatories that repeated exposure to discrimination and
racist attitudes-whether intentional or out of ignorance-is oppressive and not good for
them mentally, physically, emotionally, and psychologically. It distracts them from their
true mission of addressing maternal and infant health care, increasing the number of
midwives of color, and better serving their communities.

The issue of race and privilege is complex and doubly confounding for midwifery. We
wrestle with race and privilege as we discuss the accessibility of our work and profession,
and we live with the issue of racial disparities in maternal and infant outcomes. The two
are clearly related.

All midwives in this country struggle, regardless of race. Yet the MANA Board

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[18] See Appendix A for the complete May 2012 Midwives Alliance of North America (MANA) Letter to All Membership re: the Resignation
Letter of 6 Members of the Midwives of Color section.

recognizes that the struggles for white women and women of color are not the same. Women of color face additional challenges that white women do not face, in ways that many of us cannot begin to fathom.

(Midwives Alliance of North America, Email communication, May 26, 2012)

To protect anonymity, I am not at liberty to disclose if any of the resigning women are represented in this study though I can say that the letter only supports my sample's data about experiences in and perceptions of midwifery professional organizations. Further, given the small black midwifery community in this country, my sample was well aware of this public resignation. In fact, I followed up with five midwives who I interviewed prior to the resignation for their thoughts and reactions; these data are represented herein.

For a wider audience, I want to be clear of the implications here. In almost all professional societies, there seems to be some variation of a black caucus that empowers and advocates for its black citizenry, including making important public statements on pressing issues and events for black Americans. In our national government, the Congressional Black Caucus empowers and advocates for the legislative and civil rights of black Americans. In Sociology, it is the Association of Black Sociologists; in Public Health, it is the Black Caucus of Health Workers of the American Public Health Association; in education, it is the National Alliance of Black School Educators. The organizational configurations are varied and many. Some are stand-alone organizations. Some are caucuses, sections or committees within a larger professional organization. In midwifery, MANA's Midwives of Color Section and ACNM's Midwives of Color Committee are positioned within the larger professional organization (MANA and ACNM, respectively) and are dependent upon the larger professional organization for financial support and other resources. They are designed to support midwives of color with networking, mentoring, tutoring and general emotional support. So, high turnover in leadership

positions within designated spaces for midwives of color or reported non-communication from

the larger professional organization with midwives of color about issues or events specific to

midwives of color are not trivial matters. Instead, it reflects an organizational fracture and culture

that is disjointed and likely breeding mistrust which ultimately only inhibits the work needed to

empower, advocate for and support midwives of color-both stated goals of the larger professional

organization and the respective sections and committees. The internal structure and resources,

too, must match those stated goals.

Along with the letter sent to all of its membership, the MANA administration also

attached the resignation letter from the Midwives of Color Section Chair and her "Inner

Council." I read on:

> We can no longer continue to participate in MANA's disrespect of us as a group, a race, as the Women our community respects. We cannot keep our heads held high and take this shit. Our view of ourselves will suffer and eventually the young ones will look at us with less than admiration. We are not "The Help - 2012 Version". This treatment is not good for us, mentally, physically, emotionally and psychologically – this is the stress that's kills us in so many ways, drains our energy and distracts our focus.
>
> These issues and these organizations distract us from our true mission; we have become myopic, focusing on these groups and not exploring global approaches to maternal and infant health care, increasing the number of MOCs, and better serving our communities.
>
> Therefore, I Darynée Blount, am resigning from the position of MOC Chair, the MOC and MANA and we Jennie Joseph, Jessica Roach, Ayesha Ibrahim, Claudia Booker and Michelle Peixinho are hereby formally resigning from the Inner Council, the MOC and MANA.[19]

(Midwives Alliance of North America, Email communication, May 26, 2012).

The emotional outpouring above solidifies the impetus and rationale behind study. While

Darlington and Edgar were both lamenting the very presence of the midwife and her work as

problematic in 1911, here in 2010-2013 midwives of color are expressing lament, but also

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[19] See Appendix B for the complete May 2012 Resignation Letter of 6 Members of the Midwives Alliance of North America (MANA) Midwives of Color Section.

sadness and anger, *at a gaping lack of* respect, value and appreciation for midwives of color

within an inclusively designed national midwifery organization. All of the respondents in my

study have expressed, in varying ways, the need for this work, recognizing, in the words of

MANA's administration, the "issue of race and privilege is complex and doubly confounding for

midwifery" (Midwives Alliance of North America, Email communication, May 26, 2012). They

communicated deep hurt and anger as a result of severely entrenched institutional racism and a

perceived lack of concerted, systematic efforts to combat it, not only in MANA's "ethos,

priorities, structure and decision-making processes," but midwifery professional organizations

and educational institutions more generally (Midwives Alliance of North America, Email

communication, May 26, 2012). This, along with black women's estrangement from the

midwifery community, as evidenced by national data, is what I have framed as the

"contemporary midwife problem". This is not a "MANA problem;" this is a midwifery problem.

The need to address this problem and all its facets is the foundation for my research.

Naming the Elephant: The Racial Formation of Birth Work

   Race is fundamental role in structuring and representing the social world. Michael Omi

and Howard Winant (1994) call this 'racial formation':

> Thus we should think of race as an element of social structure rather than an
> irregularity within it; we should see race as a dimension of human representation
> rather than an illusion. These perspectives inform the theoretical approach we call
> racial formation. We define racial formation as the sociohistorical process by
> which racial categories are created, inhabited, transformed and destroyed….First,
> we argue that racial formation is a process of historically situated *projects* in
> which human bodies and social structures are represented and organized. Next we
> link racial formation to the evolution of hegemony, the way in which society is
> organized and ruled. (pp. 55-56)

Race is still a great determiner of access to power and resources. In my mind, the poor black

birth outcomes and relatively few black midwives in this country are, in Omi and Winant's

(1994) terms, racial projects that are representative of the country's racial formation, i.e. its representation, organization and rule of human bodies. What does it mean that socioeconomic status, specifically education attainment, is not an explanatory factor for poor black birth outcomes? What does it mean that even post the feminist and women's health movements of the 1960s and 1970s, and the subsequent "revival" of midwifery, black midwives represent less than 2% of the reported 15,000 midwives in this country? What does it mean that six midwives of MANA's 2012 Women of Color Section resigned citing the organization as racist? What does it mean, that while presenting this research throughout its various stages, I have been asked why or how my samples' experiences and perceptions are "valid" or why their experience is "concrete evidence," generally evoking uncomfortable, sometimes angered responses from whites and non-whites alike. I will explicitly address issues of validity and evidence in the next section of this chapter but it is an important to note that these questions raise powerful questions not only about the social value for subjectivity but specifically *black* subjectivity.

Omi and Winant (1994) assert, that "racial projects connect what race *means* in a particular discursive practice and the ways in which both social structures and everyday experiences are racially *organized*, based upon that meaning" (p. 56) This study places the everyday experiences of 22 contemporary black midwives in their educational institutions, professional organizations and daily birth work at center to elucidate the racial organization of national, mainstream midwifery institutions and social structures.

Birth and birth work is but a microcosm of a racist society. In midwifery and throughout the United States, a color-blind ideology is often perpetuated. Eduardo Bonilla-Silva (2009) has theorized the dangers of color-blind ideology in contemporary America. Using the 1997 Survey of Social Attitudes of College Students and the 1998 Detroit Area Study, he conceptualized four

frames-or "paths for interpreting information"-central to the color-blind ideology: abstract liberalism, naturalism, cultural racism and minimization of racism. For my purposes, abstract liberalism is the most relevant. Abstract liberalism, he argues, is the foundation of color blind ideology. Central to liberalist ideology is an emphasis on individualism (specifically choice), universalism and egalitarianism. Abstract liberalism "involves using ideas associated with political liberalism (e.g. equal opportunity, the idea that force should not be used to achieve social policy) and economic liberalism (e.g. choice, individualism) in an abstract manner to explain racial matters" (p. 28)

Political and economic liberalism's emphases on equality of opportunity, choice and individualism, however, elude the ways in which opportunity, access and resources are deeply stratified by race and class. Sure, for example, everyone has access to public elementary and secondary education in this country but equality of *condition*-school funding, teacher quality, school infrastructure etc.-are another matter altogether. Educational opportunity is supposed to lead to greater outcomes but the differences in birth outcomes between blacks and whites, as Kim Anderson demonstrates, reflects otherwise-this is not about individual choice, behaviors or lifestyle patterns (Unnatural Causes, "When the Bough Breaks Transcript," 2008).

It is easy to forget that during the 1960s and 1970s, with the civil rights and anti-poverty movements, the overall health of blacks began to improve not because of changes in individual choices or behaviors but because of a *federal* commitment to greater investments in education, job opportunities, housing. Black maternal and infant mortality rates declined. Yet, beginning in the 1980s, with deceased federal funding for social programs, the gains made during those decades steadily declined and ultimately have not been recouped since (Darling-Hammond, 2010; Massey & Denton, 1993). Perpetuating and reifying a problematic understanding of choice

and individualism removes the responsibility of political, economic and social structures to ensure equality of condition.

Toward Survival and Empowerment

Despite the reported safety, efficacy and economic cost benefits of the Midwives Model of Care, the dominance of the medical model and the incredible financial and lobbying power of national medical organizations, specifically the American Medical Association and the American College of Obstetrics and Gynecology, cannot be underestimated. For me, part of this story is about improving the survival rates of all U.S. mothers and babies, and here in this study, specifically that of black mothers and babies. The birth outcomes horrifyingly elucidate the urgent need to improve outcomes. The other part of this story, too, is about empowering all mothers, here black mothers and babies, via the Midwives Model of Care. Its advance, though, must be situated within the context of the American value of and access to emotional labor.

Hochschild (1983) has conducted a thorough investigation of emotional labor in *Managed Heart: Commercialization of Human Feeling* and her work has much informed my thinking here. Studying flight attendants ("being nicer than natural" and bill collectors ("being nastier than natural"), she finds that emotional labor-managing and expressing emotions and demonstrations of care as part of required work performance-is emerging as an increasingly profitable commodity bought and sold in the labor market. Hochschild asserts that we need only look at "the profit-seeking drive for efficiency, the downsizing of public services, the growing gap between rich and power, and globalization" to understand the increased demand for social labor (pp. xi-xiii). Appropriate to this discussion, she explores the shift in the roles of nurses:

> Nurses formerly assigned to a particular group of patients were now assigned to 'float'
> from unit to unit, depending on the number of beds filled on a given day. Staff was laid

off. Stripped form the nurse's role were tasks now defined as menial-positioning a post-surgical patient on a chair, feeing an elderly patient, or helping him to the bathroom. Such tasks were now assigned to untrained, lower-paid workers….Encouraging a patient to ear, listening to a patient's story, making a joke, patting an arm-such acts lost importance. They were absent from the medical charts. And these days, 'if something isn't on the charts,' as one observed noted, 'it didn't happen.' Emotional labor became invisible." (p. xii)

This does not that mean nurses, midwives or other care providers did not and do not perform emotional labor but do so within a technologically-obsessed, capitalist society that is constrained by values of systematization, management, efficiency and control indicative of the medical model of pregnancy and childbirth (Block, 2007; Davis-Floyd, 1994; Martin, 2001; Ritzer, 1993; Rothman, 1982). It's interesting to note that a common misperception of midwives is that they are "non-interventionist," problematic first because CNMs and CMs may use medical technology to intervene in the labor process and, second, *all* midwives perform emotional labor. The Midwives Model of Care is, in fact, emotional labor and it, too, is an intervention. "Intervention" should not be solely equated with medical intervention.

And yet, those with the capital-economic, social, cultural[20] and otherwise-are able to afford personalized care, i.e. purchase emotional labor. For example, Hochschild (2003) references the high-end concierge doctor, the maître d', and the room service clerk at an elite hotel, each who personalizes service, honors guests and makes them feel safe and welcome. The gap between the rich and the poor, Hochschild references, have made some forms of emotional labor the privilege of the privileged. Again, nationally, 7.9% of births are attended by midwives with the majority of those in hospitals with CNMs (Martin, Hamilton, Osterman, Curtin & Matthews, 2013). Though the 1% of births occurring outside of the hospital is slowly increasing, about 90% of the increase is attributable to increased use of midwives by non-Hispanic white

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[20] Social capital refers to the collective currency of social networks; cultural capital refers to collective currency of education, exposure, speech patterns etc. that demonstrate power and status (Bourdieu 1986). I further expand on these concepts in subsequent chapters.

women (MacDorman, Mathews & Declerq, 2012). My interest here is in the realization of true choice. That is, I want to be clear, I am not anti physician-attended birth. It has its place, particularly in truly high-risk cases. Yet, for normal birth, which most births are, treating all women as high risk is very dangerous and costly. Relatedly, greater access to midwifery is constrained by the jurisdictional disputes that Abbott (1979) describes. The Midwives Model of Care, its skilled execution of both physical *and* emotional labor, should be a right-not a privilege.

The implications for black women and babies are great. Spaces and experiences of power for black women in this country are minimal at best. Despite the oft cited successes of the feminist and women's health movements of the 1960s and 1970s, black women and other women of color have largely felt or been absent or excluded from such movements and discourses that sought female empowerment (Collins, 2000; Davis, 1981; Lorde, 1984; Moraga, 1981; Combahee River Collective Statement, 1978). Power, then, is a privileged, raced and classed possession and experience. Kimberlee, a Certified Nurse Midwife with 20-25 years of experience represented in this study, says this best:

> It's a beautiful and amazing experience. There is none like it….for a woman-not me, not a doctor-just her….to see her push whether in the hospital, at home or a center, to see her be the very first person to touch, hold and love on her baby…it's amazing and it is power. We, we black women, simply do not have many opportunities for power in in this world. You can have all the education in the world but your power is not the same as a white woman's. But I have to believe, and my women tell me, that feeling that since of power in birth gives them a feeling of power they will have for the rest of their lives. And….it's an achievement, a unique experience for black women in our society. It's such a honor to bear witness to this.

Kimberlee's words are supported by the work of Emily Martin (2001) and Noreen Esposito (1999). Martin's thesis in *The Woman in the Body: A Cultural Analysis of Reproduction* is that women's bodies are often described in medical texts as if they were mechanical factories or centralized production systems: "Most of these metaphors clearly relate to familiar forms of

mass production, where value is placed on large quantities and on efficiency of scale" (p. xxiv).

In such a system, the woman, the mother, becomes a worker, treated as separate from the

product, her baby (Armstrong, 2000; Davis-Floyd 1994; Rothman, 1982; Young 1984).

Resistance to such deeply ingrained ideology, solidified in the dominant medical model of birth,

is a challenge for all women. Yet, Martin (2001) finds that exercising-and even recognizing-the

power of resistance differs by race and class:

> The ways women are able to resist what they dislike about their medical treatment
> of birth is clearly affected by their class and their race. Young black women in a
> very real sense have more to resist; not only a greater chance of having
> interventions and operations used on them, but the demanding burden of racism
> instantiated in the ways they are treated. For a white middle-class woman, the
> salient issue may b to stall going to the hospital so the clock cannot bed started or
> to organize and demand that all hospitals in the region install birthing rooms; for a
> white-working class women, stalling many be an issue, but behind it lurks the
> larger issue of finding a way to pay for prenatal, obstetrical, or infant care; for a
> black working-class women, the issues of stalling and paying may be crucial, but
> even if she contends with them, she still may have to find a way to avoid
> downright mistreatment or to manage to have matters explained to her at all. (p.
> 155)

Esposito, in 1999, compared the birth experience of minority women in the technocratic model

(much like Martin describes) with the experience in a birth center model. Esposito argues that

because minority women experience relatively less power in everyday aspects of their lives, the

birthing center offered "unconditional acceptance and respect for each individual women,

promoting critical interpersonal connections. Given an opportunity to negotiate a birth plan that

would actually be enacted, the developing trust in the midwives, 'compassionate competence"

gave the women a sense of control" (p. 123) She concludes that women birthing in the hospital

experienced a lack of control, a perceived lack of access to information, discrimination and

racism.

Theory and Epistemology

As a sociologist, I've identified the most with Herbert Blumer (1986) and his theoretical work on symbolic interactionism that posits three main theses: Humans act toward things on the basis of the meanings they ascribe to those things; The meaning of such things is derived from, or arises out of, the social interaction that one has with others and the society; These meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he/she encounters. Ultimately, human beings act on things based on meanings that grow out of interaction. That is, when I interact with "X", I'm also interacting with the meaning attached to "X." Those meanings, handed in and modified through people, grow out of interactions and are in constant flux as meanings are an emergent, contested property. Symbolic interactionism is the main sociological theoretical approach of this study. Black midwives' process of making meaning of their experiences is central.

My work has also been greatly influenced by the work of Dorothy Smith (1974, 1987), a feminist sociologist, who theorized a "sociology for women" on the heels of the women's movement. Influenced by Marxist theory, Smith, nor I, take lightly the role and responsibility of sociologists in contributing to our society and its governance: "The governing of our kind of society is done in concepts and symbols. The contribution of sociology to this is what of working up the conceptual procedures, models and methods by which the immediate and concrete features of experience can be read into the conceptual mode in which the governing is done" (Smith, 1974, p. 29). The epistemological question is what and who is being represented? What is the point of departure for "knowing"? The concepts and symbols "read into the conceptual mode" for social governance claim to represent the social world without placing lived, bodily,

experiential knowledge at center. She says, "the actualities of our everyday world are already socially organized. Settings, equipment, environment, schedules, occasions etc. as well as the enterprises and routines of actors are socially produced and concretely and symbolically organized prior to our practice" (Smith, 1974, p. 29). All knowledge, then, is socially situated and the way to understand a socially constructed world is within it. The sociologist, she argues, must make direct experience of the everyday world the ground-the "problematic-"from which to develop her work.

Building on the work of Dorothy Smith (1974, 1987), Nancy Harstock (1983) and others further theorized feminist standpoint epistemology, beginning with research questions rooted in women's lives (Haraway, 1988; Hesse-Biber & Yaiser, 2004; hooks, 1984). Standpoint is rooted in the Hegelian idea that the oppressed have a dual perspective: their own experiential perspective and the perspective of their oppressor. In our highly stratified society by race/ethnicity, class, gender, sexuality, disability, nation etc., those in power essentially structure-through influence, opportunity and resources, policy-the experiences of those oppressed and marginalized. Using their often unexamined experience as a point of departure well elucidates structural complexities and makes power visible. *This* is validity. *This* is evidence.

bell hooks (1984) and Patricia Hill Collins (2000) have theorized that black women have a unique feminist standpoint epistemology. Collins in particular argues that black women have distinctive oppositional knowledges and forms of resistance because of histories of institutional racism, racial segregation and controlling images associating black women with subservience, care work and hypersexuality (Collins, 2000). Social theories developed from grounded black feminist standpoint epistemology, Collins asserts aims to find ways to escape from, survive in,

and/or oppose prevailing social and economic injustice. In this study, the aim is to find ways to oppose and resist systems that do not serve the best interest of black women and their babies.

Conceptualizing Blackness

I wish to make one important clarification about my understanding of identity here. Throughout this project, some of my colleagues have asked how I am conceptualizing "blackness" in my study. I want to be very clear that race, here "blackness," is but one aspect of identity I accept and seek to employ an intersectional approach herein. Crenshaw (1991) and Collins (2000) have been formative in developing intersectionality as theory and method, essentially arguing that social oppressions-racism, sexist, classism, homophobia, transphobia, ageism, abelism, nationalism etc.-do not operate independently of one another but intersect, creating a *system* of oppression or matrix of domination. I do not seek to ignore other salient aspects of identity; rather, I do unapologetically seek to privilege race because, as the MANA resignation letter and the data I report herein demonstrate, race continues to be the greatest predictor of experience.

My colleagues, influenced by the work of Elizabeth Grosz (1994), Jasbir Puar (2007, 2011) and others in this tradition, have challenged me to consider blackness not solely as an entity, attribute or identifiable marker of subjects, as intersectionality purportedly holds, but as events, actions, and encounters between bodies. That is, blackness is not static; it is fluid and transient. Puar (2011) explains these perceived inadequacies, specifically the static (noun) of intersectionality, saying:

> But what the method of intersectionality is most predominantly used to qualify is the specific 'difference' of 'women of color', a category, that has now become, I would argue, simultaneously emptied of specific meaning on the one hand and

overdetermined in its deployment on the other. In this usage, intersectionality always produces an Other,
and that Other is always a Woman Of Color (WOC), who must invariably be shown to be resistant, subversive or articulating a grievance. Despite decades of feminist theorizing on the question of difference, difference continues to be 'difference from', that is, the difference from 'white woman.' (p. 2)

There is a lot of value in Puwar's words though I argue that this is reflective more of an issue with intersectionality's operationalization as method rather than with the concept or theory itself. I, too, recognize blackness as event, action or encounter between bodies; in that, the meaning(s) attached to blackness are created in and through intersection, hence my overarching symbolic interactionist frame. As my work demonstrates, meanings of "blackness" have even shifted throughout this research process and yet, at the very same time, much have stayed the same. While Puwar asserts that "bodies are unstable assemblages that cannot be seamlessly disaggregated into identity formation," lived experience occurs within and is constrained by the body (p. 4). Sociological, anthropological and philosophical works on the medical model of pregnancy and childbirth (Block, 2007; Davis-Floyd, 1994; Lupton, 2000; Martin 2001; Rothman 1982; Young 1984), have sought to put the woman back in the body, to use Emily Martin's (2001) phrase, precisely for this reason. The black body, historically, is socially marked by legacies of slavery, Jim Crow and racist research and social policies that institutionalized and constitute daily forms of experience for those inside of a black body (Brandt, 1978; Briggs, 2000; Roberts 1997; Roberts 2000; Skloot 2011; Washington, 2006). For this reason, I have simultaneously conceptualized identity as intersectional (and make every effort to address these intersections directly, specifically the intersections of race and class), fluid and transient.

On Reflexivity

Prior to doctoral studies, I earned a Master of Arts in Women's Studies. In one of my

Feminist Research Methods courses, I was tasked with crafting a "dream research project" grounded in feminist methodology. The most important piece of the assignment, Professor Cynthia Deitch insisted, was to thoroughly discuss our reflective practice, i.e. how the complexities of our identity impact our project's design, research questions and overall process. In designing this project, I kept this experience in the forefront of my mind. I had never before had to reflect upon the complexities of my identity as a young black women, particularly as a scholar.

As I have discussed and presented my research over the past three years, I have often heard these two questions: (1) Why midwives? and (2) why black midwives? A bit of my background is helpful herein answering these questions. Prior to pursuing my doctoral studies, I was first a middle school Language Arts teacher and later a school administrator, my students were predominantly low-income black and Latino children. I observed that my students' reading levels and overall literacy engagement was profoundly impacted by their mothers' literacy practices both independent of and with their child(ren). I intended, then, to study the relationship between black maternal literacy patterns and their children's academic achievement and engagement.

Upon entrance into the City University of New York Graduate Center, however, I began thinking about black motherhood more generally. I wrestled with a number of questions: How do, what Patricia Hill Collins (2000) calls, "controlling images" of U.S. black women, i.e., the mammy, the matriarch, the jezebel, the welfare queen, impact their experience as mothers and how has the impact, if at all, shifted over time? What does it mean to be a "good" or "proper" mother and how is this social perception raced and classed? How do inequalities in access to quality health care, education, employment and housing impact the resources and opportunities

available to black women and their children? How do social policies demonstrate (or not) value for black women and children? I kept simultaneously recalling Edgar's (1911) call to "save *our women*" and the title of Paula Giddings's 1984 book *When and Where I Enter: The Impact of Black Women on Race and Sex in America*. I realized I was not only interested in the when (changes over time) and the where (specific social location) but also the *how*. That is, *how* black children, and all children, enter the world matters. How are U.S. black women and their babies cared for and attended to during pregnancy and childbirth?

This led me to the midwife and the dearth of literature on contemporary black midwives-the impetus for this work.

The process of qualitative work itself is an embodied process. For sure, access to my sample and the depth of information shared with me was certainly mediated by my identity. In fact, I made a note of three separate occasions in which a midwife directly asked if I am black prior to agreeing to an interview. I also venture to guess that had my first name not been so ethnically identifiable, the question would have been asked more than the three times I noted.

In many ways, I was treated like a daughter, sister or friend, warmly welcomed into private homes, birthing centers and office spaces. Throughout the data, midwives' words and phrases like "trust," "we," "us," and you know," are used throughout, reflective of the race concordance between my research subjects and myself. This experience is consistent with other race concordant research (Boylorn, 2011; Brown, 2012) Scholars Few, Stephens and Rouse-Arnett (2003) describe this phenomenon as "sister-to-sister" talk or Afrocentric slang to describe congenial conversation or positive relating. Collins (2000) also argues that there is a special relationship between black female scholars and the general community of black women:

> The commonplace, taken-for-granted knowledge shared by African-American women growing from our everyday thoughts and actions constitutes a first and

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most fundamental level of knowledge. The ideas that Black women share with one another on an informal, daily basis about topics such as how to style our hair, characteristics of "good" Black men, strategies for dealing with White folks, and skills of how to 'get over' provide the foundations for this taken-for-granted knowledge.

(p. 34)

I maintained a research journal throughout this process to capture and reflect upon feelings and emotions-expressed both by midwives and myself-that are important to data interpretation and representation. These reflections are mentioned and addressed in the data chapters.

Scholarly Outline and Goals

I have framed this work into three key sections: the "What", the "So What" and the "Now What." The "What", is this chapter in which I have placed the MANA resignation letter in historical and contemporary context, supported with data, to espouse the need for this study, its theoretical frameworks, its methodology, thoughts on reflective practice and its scholarly goals.

The "So What" section includes the three data chapters. The first data chapter, "Being 'Proper': Midwives, Credentialism and the Reconceptualization of Skill" details a history of black midwifery in this country, marred by racism, that is having a profound impact on not only the relative privileging of medicalized midwifery credentials and educational pathways, but also the admission to, experience in and retention of black women in midwifery educational programs, pathways and institutions. This work seeks to build upon the sociological works of Max Weber (1948) and Collins (1979) on status and credentialism by drawing specific attention to race. The second data chapter is "Another Bitter Pill: On the 'Common Sense' of U.S. Black Birth Outcomes and Black Underutilization of Black Midwives." Midwives' implicitly employed social determinant theory and theoretical frameworks in media studies to interpret their lived experience serving as black female birth providers. They argue that legacies of racism

and current manifestations of everyday racism are the greatest explanatory factor for poor black birth outcomes. As noted above, this is supported by recent public health research. The third and final data chapter is a critique of the celebratory, capitalistic nature of diversity work and the subsequently lucrative diversity industry of which midwifery organizations have become clients, ultimately arguing for more internal attention to-both in listening and action-to midwives of color more generally. Again, as feminist standpoint theory teaches us, those who are oppressed reveal the most about those in power.

The third and final section, the "Now What," theorizes black midwifery-both the recruitment and retention of black midwives and increased black awareness of and access to midwifery care-as fundamental to what I have framed as a womanist ethic of caring justice. Because women of color reported absences and exclusions in the discourses and organizational representation of the feminist movement of the 1960s and 1970s, Alice Walker (1983), coined the term "womanist."[21] Womanism seeks social change or a movement, built upon the everyday experiences of black women and other women of color, and more broadly seeks empowerment for all people. I use this, the body and lived experience of black women, as the point of departure for the womanist ethic of caring justice. Acknowledging a history of institutional racism and controlling images that continue to systematically impact the lived experience of black women, the womanist ethic of caring justice demands liberty, equality and freedom-demonstrated in policy and in practice-to support and empower black women as women, mothers, partners, sisters and friends. I develop this ethic in greater detail. This chapter also looks forward to the possibilities of new and burgeoning midwifery credentials and educational pathways and makes a case for the development of a National Midwifery Association to represent the varying

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[21] The term, introduced by Alice Walker (1983) in *In Search of Other Mothers' Gardens*, refers to "the term from the Southern black folk expression of mothers to female children 'you acting womanish' " (Collins, 2001, p. 10).

organizations in the current midwifery organizational landscape in an effort to garner collective

lobbying and bargaining power. Study limitations and further areas of research are discussed.

Experiential Knowledge for Activism and Empowerment

Grounded in black feminist methodology and epistemology, I seek to connect this

scholarship with activism and empowerment:

> For feminists, power is conceptualized not as a limited resource but that which is created, maintained, lost and/or regained in the processes of social interaction. Though the use of Black feminism as a tool of analysis, the domains of power that constrain are conceptualized into action (Collins). Black feminists strive to make research practical, accessible, and empowering for the informant, the researcher, and the communities of which both are a part.
> (Few, Stephens, Rouse-Arnett, 2003, p. 206)

Black men and women have historically experienced disempowerment, racism and abuse

in research (Brandt, 1978; Briggs, 2000; Roberts 1997; Roberts 2000; Skloot 2011; Washington

2006). Omi and Winant (1994) remind us that,

> ….it is not possible to represent race discursively without simultaneously locating it, explicitly or implicitly, in a social structural (and historical) context. Nor is it possible to organize, maintain, or transform social structures without simultaneously engaging, once more either explicitly or implicitly, in racial signification. (p. 60)

Centralizing the experiential knowledge of black midwives, empowerment, activism and

transformation are central aims of this study.

Chapter Two

Becoming Proper: Midwives, Credentialism and the
Reconceptualization of Skill

We acknowledge that the midwifery history taught in most midwifery programs and promulgated at conferences fails to bear witness to the fact that midwifery history is, in the United States, largely a history of midwives of color. A history of direct-entry midwifery that begins in the 1970s with the "white revival" describes only the thinnest of top layers on a great foundation of centuries of work by African-American, Native American, Latina, Asian-American, and ethnically marginalized immigrant midwives. Similarly, a history of nurse-midwifery that begins with the differentiation between professionalized nurse-midwives from (women of color) lay midwives does not acknowledge the truth of midwifery history. We recognize that the process of licensing and certifying midwives after the 1960s in many cases served to marginalize and exclude practicing midwives in communities of color. We recognize that in many cases our legitimation as providers rested on deliberately differentiating ourselves as "better educated," more "hygienic," and/or more "scientific" than these midwives of color, while at the same time excluding them from these paths to "legitimate" practice. We posit that white midwives' failure to acknowledge this history while laying claim to "traditional knowledge" from the 1970s onward is an act of violence, erasing midwives of color from the past and creating an "innocent" present for white-dominant midwifery.
Anti-Racism and Anti-Oppression Work in Midwifery   (AROM)

Midwives Alliance of North America (MANA) Midwives of Color
Section Committee Post Resignation Public Facebook Forum Post
June 8, 2012

After the June 2012 resignation of six members of the Midwives Alliance of North

America (MANA)'s Midwives of Color Section, I became engrossed with a series of posts and

exchanges on a public Facebook forum that was a designated space for members of the

midwifery community to share and respond to the sudden resignation. The range of emotions

expressed-sadness, pain, anger, frustration, disbelief, resentment, hopefulness and the like-

confirmed, definitively, the need for greater attention to the experiences of the relatively few

contemporary midwives of color in the United States. From these posts, one recurring question

became etched in my brain: How did we, as a midwifery community (including myself, though a

new member), get *here*? That is, what are the conditions by which an already marginalized

profession, whose fundamental value is care, loses valuable midwives of color for reported institutional racism?

And then, I read Anti-Racism and Anti-Oppression Work in Midwifery (AROM)'s quote this chapter opens with. Understanding the "how we got here" tale is as beautiful and messy as birth itself. The historical and cultural meanings and values attached to "legitimate" education and practice, science and hygiene that AROM brings forth are crucial to the history of black midwifery, the medicalization of pregnancy and childbirth and the subsequent credentialism of midwifery in the United States. Further, such meanings and values of legitimacy, science and hygiene contextualize the deeply raced and classed nature of credentials elucidated in the data reported in this chapter and in the post-resignation Facebook forum.

A History of Black Midwifery in the United States

The Antebellum Period: Grand Midwives as Birth Workers, Healers and "Othermothers"

The history of black midwifery in the United States, particularly in the cultural imagination, begins in the South with the "granny" midwives. These midwives were generally well-respected, esteemed, older, wise women who were first transported from Africa to the Americas on slave ships in the 17th century. They attended to other slaves and planation mistresses in birth, well-woman care, and healing well into the mid-20th century post-emancipation (Lee,1996; Mongeau, Smith & Maney, 1961; Tunc, 2010). The term granny, however, is contested as it echoes connotations of passivity and servility and is closely related to the image of the mammy, caretaker for slaveowners and their children. Neither the term granny nor mammy accurately portrays the immense wisdom these women possessed. That is, there is often a historical assumption that granny midwives relied solely on "divine intervention" because

of "the call" to be a midwife (Haynes, 2003; Lee, 1996). While the "calling" and a connection to the spiritual realm are central to midwifery, it does not follow that granny midwives practiced without knowledge of and skill in pregnancy and childbirth. The historical presence and significance of skill, I will demonstrate, is important to contemporary debates of required midwifery credentials.

Patricia, a CPM with 20-25 years of experience, reflects on the term "granny":

> Granny and mammy are not terms of endearment. They are not terms that signal intelligence, respect…uh…admiration. Or skill. I feel like they trivialize their strength and grace. For black women, it's one of the first marks on our history these terms…they need reimagining. Most of us refer to them as grand midwives.
>
> *Patricia*

Out of respect for this history, I will refer to these women as grand midwives going forward.

During slavery, as Schwartz (2010) and Tunc (2010) have articulated, midwifery required special skills gained via the spiritual realm *and* in practice with a more experienced midwife. Spiritual aid and guidance were present in birth but the calling did not freely provide one access to birthing women or the community: "To be accepted in the slave quarter, a woman had to gain the confidence of other slaves by demonstrating an aptitude or calling. A woman who did not have the support of her people would not have attempted to assist in childbirth" (Schwartz, 2010, p.)

A common theme throughout this history is that of midwives as important community figures. During slavery, midwives literally aided in the building of community by caring for and supporting women throughout pregnancy and during childbirth as they brought forth new life. Midwives also reportedly acted as what Patricia Hill Collins (2000) called "othermothers" common in communities of color, specifically the black community, who were biologically and

socially related women that provided care, nurturance and empowerment to children, other women and families.

The social value of midwives' roles cannot be underestimated under the oppressions of slavery. Enslaved women, for instance, were an important commodity-dehumanized as a good to be bought and sold-to slaveowners as they sought to maximize their capacity for bearing children (thereby increasing labor supply) along with performing productive labor of their own. Slaveowners and physicians collaborated in efforts to increase fertility among slaves, beginning in puberty and continuing throughout their reproductive years. Obstetric cases allowed burgeoning physicians the opportunity to practice and acquire skills on the bodies of enslaved women and to participate in active medical debates about women's health, specifically childbirth, that were beginning in Europe and the northern United States (Briggs, 2000; Edwards-Ingram, 2001; Kobrin, 1966; Schwartz, 2006). An interesting irony emerges here: in the slave community, a woman was not recognized as a midwife until she had witnessed, assisted and supervised the birth of numerous babies, while medical students, during the late 19th and early 20th centuries, likely graduated as obstetricians without having witnessed or attended a single birth (Borst, 1990; Darlington, 2011; Edgar, 2011; Flexner, 1910; Kobrin, 1966). I expand on this further in the next section of this chapter.

Nonetheless, physician dominance of birth was beginning to take a strong hold. While in the beginning of the 19th century the majority (approximately 70-90%) of white plantation births were attended by midwives (enslaved or white), by 1860, an estimated 40-50% of plantation mistresses were delivered by physicians. This pattern of increase continued well into the 20th century (Tunc, 2010, pp. 411-412).

For black women, however, the majority of births continued to be attended by midwives. Post emancipation, grand midwives, along with other midwives of color and European immigrant midwives, remained primarily in the South. In a culture of dehumanization and oppression, midwives (also dehumanized and oppressed themselves) operating as birth workers, healers and othermothers served an important role as skilled caretakers and nurturers.

The latter half of the 19th century, however, was to bring a fundamental "scientific" shift to traditional midwifery practice.

Post-Emancipation to Early 1900s: Sanitary Science, Germ Theory of Disease and Scientific Mothering

Beginning in the 1830s, though becoming popularized in the 1860s and 1870s, white physicians and public health reformers developed a "sanitary science" that "linked organic chemical impurities or ferment's in the air and water to the rising incidence of diseases such as cholera and typhoid fever" (Tomes, 1997, p. 37). An increasing number of scientists extended the premise of sanitary science to conclude that the roots of varying human disease were in fact living microorganisms, or germs, thereby cementing the "germ theory of disease." Because soil, air and water were found to be plagued by dangerous germs, including those responsible for human diseases, it was believed that the germs could and should be killed with the use of high heat and chemical disinfectants to ensure proper sanitation. The germ theory became widely proselytized by the medical and public health establishment. This sparked a widespread obsession with the cleanliness of American homes to prevent deadly diseases. It was the responsibility of mothers, and women more generally, to ensure the safety, sanitation and

cleanliness of the nation by mothering scientifically (Feldstein, 2000; Wilkie, 2003). That is, to mother well is to mother is to conform to the dominant ideologies and discourses of the time.

The discourse of sanitary science and germ theory of disease positioned midwives-distanced from the credentialed legitimacy of physicians and the perceived precision of modern scientific knowledge and application-in a very vulnerable position. Physicians and hospitals became definitive symbols of safety, sanitation and cleanliness. The conventional thought regarding the ignorance, incompetence, unsafety and uncleanliness of midwives of the time cannot be disassociated from race, and specifically for my purposes, blackness.

Laurie Wilkie (2003), in *The Archaeology of Mothering*, illustrates this well. Wilkie's work investigates the life of Lucretia Perryman, a widowed, black midwife living and working in Mobile, Alabama, in the 1880s and 1890s. In 1994, a landscaping and expansion project excavated from a well some items of Perryman's from her time as a midwife in the late 19th century. Perryman's artifacts offer a valuable opportunity to investigate *pre* midwifery training, regulation and credentialing that became rampant in the South during the 1920s. Fascinatingly, the artifacts recovered in the late 19th century indicate Perryman's adoption of the sanitary science and germ theory of disease Tomes (1997) describes and what Wilkie (2003) determined to be "scientific mothering" :

> Artifacts recovered from the well suggest that the sanitation gospel of scientific mothering was adopted within the midwifery practice as well as in family life-spread of germs contained through the use of antiseptics, adoption of Castoria used for children. In her selection of patent and proprietary medicines, Perryman adopted for well-known brands that had identified themselves in consumers' minds as particularly safe and reliable for the treatment of children-again, reinforcing that through making the proper purchases, proper mothering could be recognized. Adoption of scientific mothering ideologies would allow Lucretia to introduce her patients to "modern' health discourse and permit them to participate publicly in the performance of good mothering through their consumer habits.
>
> <div align="right">(Wilkie, 2003, p.)</div>

The raced and classed nature of that which is "proper" is the rationale for this chapter's title and the theory of credentials as raced and classed I developed throughout this chapter. Perryman's recovered artifacts-including a toolkit of white (symbol of cleanliness and purity) gloves, caps, and gown, silver nitrate, sterile eye wipes, and the like-indicate that she, too, worked to be a "proper" midwife and othermother of her time-creating a reasonable, safe distance from a seemingly "unfit" past. Wilkie argues that "….scientific mothering provided a means for African-American women to challenge mothering as an exclusive domain of white women. If good mothering was a matter of practice and learning, African American women who could appropriate these behaviors as their own, providing through practice a counter-image to the racist stereotypes" (p. 180).

Perryman's artifacts certainly indicate an attempt to counter-image racist stereotypes of blackness. However, such stereotypes would be reified in the training, supervision and regulation period of traditional midwifery beginning in the early 1900s.

Early 1900s: The Professionalization of Obstetrics and The Reconceptualization of Pregnancy and Childbirth

In 1910, 50% of all US birth were attended by midwives and the other half by general surgeons or gynecologists-not obstetricians (Lee, 1996). Physician-attended births were primarily to middle and upper-class white women. Noteworthy, more immigrant women of the time began seeking physician maternity care:

> Because the midwife carried the stigma of the pre-modern culture to which their mothers clung, some immigrants' daughters declined her services….when the family economic situation improved, they discarded the midwife, not associated with ghetto life and public clinics. Finally, the congressional restrictions on immigration in the 1920s posed significant barriers to sustained demand for midwifery services.

For black women, however, the majority of all births continued to be attended by grand midwives.

By the end of the 19th century and into the early 20th century, allopathic physicians-and not "competing sections of healers" vying for "public recognition and support and for the financial rewards of medical practice"-were institutionally represented by the American Medical Association (AMA) founded in 1847. (Brickman, 1983, p. 67) The AMA sought professional homogenization and increased standards for medical education (Brickman, 1983; Flexner, 1910). Meanwhile, the obstetrics specialty struggled to achieve respect and recognition within the medical community. The specialty was thought of as an opening for younger, less experienced physicians to garner skills and later transition to more prestigious, lucrative specialties (Brickman, 1983). Borst (1990) notes that for much of the first half of the 20th century, there was little to no agreement on what constituted an obstetrical specialist.

In the 1920s, however, the American Board for Obstetrics and Gynecology was established to determine the educational qualifications of physicians who were practicing obstetrics and gynecology. Along with solidifying the boundaries of the specialty, Borst (1990) contends that the specialty, too, "reconceptualized pregnancy as a process with a 'trajectory'; that is, the normative course of pregnancy was understood, but it was also soon to be influenced by systems both within and without the body" (p. 205). She contends that the physician-patient relationship also shifted with this reconceptualization of pregnancy and childbirth:

> Birth was now something to be managed, rather than to be either attended or dominated. All births and all pregnancies were carefully controlled by a process of monitoring. This process of monitoring meant that obstetrics became organized as a hierarchical team. (Borst, 1990, p. 206)

This hierarchical relationship represents a fundamental difference between physician-*managed* and midwife-*attended* maternity care.

Kobrin (1966) further describes, that in order to combat the fallacy of normal pregnancy and birth, it required obstetricians to "develop a demand from the public for a higher standard of obstetrics":

> 'We can teach the expectant mother what she deserves, and when she demands it, she will get it.' They urged accordingly that every mother has a right to such care which, they said, the midwife cannot provide since the necessary skills are difficult to teach. Combatting the 'fallacy' of normal pregnancy and delivery was necessary not only to enhance the value of obstetric skills but also to make the American mother not merely respect, but fear, possible danger and so consider no precaution excessive. (p. 359)

Fear and danger were foundational to the discourse of risk heavily promulgated by early obstetricians of the 20th century like Darlington (1911) and Edgar(11) I cited in chapter one. The concept of risk is really quite interesting. As Lupton (1993) notes, "In its original use, 'risk' is neutral, referring to probability, or the mathematical likelihood of an event occurring. The risk of an event occurring could therefore relate to either a positive or negative outcome, as in the risk of winning the lottery" (p. 425). In public health discourse, however, risk is not neutral but is *synonymous* with danger. Social scientists, like Lupton, treat risk as a sociocultural concept, arguing that the public health conception of risk is divorced from its original usage and is instead steeped in power relations-here, power of the state and of professional obstetrics organizations (Lupton, 1993; Lupton, 2000; Peterson, 1996; Scamell, 2011). Situating pregnancy and childbirth as risky, combined with the sanitary science and germ theory of disease solidified in the late 19th century, positioned surgical interventions of high forceps operations and cesarean sections as appropriate, safe, life-saving procedures (DeLee, 1920; Leavitt, 1983; Leavitt, 1986). Further, because of women's desires for less painful births, hospitals and physician-attended

births offered analgesic drugs, even "twilight sleep" (the combination of scopolamine and morphine), which midwives were unable to provide (Leavitt, 1980; Susie, 1988).

Collectively, the reconceptualization of pregnancy and childbirth as requiring risk management, the medical offerings of childbirth pain relief and the country's poor maternal and infant mortality statistics of the time placed midwives in a rather vulnerable position. The beginning of the 1920s began a public health solution to the "midwife problem" of the time.

The Sheppard-Towner Maternity and Infancy Protection Act of 1921 and the Burgeoning Professionalization of Midwifery

As Ladd-Taylor (1988) reports, "In 1915, approximately six women-eleven black women-died for every 1,000 live birth in states where statistics were collected: one hundred infants, and 181 black infants, died for every 1,000 live births" (pp. 256-257). Though the greatest contributing factor for the deaths was found to be poverty and not inadequacies in midwifery care, national concerns of maternal and infant mortality put midwives in a rather weakened position.

Soon after 1910, progressive, middle-class white women reformers began advocating for the establishment of infant health clinics, pure milk depots, and lobbying government to assume responsibility for child welfare. Their work resulted in the establishment of the United States Children's Bureau in 1912 and the eventual passage of the Sheppard-Towner Maternity and Infancy Protection Act of 1921 that provided federal funding to states to implement maternity and child care programs. This era introduced state and municipal bureaus of child hygiene, prenatal and child health conferences, educational programs for birth attendants and mothers and, believing midwives to be responsible for the poor health outcomes, the issuance (or denial) of

licenses to midwives. The Act required midwives to be formally supervised, trained and evaluated by public health nurses. It is important to note that nurse-midwifery was also established during the 1920s in response to the national concerns of maternal and infant mortality. Following the model of nurse-midwifery in Europe, early nurse-midwives reportedly worked alongside public health nurses funded by the Act. This marks the early beginnings of a divided-and racially divided-midwifery community: primarily white nurse-midwives and primarily black lay (grand) midwives. Though these trainings were actually not the primary emphasis of the Act, the formal supervision, training and evaluation fundamentally shifted midwifery practice in the United States.

By 1924, 17 states administered classes for midwives (Ladd-Taylor, 1988).[22] Positioned as a "necessary evil"-an intermediary until the complete medicalization of pregnancy and childbirth-Sheppard-Towner administrators either infantilized grand midwives ("The negro women, although illiterate and ignorant, are natural nurses and are tractable, teachable, and for the most part, easier to learn the 'white folks' way" said a Mississippi nurse) or demonized them as dangerous, dirty and "superstitious" practitioners (Darlington, 1911; Edgar, 1911; Ladd Taylor, 1988). As midwives in my sample indicate later in this chapter, the associations of blackness with ignorance, danger, dirt, superstition, especially uncleanliness, solidified in the midwifery trainings of this time, are continuing to have an impact on their work.

The focus of the classes, in fact, was on cleanliness both of the birthing environment and of midwives themselves. The instruction of a "germ-free" environment and safe, sterile and sanitary birthing procedures was pivotal (Tomes, 1997). Midwives were informed of the appropriate use of silver nitrate eye drops for the prevention of gonococcal blindness (Perryman,

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[22] See Matthews (1992) and Mongeau, Smith and Maney (1961) for a detailed discussion of midwifery during the Sheppard-Towner Act and into the 1980s in North Carolina. See also Roberts and Reeb (1994) and Smith (1994) for a similar discussion of midwifery in Mississippi.

remember, incorporated these in her practice at the end of the 19th century), how to immediately consult physicians in "risky" cases and how to accurately complete birth records (Fraser, 1998; Ladd-Taylor, 1988). As a result, functional literacy and participation in medical procedures became a condition for midwifery practice-often leading to the elimination of many older grand midwives (Logan & Clark, 1991; Smith & Holmes, 1996). Nurses inspected midwives bags to ensure that they contained only the supplies legitimated by the health department and not substances considered contraband, such as roots, herbs or homemade salves, all of which were forbidden. Failure to maintain an appropriate midwifery bag, attend a monthly training, or simply by being past a state-assigned mandatory retirement age, often resulted in a rejection of license renewal (Ladd-Taylor, 1998; Lee, 1996; Logan & Clark, 1991; Smith & Holmes, 1996).

The inspection of midwives' personal appearance, however, suggests that the demand for cleanliness went beyond the birthing environment. Ladd-Taylor (1988) relates this well:

> Nurses described midwives as 'dirty' and 'untidy,' and tried to change their appearance. Claiming that women who were not 'spotlessly clean' were 'unworthy' to care for new babies, nurses promoted their own cultural values of order, purity, and discipline. Sheppard-Towner administrative reports chronicle numerous 'successes,' such as the transformation of a 'disorderly' group of tobacco-chewing midwives wearing fancy hats and wool dresses into an eager, well-behaved class wearing starched dresses. Clean, sterile, and dressed in white, midwives were symbolically cleansed of their race, their sexuality, and their motherhood. (p. 267)

Again, because the majority of midwives practicing at this time were black women, associations of dirtiness, untidiness, disorder, impurity, and overall improperness were tied to cultural understandings of blackness. Given the credentialed legitimacy of physicians and the marked cleanliness and sterility of hospitals, how was black midwifery to survive?

A coalition of medical organizations, chief among the American Medical Association (AMA), fought at the local and national level against the renewal of the Sheppard Towner Act in

1927 because they feared the Act to be promoting a socialist agenda toward the universal spread

of government control over the budding medical profession (Brickman, 1983). After all, great

gains were made in the late 19th and early 20th centuries toward professional homogenization

with increased standards for entrance into and curriculum in medical schools and greater

legitimacy for the obstetrics and gynecology specialty. Prior to this time, the specialty had been

little more than an opening wedge through which younger, lesser trained physicians gained more

training and/or the general practitioner sought and won patients (Borst, 1990; Flexner, 1910).

Despite such strong opposition, supporters did succeed in securing federal funding for

two more years but the Act was ultimately repealed in 1929. The withdrawal of funds officially

restricted the operation of midwife training and regulation, allowing lay practitioners to continue

practicing in remote areas[23]. I want to be clear that the sum total of the Sheppard Towner Act was

not all bad. However, it fundamentally altered the scope and practice of midwifery in this

country, particularly for midwives of color.

1930s-1950s: "I don't know nuthin' bout birthin' babies!" and "Germs Know No Color Line"

By 1935, midwives attended 10% of all US births (a 30% decrease from 1915) . Of those

1935 births, midwives attended only 4.5% of white births but 54% of non-white births (Devitt,

1977, pp. 47- 48). Still, the practice of midwifery was largely concentrated in the rural South

where the number of black residents exceeded the number of white residents (Tunc, 2010).

Within the black community, those that sought midwifery care and those that did not, was

largely divided by class. Black middle-class club women of the time began espousing the merit

of physician and hospital care as the vehicle to combatting the high maternal and infant mortality

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[23] Though official ended in 1929, the production of a 1953 "educational" film for grand midwives called All My
Babies by George Stoney of Georgia's Department of Public Health indicates otherwise. The same messages of
sterility, hygiene and cleanliness are evident in the film.

rates. Booker T. Washington, prominent black leader of the mid-18th and early 19th centuries,

infamously asserted, "germs know no color line" (Morone, 2005). Prissy, the young maid in the

1939 classic film *Gone with the* Wind, infamously asserted "I don't know nuthin' bout birthin'

babies!" (Fleming et al., 1939). The cumulative effect of such real and fictional representations

contributed to the portrayal of rural black women, and in relation, midwives, as ignorant disease

agents. On one hand, black women and midwives were victimized by a public smearing

campaign, deeply racist and classist trainings under the Shepherd-Towner Act and pressured by

the demands of scientific mothering (Ehrenreich and English, 2010; Kobrin, 1966; Wilkie,

2003). On the other, middle-class black women, men and even professional organizations (the

National Association for the Advancement of Colored People (NAACP), for example, never

defended midwifery), encouraged black women to seek hospital births and also called for the

training of black nurses and physicians (Wilkie, 2003).

Though this was a noble goal in and of itself, it had a counter-effect of further eliminating

black midwifery. The Hill-Burton Act of 1946, providing federal funds for the construction of

hospitals in rural areas, also was monumental in shifting birth from the home to hospital,

particularly for black women. For example, in 1935, the percentage of births in hospitals was

27%, by 1950 was 88% and by 1960 was 96% (Devitt, 1977, p. 47).

Devitt (1977) presents an irony of the mass exodus from home to hospital from 1930 to 1960:

> While the techniques of modern hospital obstetrics have saved the lives of many women and infants from genuine pathologies of birth, the literature of obstetrics in the United States from 1930 to 1960 does not show that healthy women with normal pregnancies benefitted from hospital obstetric care. Although statistically inconclusive, most of the comparable studies of home and hospital birth from the period, show that the incidence of birth injuries and obstetric mortality was greater in hospitals, probably due to interference in the normal birth process. These studies suggest that, despite the poverty, ill health and frequent high risk conditions of women who delivered at home….birth was not less safe than hospital birth from 1930 to 1960. (Devitt, 1977, p. 57)

As the Burton Act opened access for birthing black women into the hospital in the late 1940s and early 1950s, the "white revival" of midwifery that AROM mentions in this chapter's epigraph was beginning to slowly gain ground.

1940s Onward: The "White Revival" of Midwifery and the Development of Professional Midwifery Organizations

Beginning in the 1940s and swelling in the 1960s and 1970s, a strong counter-movement against the medicalization of pregnancy and childbirth developed. As obstetrics and gynecology shifted its focus from the management of the woman, to monitoring and surveiling the fetus, women began to demand more attention to their needs (Borst, 1990). Resisting being treated as "patient," women desired to awake, aware and fully present during birth.

The introduction of the Lamaze technique of "childbirth without pain" in the 1940s, Grantly Dick-Read's *Childbirth without Fear* (1944) and Ashley Montagu's (1955) article, "Babies Should Be Born At Home," in the *Ladies Home Journal* sparked a national dialogue on the increased rates of chemical stimulation of labor, episiotomies, cesarean sections and the then common practices of not allowing the mother's partner or other family in the birthing room and separating mother and newborn immediately after birth.

The late 1950s and the next two decades were a period of great social and cultural transformation with the civil rights movement, feminist movement and women's health movement with a rise of freestanding birth centers and home births. As noted in chapter one, however, women of color reported feeling disconnected from the primarily white and women's health movements for inattention to issues specific to women and birth providers of color (Collins, 2000; Craven & Glatzel, 2010). This connection is still manifesting itself today as

chapter four demonstrates my sample's feelings of disconnection and exclusion from mainstream professional midwifery organizations.

Ironically, though unfortunate, increasing scientific evidence confirmed as advantageous and safe the traditional practice of grand midwives (i.e. keeping women ambulant during labor and the use of herbal teas and oils) who were by this time passing on after having been subjected to marginalization and eventual elimination by the medical profession. This greater attention to the efficacy and safety of traditional midwifery increased their clientele and thereby fostered a need to appeal to a broader range of women, not just those who were part of their immediate community which had hitherto been the case.

Nurse-midwives were gaining solid ground with the establishment of their professional organization, the American College of Nurse Midwives (ACNM) in 1955 which later established national standards for education and certification for the title of Certified Nurse-Midwife (CNM) and expanded their scope of practice from primarily home-based to hospital-based.

To this end, in 1982, the Midwives Alliance of North America (MANA) was established as a professional organization for all midwives. MANA, in 1987, created the North American Registry of Midwives (NARM) which is an international certification agency that establishes standards and administers certification for the Certified Professional Midwife (CPM) credential. The CPM recognizes the diverse ways in which people enter into midwifery: apprenticeship, self-study, private midwifery schools, college- and university-based midwifery programs and nurse-midwifery. Identifying the need for an organization specifically devoted to the advancement of the CPM credential and profession, the National Association of Certified Professional Midwives (2000) was formed in 2002.

The history of black midwifery in this country leads me to end this section as I began it, with the quote from AROM: "A history of direct-entry midwifery that begins in the 1970s with the "white revival"[24] describes only the thinnest of top layers on a great foundation of centuries of work by African-American, Native American, Latina, Asian-American, and ethnically marginalized immigrant midwives." The question now is how does this history-of that which is proper, legitimate, scientific, hygiene, clean-continue to be reified in credentials alongside racist and classist imagery of black women and black midwives? How will the increase and diversification of midwifery be supported (gateways) and inhibited (gatekeepers) in a the credential society?

Midwifery and the Credential Society

The theoretical and empirical contributions of Sociology of Education conflict theorists Max Weber (1948) and Randall Collins (1979) are central to understanding current manifestations of credentialism. Sociologists in the conflict theory tradition have typically viewed society as based on the ability of dominant groups to impose their will on subordinate groups through force, cooptation or manipulation. The focus is not on physical force and so on but more on the ability of dominant groups to create and perpetuate an ideology or discourse that serves to maintain or enhance their position. Though Karl Marx (1848, 1867) did not write extensively about education, his work on economic inequality has served as much of the theoretical grounding for conflict theorists in the Sociology of Education. Max Weber (1948), however, asserted that class differences alone do not capture the intricacies of hierarchies and belief systems. Instead, he suggested more attention should be paid to the creation and

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[24] See Nestel (2006) for a discussion of white midwives' complicity in the exclusion of women of color and immigrant women from Ontario, Canada's midwifery movement.

maintenance, primarily via consumption and socialization, of status groups. He theorized that a consequence of an increasingly bureaucratic society is the rise of "the specialist," certainly relevant to the rise of the obstetrics specialty. Randall Collins (1979), a contemporary Sociology of Education theorist in the Weberian tradition, argues that education credentials, in this age of the specialist, are status symbols more than indicators of academic achievement or skill. It is not, he argues, that society is becoming more expert or even that an increasingly technologically advanced society demands more expert knowledge but that credentials are used by dominant groups to secure and maintain more advantageous places in the occupational and social structure. Professional organizations secure boundaries by raising entry-level requirements using a functionalist argument that such credentials were necessitated by increased skills of the professions.

What does this mean for the history of midwifery and contemporary midwives? Critical to this discussion is power. Obstetricians, largely through the American Medical Association (AMA) and the American College of Obstetricians and Gynecologists (ACOG), in lobbying and mobilizing efforts, economic and political resources, hold the power in defining a specialized body of knowledge and corresponding skills. To have such knowledge and skills, certified with the credential to practice specialized medicine, is to have the power of access and, equally important, to have the power of superiority in the cultural imagination.

Discourses of risk as danger and of the fallacy of normality have both micro and macro implications. First, the history of birth in this country and birth statistics post 1950s well document the extent to which American women and families have internalized this. As a researcher, teacher and as a woman, I know that refrains like, "having a baby outside of the hospital is dangerous and risky" or "I don't want to put me or my baby at risk" are all too

common. One of the ironies, of course, is that entrance into the hospital increases "risk" of cesarean etc., largely reflective of our postindustrial, capitalist society that places a great emphasis on speed, efficiency and technology (Ritzer, 1993; Rothman, 1989). Recalling Wilkie's (2003) discussion of Lucretia Perryman's use of artifacts to demonstrate "proper," scientific mothering, so too does being a proper mother demands one not put their baby at risk, which elevates the proliferation of the medical model in the media, in public statements released by professional medical organizations, insurance companies etc. as not simply "information" but mandates. This is despite the astronomical cost and ironic evidentiary danger of essentially treating all women as high risk. That is, despite incredible counter efforts, "birth" is synonymous with and "doctor" and/or "hospital."

Further, credential power often, as is the case here, grants authority to shape and/or aid in the creation and administration of boundaries for non-physician practitioners a la midwives. As "experts" or "consultants," secure in credential, specialized body of knowledge and skill, physicians have historically and continue to regulate all midwives' scope of practice with more medicalized credentials (CNMs or CMs) having greater access than other midwives but still often under the supervision of physicians. This ultimately has great policy implications as those not only with the credential-but the *proper* credential may sit at the proverbial table.

Gateways: Supporting the Increase and Diversification of Midwifery

One of the central research questions of this study concerns how black midwives interpret the increasing credentialism of midwifery and its impact on their work. I have conceptualized this section as gateways in an effort to focus specifically on experiences in and perceptions of the varying educational programs and pathways to a midwifery credential and/or practice. As

previously mentioned, while there are new, burgeoning programs and opportunities preparing

midwifery researchers and advocates, such as, Associate degree programs in Midwifery, a

Masters in Maternal Child Health with an emphasis in midwifery and a Doctorate in Midwifery,

which I discuss further in the last chapter, this chapter's focus is on the Certified Nurse Midwife

(CNM), Certified Midwife (CPM) and Certified Professional Midwife (CPM) education

programs and pathways as I spoke with only CNMs, CMs and CPMs, mostly representative of

the midwifery credential landscape. The details of their pathways and programs are given special

attention here.

The Accreditation Commission for Midwifery Education (ACME) is authorized by the US

Department of Education to accredit midwifery education programs and institutions for CNMs.

CNMs are generally required to have a Bachelor's degree from an accredited college or

university to be granted admission to a Midwifery Education Program, with some variation in

Registered Nurse (RN) licensure prior to enrollment but it is a requirement for the certification

exam. Their clinical skills training must meet Core Competencies for Basic Midwifery Practice

under the supervision of an American Midwifery Certification Board-certified CNM/CM or

Advanced Practice Registered Nurse (APRN) who holds a graduate degree and has clinical

expertise and didactic knowledge commensurate with the content taught. Upon completion of

required coursework, CNMs are granted a Master's or doctoral degree and are eligible to sit for

the certification exam administered by the American Midwifery Certification Board (AMCB).

Certification must be renewed every five years.

The Midwifery Education Accreditation Council (MEAC) is authorized by the US

Department of Education to accredit midwifery education programs and institutions for CPMs.

There are two primary pathways for CPM education, with differing admission requirements. The

first is the Portfolio Evaluation Process (PEP) pathway which is an apprenticeship program with no degree or diploma required. Students must work with a midwife preceptor who is nationally certified or state licensed, has practiced for at least 3 years, and attended at least 50 out-of-hospital births. Upon completion, students submit their portfolio for university review to determine their eligibility to sit for the certification exam. No degree is granted through the PEP pathway. The PEP pathway was greatly contested in my data, as demonstrated below. It is important to note that just recently, as of April 2014, portfolios now must be reviewed by an accredited university.

The second pathway is similar in nature to that of the CNMs-via an accredited formal education program in which admission requires a high school diploma from an accredited school. Their clinical skills training must meet Core Competencies for Basic Midwifery Practice developed by the Midwives Alliance of North America under the supervision of a midwife who must be nationally certified, legally recognized and who has practiced for at least three years and attended at least 50 out-of-hospital births. MEAC-accredited programs vary and may grant a certificate or an associate's, bachelor's, master's, or doctoral degree. Most graduates attain a certificate or associate degree. There is no minimum degree requirement for the CPM certification exam administered by the North American Registry of Midwives (NARM) but candidates must have completed the PEP pathway, graduated from a midwifery education program accredited by Midwifery Education Accreditation Council (MEAC), be a AMCB-certified CNM or CM or completed a state licensure program. Certification must be renewed every three years.

In preparing the proposal for this research, I hypothesized that black midwives would report some level of resistance to the increasing credentialism of midwifery. That is, I

anticipated midwives might, in some ways, report that increased and pervasive credentialism somehow had a negative impact on historical, non-institutional and intuitive ways of knowing. I was partially correct. A sense of respect for midwives as pillars of their community, as "othermothers," was often articulated as a loss, but credentialism was generally unquestioned. The contemporary need for credentials-"especially if you are black"- was accepted as reality and fact.

Though there was some debate as to whether a minimum requirement for midwifery should be "some college" or a Bachelor's degree, overwhelmingly, a high school diploma was determined to be an insufficient minimum requirement. It is important to keep in mind that everyone in my sample has earned at least a Bachelor's degree.

Whether CNM, CM or CPM, and across age and location, midwives overwhelmingly reported overall satisfaction with the preparation they received in midwifery education institutions. Of course, some things must be learned by doing-"Nothing really prepares you for that first birth" was a common refrain-but those in my sample report great preparation and satisfaction. This finding is great news. It is a testament to all midwives and midwifery educators. Great work is being done and this should be commended and celebrated. Dorothy (CNM, 5-10 years experience), Nikki (CPM, 25-30 years of experience) and Toni (CPM, 20-25 years of experience), each have different credentials with varying years of service, yet they all are consistent in their praise of the education they received:

> My program was awesome! It was incredibly well structured and organized. I felt very well prepared.
>
> *Dorothy*

> I think I use what I learned in my program every time I am with a mama. Experience comes with time but, of course, it was a great experience overall. I was and am well prepared.
>
> *Nikki*

My program was outstanding. The online structure was incredibly convenient but just….solid. It wasn't just a bunch of discussion boards but real group work and close connections with my Professors. The content was awesome. It was well worth it.

Toni

So, what of those midwives who do not receive formal training in a midwifery education institution and instead embark on the PEP pathway toward the CPM credential? As Audre (CPM, 10-15 years of experience) notes, "it is the Achilles Heel of Midwifery." June (CNM, 35-40 years of experience) makes a similar claim: "Apprenticeship should be *a part* of any education program-not the sum total of the education program." This is especially complicated when there is a cultural understanding of "nurse". Consider Phyllis' (CPM, 15-20 years of experience) words on this matter:

> Let's face it. You get it, you know? You know that being black or any minority in this country is a challenge. Degrees are what you need. Midwives need to be at the table. Like….midwives were not at the table when all the conversations about health care were going on. I think the PEP process cheapens the CPM credential. In a lot of ways, I think they are at a disadvantage because people know and have a framework for what it means to be a nurse and don't have that for CPM. They may not know CNM but people know nurse! CPM requires more….you know…explanation. A lot of times, people aren't interested in the explanation. They want to be able to recognize something. So…basically….I just think that they all need to go through an education program and get good clinical skills. From what I understand, the clinical skills are not the same with CPM education programs and our clinical skills preparation.

Phyllis

Both Audre and Lorraine (20-25 years of experience), both CPMs, consider, at the very least, the importance of *some* college in order for the credential to be taken seriously:

> I think there should always be a place for traditional midwives. They….um…are our history. But we are trying to grow and serve more women. We want to be taken seriously. It's just not good enough and, quite frankly, it is hurting us. What I mean by 'not good enough' is that the work we all do is valuable but because we're trying to grow and gain access, everyone needs to have at least a Bachelors degree and everyone should be going through an education program. There are a lot of issues that come with that though. White girls can get away with PEP. We can't. The piece of paper is important.

Audre

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> This is strange to say because I am a CPM and I value and respect the PEP process. Many people who I…I respect have, you know, gone through the process. This is hard. But, I'll be honest. We need to raise the bar. You need at least two years of college to develop basic analytical skills. A high school diploma, in this day and age, is like an 8th grade diploma. It's simply too basic.
>
> *Lorraine*

Both Audre and Lorraine are signifying the salience of credentialism, though Audre complicates the credentialism thesis by considering its fundamentally raced nature.

A few points really strike me here. First, there is a clear, well-established hierarchy of credentials; the more medicalized the credential, the more power, prestige and, to engage Weber (1948) and Collins (1979), *status*. Phyllis says, "people know and have a framework for what it means to be a nurse and don't have that for CPM. They may not know CNM but people know nurse! CPM requires more….you know…explanation." Today, the likelihood of people being, knowing or encountering a nurse in their lifetime is far greater than being, knowing or encountering a midwife. The general public understands, with little explanation, the nature of the nursing profession, including their education pathway. Yet, the general public does not naturally or conventionally understand the nature of midwifery, particularly not the varying types of midwives and differences in corresponding education programs and pathways.

Medical professional organizations, including nurse and nurse-midwifery, have been very successful in ensuring the recognizability of and relative respect for their credentials. One need only remember Booker T. Washington's urge to increase the corps of black nurses. This, despite my incredible respect and admiration for CPMs, realistically puts them at a disadvantage in the midwifery education landscape, especially without greater mobilization and partnership on the part of their professional organizations to increase the credential's recognizibility and respect. As I mentioned above, CPMs all reported great satisfaction with their education programs; I, too,

have been witness to and participated in this great work and know of great efforts on the part of

MANA and NACPM in this area. Yet, ultimately, it is state-level and insurance policymakers

who first need to know and understand the value-in terms of quality, increased access and cost

effectiveness-of the CPM. The empowerment of CPMs, and all midwives, rests with such

policymakers. With policy changes, the quality, access and cost of maternity care will be

positively impacted by the effectiveness of the work of midwives.

 Secondly, garnering respect for the CPM credential seems to be greatly hindered by the

PEP pathway-the Achilles heel, as mentioned earlier. The fact is that the "piece of paper"-that

Audre (again, a CPM herself) references is important to the profession. A high school diploma,

for example, is also a piece of paper yet its currency in the proverbial education marketplace is

low in comparison to, say a, Bachelor's degree. In the interview, I intuitively knew that Audre

was referring to the Bachelors degree credential when she said "piece of paper" but followed up

for clarity to which she responded, "C'mon. Of course I am talking about a Bachelor's degree.

You know."

Interestingly, Alice, another CPM practicing on the opposite side of the county from Audre

echoes her sentiments. Alice, a relatively new CPM with 5-10 years of experience, says this

about the PEP pathway:

> It just assumes too much. Here are trying to play the game of birth we began that's
> been kind of hijacked, you know, but we need to play it. Think what happened
> to…you know, the grannies when they didn't have the credential. They needed to be
> legitimated, validated by an institution. Sad, but true.

Here, Alice is expressing a continuity of black midwifery history. Later in the interview, she

extends her discussion of legitimation and validation beyond midwifery to black Americans at

large by referencing Steve Jobs, the late co-founder of Apple Inc., and Mark Zuckerberg, the

founder of Facebook, both of home famously never earned a college degree. Alice says, "I tell

my family and friends all of the time…YOU are not Steve Jobs! YOU are not Mark Zuckerberg! You need to go to school. We need that to eve get in the door and be taken seriously. This is just a gamble whites can take because people assume…intelligence and whiteness are associated. It is just not the same for blacks."

The "*You* know" from Audre and the "we" from Alice brings me to my third point, here reflective of the "sister-to-sister talk" Few, Stephens and Rouse-Arnett (2003) theorize. There is a familiarity, an understanding-spoken and unspoken. The fact is, those seemingly simple phrases and words are making an important statement on the ways in which credentials become raced and classed. That is, "alternative pathways" may be acceptable for "the white girls," and Audre is certainly assuming they are white women with resources. Instead, you must "work harder, be better" in order to "play the game." In fact, I could use myself as a data point here to support Phyllis, Audre, Lorraine and Alice's claims. The message from my parents was not simply to attend school-that was the expectation- but to *excel* in socially *proper* schools. The expectation was not simply to obtain a Bachelor's degree, but the *proper* degree, i.e. that which is transferrable in the marketplace. I have worked to obtain a PhD., a title which is certainly recognizable and well-respected in the marketplace. Nurse, again, is a title that is certainly recognizable and well-respected in the marketplace. These "alternative pathways" are a gamble then, but a pathway that white women may be able to take because of white privilege and networks?

In one of my favorite articles, Peggy McIntosh's (1990) "White Privilege: Unpacking the Invisible Knapsack," McIntosh, a white sociologist, brilliantly reflects upon and lists 50 effects of white privilege in her daily life. A few favorites from her list, are:

> 7. When I am told about our national heritage or about "civilization," I am shown that people of my color made it what it is.

8. I can be sure that my children will be given curricular materials that testify to the existence of their race.

16. I can be pretty sure that my children's teachers and employers will tolerate them if they fit school and workplace norms; my chief worries about them do not concern others' attitudes toward their race.

20. I can do well in a challenging situation without being called a credit to my race.

21. I am never asked to speak for all the people of my racial group.

22. I can remain oblivious of the language and customs of persons of color who constitute the world's majority without feeling in my culture any penalty for such oblivion.

24. I can be pretty sure that if I ask to talk to the "person in charge", I will be facing a person of my race.

50. I will feel welcomed and "normal" in the usual walks of public life, institutional and social.

(p. 31)

McIntosh's work signifies the deeply institutionalized nature of white privilege. I imagine if the midwives I interviewed were to craft sentences of their own, they might reference the "white girls' network" and its power to secure preceptorships for its white student midwives and also secure, though, I am willing to bet, usually unintentionally, the continued increase and demands of white midwives (see "Gatekeepers" section of this chapter). I imagine these midwives might state that the PEP process, a demonstration of traditional ways of knowing only with the absence of the credential, is a pathway of privilege.

Finally, these conversations about the proper credential were complicated by a notion of "realness." It is hard to explain the extent to which this discussion of credentials-legitimacy, access, proper-made me feel an unexplainable level of tension and discomfort. The notes after my second interview with two CNMs have "'us' and 'them'; 'real midwifery'" scribbled in the margin. I wasn't entirely clear what I myself meant by that but I researched and stumbled upon a 1990 guest editorial written by Helen Vurst (1990), a CNM, in the *Journal of Nurse Midwifery* aptly titled "Real Midwifery." Though Vurst's piece focuses on tensions within the nurse midwifery community, i.e. primarily in-hospital practicing nurse-midwives versus primarily out-of-hospital practicing nurse midwives, Vurst's opening words well exemplified my feelings that

arose with contemporary black midwives in all scopes of practice:

> Since the 1970s, nurse-midwives have heard accusations that some or all of us were not practicing "real" midwifery. The accusers have been both within and outside of the profession. The result has been that many nurse-midwives at one time or another have felt belittled or unappreciated, hurt, angry, and bitter.
> There are those who define the practice of "real" midwifery by locale, claiming that "real" midwifery can only be practiced in the home or in a freestanding out-of-hospital birth center. There are those who define the practice of "real" midwifery by the availability of choices concerning IVs, delivery position, and presence of significant others. There are those who variously denounce others as "macho," "earth mother," "nursey," "cosmic," or "medical" while proclaiming themselves as practicing "real" midwifery. There are those that believe that one has to be a nurse to be a midwife and those who question if a nurse can be a "real" midwife. (p. 189)

In the nurse midwifery community, Vurst traces the origins of such tensions to the mid 1950s when midwives scope of practice was expanded. There followed a series of statements on home birth from ACNM purporting the "safety" and "distinct advantage" of the hospital for women and babies, leaving nurse midwives practicing in the home feeling rejected and alienated. With the counterculture movement of the 1970s and the rise of freestanding birth centers in the 1980s, a history already reported herein, it was the hospital based nurse-midwives feeling rejected and alienated, a sentiment expressed in my study amongst my cohort of nurse and non-nurse black midwives. Marie, a CNM with 20-25 years of experience frames this as "selling out":

> It's kind of like the *med*wives thing, you know? That we're steeped so deeply in medicine and it's kind of like 'stay away.' That maybe…maybe we've 'sold out' to the medical establishment. The fact is that there is like a line…a…um…continuum if you will of how medical you get, how much you intervene, the culture in the hospital…you know what I'm saying? I think grouping us all together is just not realistic.

Perhaps the grouping is unrealistic, as Marie exclaims, because there is some perception that "real midwifery" is practicing, as Dorothy, a CNM with 5-10 years experience, says, "where the women are":

> I have a very simple response to your question. I want to be where the women are. My women. Black women. They are in the hospitals. They are in the clinics. They are not the ones having the home births or paying out of pocket in the birthing centers. Our women

don't want that, don't know about it….whatever the case, CNMs work, black CNMs work where our women are. And you really need good clinical skills for our women who show up with a different set of challenges than other women-preeclampsia, diabetes, gestational diabetes and not to mention all of the other stuff going on in our lives that manifest on our body. It's tough but it's the truth.

Yes, the majority of black women-and all women-are birthing in the hospital because of legality, insurance coverage, and, frankly, the success of the medical model. Those with nursing education certainly do have the "good clinical skills" Dorothy refers to but, I wonder, does this imply that non-nurses don't have such skills? I am not sure it is an either-or debate. Unfortunately, there is simply a lack of consistency or clarity about the skills, clinical and otherwise, that CPMs must master. This is important area of attention for organizations devoted to advancing the CPM credential to understand and take into account.

Relatedly, the perceptions of which midwives' work is "harder" demands attention from national midwifery organizations to inform policy agendas that will alleviate some of the reported difficulties. Consider Octavia, a CPM with 15-20 years of experience, who related the following:

> Our work is…I don't want to say harder but…harder? We have to work hard to get the clients because we don't have the safety of consistency like what's in the hospital. So our work is really the teaching-teaching that birth is safe, that the hospital is not your only option…this is our work. Especially for women of color. Black women. I wanted to be a part of that. Nursing never appealed to me. I want to be in line with the history of midwifery. Nothing less was going to do.

Again, the majority of CNMs working in hospitals in this sample reported that the majority of their clients were women of color. Octavia, a CPM working in a birth center, indicates that she, and arguably all CPMs, are doing the "teaching" of the safety and efficacy of the Midwives Model of Care when employed outside of the hospital. For women of color, especially black women as Octavia claims, it simply requires social and cultural capital to be aware of and have access to midwives. Though the CNMs in my sample may already have a captive audience of

women of color-primarily women with Medicaid-can we conclude that nurse midwives, too, don't do the same kind of "teaching" to which Octavia refers?

Despite this lack of clarity on skills and internal tensions, there is hope in this story. I love Kimberlee's account of taking on 'real midwifery', as a CNM practicing both in the home *and* in the hospital, which is a rarity:

> I'm not sure the gap…or division….or…..I'm not sure it needs to be bridged. Like me [stands up], I am a nurse [shifts to left], I also do home births [shifts to right] and I feel [moves to middle] give me the respect I deserve. Respect and honor me when I see you as I you. Let's stop all the catty stuff…black women…we can't afford to do that…let the white women do that. We need unity. We are *all* midwives. And I feel confident saying we all want the best for our women and babies even if our paths are different.

I sensed a desire, from all of the women I interviewed, to honor the centuries of great midwives and traditions in their own work. For all of its pain and struggle, it is also a beautiful history of "knowing," of skill, community, family, and love. I understand and respect this desire; I desire it, too. In our highly industrialized, commodified society, we are seeking authenticity-a return to our roots, a sense of realness. Yet, I caution us to consider the larger structural question: how is this framework of "real midwifery" impeding the goal of better births for all women? This, I am fully confident in saying, it is the goal of every midwife with whom I spoke and all midwives for that matter. Reconciling such internal divisions, and what appear to be great misunderstandings of each other's pathways and experiences, seems to be the first obstacle to structural change. This work should begin with greater communication and collaboration among midwifery professional organizations, education institutions and accreditation agencies. Leadership, I believe, sets the tone and expectation, for practitioners. Failure to immediately communicate and collaborate, especially for and among black midwives, stalls the goal of making a positive impact on United States birth outcomes and experiences for women.

Gatekeepers: Inhibiting the Increase and Diversification of Midwives

A focus of this study was to investigate the experiences of midwives in their varying educational institutions. The following discussion centers around two recurring aspects of midwifery education-school climate and preceptorships- which I have framed as "gatekeepers" to the increase and diversification of the U.S. corp of midwives. That is, the climate of education programs and difficulties student black midwives experience in securing preceptorships may inhibit the retention of black midwives, and arguably midwives of color more generally. Again, the experiences of CNMs, CMs and CPMs are far more similar than different, signaling the need for continued, cross-organizational work in these areas.

School Climate

In recent years, I have had the pleasure of doing consulting work with Dr. Brian K. Perkins, Director of the Urban Education Leaders Program at Teachers College, Columbia University, Director of the Center for the Study of School Climate and Chair of the Council of Urban Boards of Education of the National School Boards Association. Dr. Perkins has administered three national surveys-students (*Where We Learn*-2006), teachers/administrators (*Where We Teach*-2007), and parents (*What We Think*-2008)-on perceptions and experiences of school climate or what he has defined as " the learning environment created through the interaction of human relationships, physical setting, and psychological atmosphere" (Perkins, 2006, p. 1). Such studies aid in understanding the experience of school community and have measurable effects on student achievement and other areas: "Research shows that improved school climate contributes to: • Higher student achievement • Higher morale among students and teachers • More reflective practice among teachers • Fewer student dropouts • Reduced violence • Better community relations• Increased institutional pride" (Perkins, 2005, p. ii).

Of particular relevance here are the student data. The *Where We Learn* survey is a nationwide survey of approximately 32,000 students in 108 city schools and is one of the most significant studies of climate since James Coleman's 1966 seminal *Equality of Educational Opportunity*[25]. The findings of this study are grouped in five cohorts: •School Safety; •Bullying; •Trust, Respect, and Ethos of Caring; •Racial Self-Concept; and •General Climate.

My focus herein is on Perkins's (2006) Trust, Respect and Ethos of Caring scale. The following are some of the major findings on black student experiences of Trust, Respect and Ethos of Caring:

- Almost a quarter of all respondents (23.3%) do not think students in their schools trust the teachers. African-American students represent 32% of that population-the largest of the surveyed racial/ethnic groups.
- 36.4% of respondents believe students do trust the teachers, but only about 11% of that total strongly agrees with this belief.
- A majority of students (59%) agree or strongly agree that the teachers in their schools respect the students. One-fifth (20.8%) of the students, however, do not believe teachers respect the students in their school. Among the 20.8% who feel students are disrespected, 31.5% are African American, compared with 17.5% for white students, 14% for Hispanic students, and 12.4% for Asian students
- 66.7% of Hispanic students indicated believe that teachers are respectful, compared with only 48.5% of African-American students who share this belief.
- A majority of the students surveyed (64.3%) either agree or strongly agree that their teachers care about their success. 12.7% of all students surveyed do not believe their teachers care about their success with African-Americans most likely of all surveyed racial/ethnic groups to report this disbelief. (pp. 3-4)

As I asked the midwives in this study about their experiences in their varying programs, interestingly, words like "trust," "respect" and "care" consistently emerged in the data. School climate, nor specifically the Trust, Respect and Ethos of Caring scale, were not identified in the research design of this study but, nevertheless, emerged. The quantitative data identified in the national study were firmly etched in my mind. I continued to recall this data as I listened to my sample describe their experiences. Consistently, perceptions of the importance of respect were

relayed. bell, a relatively new CNM with 5-10 years of experience says, " You have to work harder. Prove your worth. It's so hard. C'mon. You know this. It's hard. Without feeling like people respect me, my work, my capabilities…..shoot, it's hard." Both Gwendolyn, a CNM with 20-25 years of experience, and Zora, a CPM with 10-15 years of experience, further the discussion by adding that respect, *safety* and *love* are essential to retention, especially when one is in a white-dominated institution or program:

> Well, you teach, you know? There is a safety…a love…a sense of respect that must be in place before learning can happen. You can put black people in your brochures all day but until you have done your work on your end…it is hard being 'the only one' or 'one of the few.' An acknowledgement of whiteness and white privilege must be there because otherwise it impacts experience. When questions of blackness come up, people looked to me. Schools everywhere, this is not just about midwifery, have to do their work. You have to really care.
>
> *Gwendolyn*

> There was one black woman on faculty and she was my lifeline. She advocated for me. She allowed me to vent. I credit her as being one of the reasons I am here today. Black students can't, or at least shouldn't do it without this. I think it's hard to be successful without feeling respected or….cared for….or feeling like the environment really values my contribution. Does that make sense? It's really hard to get to content without some of the more 'abstract' stuff being in place. And this, from my experience and the experience of my friends, is necessary in person *and* online!.... Thankfully, I had a sister in my class. We cheered each other on. It was like ride of die. She was my safety. I don't want to be dramatic but it's honest. It's my experience.
>
> *Zora*

All midwives are expected to learn and practice within the Midwives Model of Care. And yet, ironically and sadly, Gwendolyn and Zora are reporting not feeling cared for by midwifery educators (midwives themselves!) and midwifery education programs. This is a great cause for concern. Midwives must midwife their midwives.

Additionally, the diversification of midwifery *faculty*-both as teachers and advisors-is also essential to perceptions of trust, respect and ethos of caring. Angela, a CNM with 35-40 of experience, explains this further:

> You know what's crazy? There was absolutely no one that looks like me in my program! No one who was teaching me that looked like me! And that was important to me because, as you know, race is so salient in midwifery. I wanted to learn from more experienced sisters who have worked with our women. That matters in theory, practice, clinical skills…all of it. But there was a black receptionist. It's crazy because she was not an educator but just here sheer presence was incredible. She got me. Do you understand what I mean by that? She knew what it meant to be black in a white institution…a place of…power. It did not matter that she was not a student. She got me. That mattered. I love that woman to this very day.

Angela indicates the significance of "someone who looks like me." Diversification of midwifery faculty is just as important as the diversity of its students. Of my sample, four midwives had formal teaching posts in midwifery education programs. This serves as a powerful resource-visually and in practice-for students.

This issue of school climate is not solely a midwifery issue; nor is it solely a black issue. It is a national issue. The focus on this cannot be lost. Yet, for midwifery programs and educators, the data have important implications. Theoretical and empirical discussions of race and racism must be central throughout all programs. Perpetuating a color-blind ideology of midwifery not only ignores the raced experience of education programs but also does not equip all midwifery practitioners with the tools to best support all women. In the area of anti-racism, I am most familiar with the efforts of Bastyr University's Department of Midwifery. Midwifery students are required to complete two courses—Undoing Racism and Cultural Competency for Midwives. Additionally, faculty are required to complete a course on the fundamentals of undoing racism to best create an anti-racist environment. The long-term impact of such courses and efforts remain to be seen but I certainly applaud them as a step in the right direction. Increased faculty of color and scholarships for students of color are vital.

Largely, these experiences suggest the importance of actively creating institutional space for trust, respect and caring.

Student midwives are required to spend time-the length of which depends upon the program or pathway-gaining clinical skills with a more seasoned midwife. The process for acquiring such a preceptorship, I learned, is often quite the challenge. In some cases, programs may systematically assign students with practicing midwives. In cases where this does not happen, students rely on social capital-theorized by Pierre Bourdieu (1986) as the "aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition" (p. 51) Consider Alice's (CPM, 5-10 years of experience) discussion of the operation of social capital amongst midwives of color though not directly employing the term:

> I have to say, here in [southwestern city], we have a community of midwives of color. There are very few of us-I am talking about my Asian sisters, you know, my Hispanic….we help each other. It's nothing formal per se but if we know someone in a program…you know, we help them because it's hard. I think it's hard for all midwives but I think there is a ' good ol' white girls network…' they look out for each other and we need to do the same. Sadly though….I'll just say it….for us as black women, though, we have to do better. We are so busy competing with each other that we don't always build together.

The competition Alice speaks of should be understood, again, within the challenges of the CPM credential. It is quite difficult to maintain a private practice or maintain work in birth centers. This is an issue for all midwives. Yet, given the challenges midwives of color have expressed, it would seem to be all the more reason to build not just supportive but also structural preceptor/job placement networks. Consider Ida's, a CNM with 35-40 years of experience, story:

> I'll never forget…I asked a white midwife here [northeastern city] if I could apprentice with her. She said no because she didn't think patients…white…would feel comfortable.

Sick. But here I am black woman, brown skin, locks[26], head wraps…you know. That is a threat. Without other options, it took me a long time to find someone.

Stories like this were all too common. Social capital-the power of networks-has the potential to produce and reproduce inequality by securing boundaries, much in the same way as credentials do. The reference to "comfort" is quite loaded. A woman not feeling comfortable with a male health care provider registers as something very different than a white midwife expressing concern about the comfort level of her white clients with a black woman present. These kinds of challenges, unfortunately, will be present independent of who does the placements but I contend that to the extent that schools are able to mediate this burden for students, it will likely have positive results. Further, this also seems to be one important initiative for midwifery professional organizations though I am aware of work on the part of MANA's Midwives of Color section and ACNM's Midwives of Color Committee to match student midwives with preceptors. Reaping the benefits of such matching, however, assumes organizational membership which, as I will demonstrate further in chapter four, presents many challenges for midwives of color.

A Contribution to Sociology of Education Literature

There's that old adage that you have to know where you come from in order to know where you're going. Though cliché, this adage helps my understanding, in this study, of the history and state of midwifery for women of color. From the "midwife problem" espoused in the early 20th century that led to the labeling of black (and other midwives of color and immigrants) as dirty, ignorant, unsanitary and the like; to the subsequent large influx of white public health nurses to license, certify and *cleanse* southern black midwives; and then the credentialing of

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[26] The significance of black hair in midwifery is theorized in the next chapter.

midwifery, with greater scope of practice and legal recognition for those practicing within the medical model and the complexities of the experience of acquiring those credentials has impacted the less than 2% black midwifery population of a reported 15,000 U.S. midwives.

I cannot stress enough the importance of professional organizations' continued work in developing and solidifying the recognizabilty and respect for their respective credentialing for midwives. Again, state level and insurance policymakers must understand the quantifiable value of midwives, of all credentials, and their work. This is perhaps most seemingly relevant to CPMs-"people have a framework for nurse"- but CNMs, too, are certainly constrained by the dominant medical discourse and practice. This, for me, is all the more reason why while I respect the "real midwifery" tensions-spoken and unspoken-I encourage us as a community to push beyond such questions because, as Kimberlee says above, "we are all midwives." Black midwives in this country are far more similar than different. The histories, both beautiful and painful, of Margaret Charles Smith, Maude Cullen, Onnie Lee Logan and other black grand midwives both known and unknown, are those of all midwives with whom I spoke. Of course, increased visibility, recognizability and respect is a midwifery issue; yet, legacies of racism-dark dirty, ignorant, incompetent-crystallized in what Patricia Hill Collins (2000) calls "controlling images" like mammy, matriarch, jezebel and welfare queen are marked on the body and continuously reified in popular culture. Combatting such images is especially challenging in what Weber (1948) theorizes as the age of "the specialist" and Collins (1979) theorizes as the credential society that are still relevant today. Ultimately, we are living in an age of specialization and the demand for credentials is great-reflective of a structural need to secure legitimacy, power, authority and professional dominance. For midwifery, this process began in the early 20th century and has only since intensified. In my thinking, the credential demand-

specifically at least a Bachelor's degree-is the modern day demonstration of early enslaved women having to earn the respect of other slave women before attending birth alone. This is certainly now complicated by admission into and retention in varying education programs but the credential is the entrance pass.

In this way, my work is only supported by Weber (1948) and Collins (1979). Yet, my work also makes three fundamental contributions to the credentialism thesis. First, credentials are steeped in power relations but are also deeply raced and classed. I need only revisit the "white girls can get away with that" exclaimed by Audre and Booker T. Washington's 19th century demand for mass entrance into hospitals for birth and nursing as an occupation for black women. Again, the demand is not simply to get the credential, but the proper credential-at the very least a Bachelor's and given the history of black midwifery in this country, a Bachelor of Science in Nursing is the proper credential for status, prestige and economic gain. In many ways, there is truth to such a claim, specifically as CPMs struggle with securing not only legality in all 50 states but also third-party reimbursements. Such policy changes are essential to the viability of increasing the number of non-white CPMs. Of the nine CPMs I spoke with, only one was partnered and presumably sharing financial responsibilities.

Second, the process of acquiring credentials, i.e. midwives' experiences in their varying education programs, is a raced experience. Using Perkins's (2006) frame, an ethos of trust, respect and caring, along with a culturally responsive environment, is essential to the successful completion of an education program. The experiences of the midwives I interviewed are consistent with the literature on black students in k-12 and higher education (Delpit, 1995; Delpit & Dowdy, 2002; Jencks & Phillips, 1998; Perry, Steele & Hilliard, 2003; Steele & Aronson, 1995; Solomon, 2009; Tatum, 1997; Woodson, 1992.) This consistency signifies the continued

work necessary.

Many great education theorists-Paulo Friere (1970), Henry Giroux and Anthony Penna (1983), Michael Apple and Nancy King (1983), among others-have theorized how the "hidden curriculum"-norms, values, expectations that are not formally written or communicated but are felt a school's community members-impacts and, in many cases, impedes academic achievement. My data demonstrates that seemingly micro interactions and experiences have macro consequences, specifically retention in midwifery education programs and ultimately the diversification of the nation's corps of midwives.

Third (and here I owe my thought process and theoretical development to many conversations with Barbara Katz Rothman), ensuring recognizability, respect and clarity. There are more conversations and work to be done with respect to communication and marketing, explicitly and deliberately communicating the *value* of midwifery skills and services. In chapter one, I have demonstrated the economic value-the cost benefit-of midwifery care for prenatal, childbirth and postnatal care. This is an important conceptualization of quantitative value. Here, though, I am arguing for marketing the qualitative value of the incredible accounts I heard in my interviews, such as: crafting birth plans in homes and in hospitals; communicating to families the efficacy and safety of midwifery; knowing[27], with both intuition and skill, when the baby is "ready"; where, when and how to assist in maneuvering the woman's body for maximum comfort and ease; taking great care to know not only the woman but her partner and other family members-their excitements, worries, frustrations. There is a fluency in both quantitative and qualitative language and value in the data I have gathered in these project. There is something so very beautiful and powerful in this.

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[27] See Davis-Floyd and Davis (1996) for a discussion of this "knowing" as authoritative knowledge in midwifery and homebirth.

We are certainly living in a highly industrialized, commodified society, experiencing George Ritzer's (1993) theoretical McDonalization-consumed by the demands of efficiency, calculability, predictability-control. Yet, from my research, I have found that actually there is more of a desire for the "authentic", a return to our roots, a sense of realness. This is beginning to be displayed in my own surroundings, for example, the Domino's Pizza in my neighborhood prominently displays a sign on its door that it specializes in the "craft of handmade artisanal pizzas" and my yoga studio, owned by the high-end fitness chain Equinox, boasts of a "true, authentic yoga experience." Collectively, across all races and scope of practice, midwives can capitalize on this authentic economy-marketing their skills of both *survival* in terms of excellent birth outcomes but also an immense amount of power and *empowerment* in the authentic, active participation of the birth experience.

Chapter Three

Another Bitter Pill: On the "Common Sense" of U.S. Black Birth Outcomes and Black Women's Underutilization of Black Midwives

"….the drag on our overall economy that comes with taxpayers, employers and consumers spending so much [on health care] more than is spent in any other country for the same product is unsustainable. Health care is eating away at our economy and our treasury. The health care industry seems to have the will and the means to keep it that way. According to the Center for Responsive Politics, the pharmaceutical and health-care-product industries, combined with organizations representing doctors, hospitals, nursing homes, health services and HMOs, have spent $5.36 billion since 1998 on lobbying in Washington. That dwarfs the $1.53 billion spent by the defense and aerospace industries and the$1.3 billion spent by oil and gas interests over the same period. That's right: the health-care-industrial complex spends more than three times what the military-industrial complex spends in Washington."

(Brill, 2013, p. 3)

In March of 2013, I retrieved my copy of a *Time* magazine special report by Steven Brill from my mailbox. The cover has an image of an aspirin embossed with "Bitter Pill" and a subtitle that reads "Why Medical Bills Are Killing Us." An accompanying note to the left of the aptly named bitter pill says "one acetaminophen tablet costs 1.5 cents. Your hospital marks it up 10,000%" (cover). The featured case studies of people throughout the United States, with and without medical insurance, who essentially have been victims of: the fee-for-service model dominant in the United States, insurance company annual or lifetime payout limits, prescription drug company monopolies, costly medical malpractice insurance, outrageous hospital administrator salaries, the ambiguity of the chargemaster that massively overcharges patients and insurance companies (consider the aspirin upcharge), rampant misuse of expensive laboratory equipment, the complexities of Medicare's "overdoctoring" and lack of competitive bidding for standard medical supplies, amongst countless other issues, is The situation is bleak, disheartening and terribly frightening.

Maternity care in this country fares no better. As noted in chapter one, the birth outcomes for black women and babies are the worst of racial/ethnic group. As maternity care providers, the cohort of black midwives I've interviewed for this study, are well poised to interpret dismal black birth outcomes and black's relative underutilization of black midwives in this country.

On U.S. Black Birth Outcomes

The Social Operation of Racism

I asked, "Black women and babies experience the reported worst birth outcomes of any racial group. How do you interpret these statistics?" Without fail, though not surprising, 100% of midwives attributed the statistics to the social operation of racism. The growing body of public health research in this area supports these assertions. Audre, a CPM with 10-15 years of experience, discusses the dangers of color blind racism:

> Black women…we, we are the example of just how bad black birth is. I am so tired of hearing stuff like 'I don't see color.' That's bullshit. It matters. It's not about prenatal care as it was originally thought. It's about treating people…black women…like shit.

Color-blind ideology and discussions of a "post-race" U.S. society in the age of President Obama obscures the deeply entrenched social operation of race and racism. Mary, a CNM with 40-45 years experience, also rejects the color blind ideology, and responded in this way:

> Racism is omnipresent and all consuming. It is unrelenting. I have been doing this a long time, you know….birth. I see it. I don't know how to explain it. But, I see it. I see it while the baby is in the mama's womb and during birth. I see it. We can have all the health care in the world. I love Obama, but unless we did something to fix this racist world we live in, we can only hope and pray. Every time a black baby is healthy and enters this world, it's a miracle. I always said a prayer, you know, because they beat the odds. We all did.

The "odds beating" Mary relays is supported by the fact that socioeconomic status is not a predictor of black outcomes.

Access to health insurance, it seems, is an important policy development. Yet, access to quality health care is not divorced from access to quality education, employment opportunities etc. Collectively, these resources have a powerful impact on matters of life and death. Maya, a CNM with 40-45 years experience says:

> We can't have healthy babies if we are not healthy. I mean that in the physical sense, you know, good food, nutrition, exercise…uh, mental health, safe relationships. White women…they are valued. Their babies are valued. I can't say the same for black women and babies. Stuff is designed for white women. You know, there are protections for them. See, the United States is not where it should be across the board. But in terms of resources-like health, education, money-stuff is designed for them. Stuff is just not designed for us. And it's killing us. Literally.

As Omi and Winant (1986) explain, history tells us race is a dynamic and fluid social construct, accompanied by dichotomous imagery and narratives of good and evil, deserving and underserving, each designed and redesigned to benefit the dominant group(s). Such imagery and narrative becomes solidified in policies and practices of the state such that racism is the state and the state is racism. David Theo Goldberg (2002) considers this in *The Racial State:*

> ….Race is integral to the emergence, development and transformations (conceptually, philosophically, materially) of the modern nation-state. Race marks and orders the modern nation-state, and so state projects, more or less from its point of conceptual and institutional emergence. The apparatuses and technologies employed by modern states have served variously to fashion, modify and reify the terms of racial expression, as well as racist exclusions and subjugation. (p. 4)

Such state apparatuses of education, a capitalist economic structure and health care are most prominent in this study. As Maya says above, "stuff is not designed for us."

These racial projects of state apparatuses manifest themselves in and through the body (Maya: "White women they are valued. Their babies are valued. I can't say the same for black women and babies"). This has been well developed and theorized by Michel Foucault, concretized in his concept of biopower-state level techniques and strategies for defining,

controlling and subjugating populations. State apparatuses have the regulatory control to discipline bodies, fostering the life of some populations and the death of others. Consider Foucault's (1978) mention of the mortality rate and longevity, in particular, as evidence of bio power:

> What does this new technology of power, this biopolitics, this biopower that is beginning to establish itself, involve?....a set of processes such as the ratio of births to deaths, the rate of reproduction, the fertility of a population, and so on. It is these processes-the birth rate, the mortality rate, longevity, and so on-together with a whole series of related economic and political problems....which, in the second half of the eighteenth century, become biopolitics' first objects of knowledge and the targets it seeks to control. (p. 243)

The state's historical and contemporary regulation of the black body, specifically the economically unprivileged black body, is clear. We need only consider the history of sexual abuse during slavery, involuntary sterilizations in Mississippi and other parts of the deep south during the 1920s and 1930s, the non-consensual removal of cancer cells for medical research purposes from Henrietta Lacks in the 1950s, the increased regulation of black birth through harmful, coercive dispensation of birth control to regulate "welfare queens" during the 1980s and federal funding cuts to Planned Parenthood in the early 21st century where a significant number of poor women receive well-women care, as but some examples (Roberts, 1997; Schwartz, 2006; Skloot, 2011; Washington, 2006) . Increased scope of practice and insurance coverage for all midwives; inconsistencies in state legislation and Medicaid reimbursement for CPMs are state regulatory controls that restrict midwives and all women, specifically women of color, even when it is cost beneficial.

Cellular Knowledge and Cultural Trauma

A quarter of the midwives interviewed extend their response to specifically point to the

concept of "cellular knowledge" from historical atrocities as an explanation for black birth

outcomes, and this was given independently of each other and without my prompting. Mary and

Kimberlee extrapolate on this idea further:

> We carry things, you know, genetically. You and I. We carry things.
> Genetic weight and beliefs. We retain what our foremothers and
> forefathers experienced within us. And then, it's so sad, but our
> environment reinforces it, you know. That pain, that experience, has
> marked us on a fundamental genetic and cellular level. We are changed
> because of it. And it marks our mamas and babies.
>
> *Mary*

> Black women have a different set of variables from anybody else. You
> know….this is real. The level of stress we have…worried about this,
> worried about that, taking care of other folk, not having support…it's in
> our body. Smarts and money don't matter. It's…cellular knowledge I
> think. Civil War, Reconstruction, Jim Crow. We pass that on. I'd rather
> kill you than have you live like this. Infanticide. Those kinds of
> choices…we….we just passed on and keep passing on. No wonder we are
> not making it like other folk. We are passing that on through birth.
> Generations of us.
>
> *Kimberlee*

Mary and Kimberlee (both CNMs) are in conversation with each other though operating on

opposite sides of the country in different settings. Mary is in a large urban hospital and

Kimberlee in a small, suburban birth center. Mary and Kimberlee's words are supported by

research investigating the intersections of race, gender, chronic stress and birth outcomes.[28] For

example, Lu and Chen (2004), analyzing data on 33,542 women in the Pregnancy Assessment

Monitoring System who delivered infants in 2000, the authors found that when compared to non-

Hispanic white women, black (along with American Indian/Alaskan Native women) reported the

highest number of emotional, financial, intimate partner-related and traumatic stressful life

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[28] Noteworthy here is Jackson, Hogue and Phillips's work that documented the everyday experiences of 600 black women living in Atlanta, Georgia, for ten years. As a result of the study, they developed the Jackson, Hogue, Phillips Contextualized Stress Measure-an instrument designed to assess the intersections of race, gender and chronic stress. This may be a valuable instrument for midwifery care with women of color. See Jackson, Hogue and Phillips (2003) and Jackson, Hogue and Phillips (2005).

events in the twelve months before delivery. Such stressors have been associated with very low birth weight and low birth weight in black infants (Collins et al., 2000; Collins, David, Handler, Wall & Andes, 2004; Mustillo et al, 2004; Rosenberg, Palmer, Wise, Horton & Corwin, 2002).

Nikki, CPM with 20-25 years of experience, echoes similar sentiments, and shares them through the story of a client:

> I just had this woman today. Pregnant with a black boy. [long pause, deep breath] I can't imagine. Look at the state of black boys in this area. You know what I am talking about…jail, discrimination, violence, no father, bad schools. And her high blood pressure is through the roof. No wonder. It's more than just diet and exercise. We are bad at that but that is another problem. It's…you know…something at our core. In our cells. In our genes. Her mama had these kinds of worries in the womb, too. And her mama. And her mama. This goes way back. From our ancestors. I believe that.

I must admit, the concept baffled me a bit. I thought back to my high school Biology teacher's lessons on Jean Baptiste Lamark's social inheritance theory. Lamark was a 19th century French naturalist who, in his 1809 publication of *Zoological Philosophy*, theorized the evolution of species. Lamark's first theory of evolution, use and disuse, and second theory, inheritance of acquired characteristics, is as follows:

> FIRST LAW
> All the acquisitions or losses wrought by nature on individuals, through the influence of the environment in which their race has long been placed, and hence through the influence of the predominant use or permanent disuse of any organ; all these are preserved by reproduction to the new individuals which arise, provided that the acquired modifications are common to both sexes, or at least to the individuals which produce the young.

> SECOND LAW.
> All the acquisitions or losses wrought by nature on individuals, through the influence of the environment in which their race has long been placed, and hence though the influence of the predominant use or permanent disuse of any organ; all of these are preserved by reproduction to the new individuals which arise, provided that the acquired modifications are common to both sexes, or at least to the individuals which produce the young. (p. 113)

That is, individuals adapt to their environment for survival and such organ adaptions, great and small, become permanent and "preserved by reproduction to the new individuals which arise" (p. 113). The result is a gradual, continuous, heredity transmission of adaptations that fundamentally alter the individual. Lamark has been heavily discussed, debated and critiqued, of course, but this concept of cellular knowledge being invoked here is an unintended invocation of his work. While Lamark is theorizing physiological adaptations, is it possible that as a collective group, as descendants of a commonly violent, traumatic history, psychological adaptions to environment, great and small, have become permanent?

Ron Eyerman (2004), in "Cultural Trauma: Slavery and the Formation of African American Identity" might say so. Cultural trauma is defined as "a memory accepted and publicly given credence by a relevant membership group and evoking an event or situation which is a) laden with negative effect, b) represented as indelible, and c) regarded as threatening society's existence or violating one or more of its fundamental cultural presuppositions" (p. 44). It is the collective memory of slavery, Eyerman argues, that solidifies African-American cultural trauma:

> A common history was thus ascribed and inscribed as memory, as well as indigenously passed on. In this sense, slavery is traumatic for those who share a common fate and not necessarily a common experience. Here trauma refers to an event or an experience, a primal sense, that defines one's identity because it has left scars and thus must be dealt with by later generations who have had no experience of the original event. Yet each generation, because of its distance from the event and because its social circumstances have altered with time, reinterprets and represents the collective memory around that event according to its needs and means.
>
> (p. 75)

He further articulates the generational nature of cultural trauma:

> These narrative frames developed out of the cultural trauma initiated by the failure of emancipation and then renewed in a continuous cycle of raised and crushed expectations. Transmitted as collective memory, they organized experience, providing cognitive maps that guided present actions. As such they could be transmitted from one generation to the next and, in the process, reworked

and revived to fit new situations and needs. It perhaps should be repeated that 'cultural trauma" is a process, one that in this case was kept in motion through the continual degradation and marginalization of American blacks. (p. 97)

I, again, take great care to reiterate that African-Americans have a rich cultural history prior to slavery. Yet, the significance of slavery, as the midwives interviewed here indicate and academic literature supports, cannot be underestimated in fundamentally altering generations of African-Americans. The de jure end of U.S. slavery, as has been well documented, gave rise to and intensified de facto slavery, with poor black birth outcomes as but one manifestation (Alexander, 2010; Massey & Denton, 1993). The distance from the traumatic event, here de jure slavery, is not relevant as generations experience its permanent scarring and wounds, codified in memory and organized in experience, that never heal as blacks are continually degraded and marginalized.

Absent the development of genetic research for a trauma gene, and I am in no way advocating for such research, all of this is, of course, theory. What I do know is that I spoke to 22 women who have cared for and counseled many pregnant black women. And a common theme amongst this sample of contemporary black midwives is that birth outcomes are greatly impacted and mediated by race, racism and racist structures. This perspective is important and valid as they are making meaning of the pregnancies and birthing moments they have born witness to. Because all knowledge is knowledge from somewhere, dependent on historical location and social identifiers, this process of meaning making puts the person back in those dismal black birth statistics reported in chapter one, reproduced in governmental and policy publications and as headlines in mass media.

The meaning making, so to speak, evident in this discussion necessitates attention to the social operation of the black body. Perhaps when a black woman witnesses another black

woman, give birth, a meaning, is attached to her and her baby in the birthing moment. Such

meaning may be deeply rooted in both a conscious or unconscious understanding of not only a

traumatic history but also how this history and the current manifestation of racist social

structures that determine unequal and inadequate access to social resources, ultimately impacts

this black body. Though all women giving birth are likely to share some similarities in the

process itself, the assignment of meaning attached to a black pregnant body is different than that

of another pregnant woman of color and further different from that of a body of a white pregnant

woman. Anna, a CNM with an incredible 40-45 years of experience, may have put it best:

> I had a diverse group of women I worked with…in terms of race. When I see
> another black women giving birth…you know, when I am there with her…I know
> her and can relate to her like I can't other women. I mean…all women can relate
> to one another but another black woman, I know her. You understand? I know
> her. I know how it feels to be a black woman in this world…walking down the
> street, at work. Stupid stuff people say. The way stuff makes you feel. That small
> stuff. I also know what it feels like to be a black mother in this world. I know
> what we been through as people and what that mean for her and her baby. We are
> a strong, smart, prideful people but it's hard. And I know them…I know her.

As this quote and the study at-large makes clear, race *matters*. Specifically, blackness, in history

and experience, matters. That is, legacies of forced removal, quasi emancipation and legal

segregation may have solidified cultural trauma and Post-Traumatic Slave Syndrome in black

Americans which manifests in pregnancy, the birthing moment and birth outcomes.

The Life Course Perspective and Social Determinants Theory

These perceptions are well supported by Michael Lu, MD, MPH, who has done excellent

research on racial disparities in birth outcomes and calls for a *life course perspective* (Lu &

Halfron, 2003; Lu, 2010). That is, he found that most studies focus entirely on differential

exposures to protective and risk factors during pregnancy, such as current socioeconomic status,

maternal risky behaviors, prenatal care, psychosocial stress, or perinatal infections. Yet, Lu relates, birth outcomes are not simply the product of nine months of pregnancy but different exposures-or social determinants-across the life course. Dr. Camara Jones, Research Director on the Social Determinants of Health for the Centers for Disease Control, posits the following:

> The social determinants of health are the social and cultural things that determine how healthy you are. They're things that are outside of your genes. They're things that are outside of what you do as an individual. And they include how much money you make, things about your neighborhood, the grocery stores that are available, the kinds of billboards, liquor stores or not, transportation, the kinds of housing that you're in, whether there are trees or not, walking trails. They include things about your neighborhood that seem even further away. Like is there a toxic dump site near you? Do you have a lot of air pollution in your area? And they also include opportunities. So social determinants of health include: How good are the schools in your neighborhood? Are the jobs available? All of those things.

> (Unnatural Causes, "Working to Measure Racism Edited Interview with Dr. Camara Jones Transcript," pp. 2-3)

As discussed in greater length in chapter one, the stress of social inequalities and everyday macro and micro aggressions experienced by people of color has chronic impact on hormonal levels, metabolic and inflammatory systems and blood pressure (Glynn, Schetter, Chicz-DeMet, Hobel, & Sandman, 2007; Jackson, 2007; Lu, 2003; Lu & Lu, 2007; Suglia et al., 2010; Sue, 2010). Richard David, a neonatologist at Stroger Hospital of Cook County, Chicago, sums this up clearly : "There's something about growing up as a black female in the United States that's not good for your childbearing health. I don't know how else to summarize it" (Unnatural Causes, "When the Bough Breaks Transcript," 2008).

This is quite a lot of pressure for prenatal care, an important intervention into which many financial resources have been invested but may not be, as sociologist John McKinlay (1994) would say, "refocusing upstream." McKinlay tells the tale of a man jumping into a river after hearing the cry of another man drowning and, upon saving him and applying artificial

respiration, he hears the cry of another man drowning and so on until he realizes he has not

considered who is upstream pushing the men in. As researchers Corey and Aronson (2013),

Dubay, Joyce, Kaestner and Kenney (2001) and Lu (2010), among others, along with the

midwives of this study posit, there is a difficulty, perhaps even impossibility, of reversing the

impacts of everyday racism and cumulative disadvantages with nine months of prenatal care.

Toward a Reformulation of "Common Sense"

Justifiably so, the "Bitter Pill" report with which I began this chapter sparked national

discussion. The Affordable Care Act does make efforts to address some of the general health

care issues addressed in the report by restricting health insurance policies from imposing payout

limits or recapturing some of the huge profits accumulated by medical device makers in the form

of a federal excise tax, as examples. Still, some of the massive inequalities that Brill refers to as

"lopsided pricing and outsize profits in a market that doesn't work" will remain post-Obamacare

(Brill, 1999 or 2013, p. 13). There is still work to be done.

The same attention must be paid to maternal and child care in this country if we are to

fully realize United Nations Millennium Development Goals of reducing child mortality and

improving maternal health by 2015 (United Nations Millennium Development Goals and

Beyond 2015, http://www.un.org/millenniumgoals/, n.d.). While The Affordable Care Act

brought great gains to all U.S. women with coverage for preventative care and access to

contraception, greater provisions for all midwives, particularly increased education funding

opportunities, scope of practice, insurance coverage, Medicaid reimbursement and state

recognition are struggles still to be won. There is an extensive body of research that supports

midwife-attended birth[29]. Given the poor birth outcomes for all women and children, as

compared to other developed agencies, and specifically for blacks, experiencing the poorest birth

outcomes independent of education, of any other racial group, the greater, systematic inclusion

of midwives into our health care system is necessary. The lives of women and children are at

stake.

An end to racism seems like an obvious macro policy recommendation but, as scholars,

students and general inhabitants of this country, we know race and racism are deeply entrenched

in our social, political, economic and legal institutions. Such a simplistic measure is, sadly,

improbable.

What if the place to begin, rather, is much more micro in nature? I have always been

struck by Omi and Winant's (1994) statement, invoking Antonio Gramsci, on "common sense":

> …ruling groups must elaborate and maintain a popular system of ideas and
> practices-through education, the media, religion, folk wisdom, etc.-which he
> called 'common sense.' It is through its production and its adherence to this
> 'common sense,' this ideology (in the broadest sense of the term), that a society
> gives its consent to the way in which it is ruled.
>
> (p. 67)

The bitter pill, Steven Brill (1999 or 2013) refers to in the *Time* special report, is a symbolic

reference to the massive upcharge of the acetaminophen pill on the magazine cover. The

majority of us, as Americans, have swallowed another bitter pill, so encapsulated that we

consider it "common sense." We have held firm to the notion that *all* pregnancy exists on a

continuum of risk, that childbirth is dangerous and in need of medical intervention, and that

midwives are unsafe and/or less than quality care when there is much evidence that reports

otherwise.[30] Our national and state policies reinforce such a notion.

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[29] See the research cited in chapter one.

[30] See research cited in chapter one.

We must reformulate our common sense; particularly for black women who have, for a variety of reasons, become so divorced from our history in midwifery. This is not to romanticize midwifery or demonize physicians. As with anything or anyone, there is good and, well, not-so-good. Yet, midwives have a place, a rightful place that must be restored in a systematic and equitable way. In the absence of doing so, we've swallowed another bitter pill and that is yet another tragic statistic. I further expand on the depths of such a tragedy in the last chapter.

On Black Underutilization of Black Midwives

Social Capital and the Availability Heuristic

The majority of all women birthing with midwives in this country are doing so in hospitals. That fact that an astounding 48% of all births were paid for by Medicaid in 2010, an increase of 19% in the proportion of all births covered by Medicaid in 2008, is a great contributing factor to this as home birth providers, primarily CPMs, are only eligible for Medicaid in 12 of 26 states in which they are legally allowed to practice (Markus, Andres, West, Garro, Pellegrini, 2013; National Association of Certified Professional Midwives).

We are seeing an increase in home birth, but 90% of the increase in home birth in this country is being experienced by white, middle-class women (MacDorman, Mathews & Declerq, 2012). I sought to understand, quite broadly who the midwives' black clients, in my study, were. Lorraine and Octavia for example, discussed a certain "type" of black woman:

> There's a type, you know? Well educated, a naturalist, only organic foods, paraban free products…with few exceptions, they is a type. They generally are paying with private insurance or out of pocket. This is one of the challenges with my work because I want to serve more black women but it's more about a kind of….status.
>
> *Lorraine*

> Yes, right now in my practice, I primarily see white women. This is no different than the national numbers. My black women are very well educated and have just decided they

want to go with what they think is natural because they are….in these circles where more and more white women are getting the hell out of the hospital. I want to be serving more black women but there are barriers to that.

Octavia

Interestingly, while conducting this research, I met a Master's degree student, Danielle Williams, conducting a qualitative study with five African-American women who used midwives for prenatal, birth and postnatal maternity care services. She sought to understand why and how her sample chose their midwifery care and their perceptions of the quality of care they received. Every woman in her sample reported finding their midwife through a "trusted source." Here, again, is the power of education and social capital. Perhaps it is through exposure to or membership in certain networks that, I would argue, may not necessarily be solely comprised of white women but also other black women and women of color of this "type" that Lorraine and Octavia describe, so that one is given the tools and resources to debunk mainstream perceptions of birth and birthing options.

Williams frames her discussion of this phenomena using psychological theory. Amos Tversky and Daniel Kahneman (1973) theorize the availability heuristic, saying that individuals estimate the probability or frequency of an event by "assessing the ease with which the relevant mental operation of retrieval, construction,, or association can be carried out" (p. 165). If an event can be recalled, it is valid and significant:

> …one may assess the divorce rate in a given community by recalling divorces among one's acquaintances; one may evaluate the probability that a politician will lose an election by considering various ways in which he may lose support; and one may estimate the probability that violent person will "see" beasts of prey in a Rorschach card by assessing the strength of association between violence and beasts of prey. In all these cases, the estimation of the frequency of a class or the probability of an event is mediated by an assessment of availability.
>
> (p. 164)

The individual estimations and assessments that Tversky and Kahneman posit as central to the availability heuristic are situated within a given society. All knowledge is knowledge from somewhere. The medical model of pregnancy and childbirth, solidified in the discourse of risk and reinforced in state legal systems, insurance policies and especially popular media, is the dominant, available heuristic in this country. Overwhelmingly, national birth statistics tell us that, for most Americans, pregnancy and childbirth equal obstetrician, hospital, and safety.

Relevant here is Gertrude Fraser's (1998) influential work, *African-American Midwifery in the South*-an ethnography of African-American men and women in their late 50s and early 90s who were bearing and raising children in Virginia from 1900 to 1960. Fraser's work investigates their perceptions of the medicalization of childbirth as a result of the varying medical and public health programs in development and execution at the time. An interesting paradox emerges in Fraser's work. On one hand, her informants expressed a sense of awe and respect for midwives:

> Waiting on women during childbirth was the central but by no means the only responsibility undertaken by midwives. They were also the individuals who normally washed and prepared the dead for burial-an activity that other women shunned. Unafraid of the corpse and thought to have spiritual gifts, some midwives also were believed to have the ability to "conjure," which entailed using certain roots, potions, and rituals to influence a person's behavior in one's favor or to cause harm. Their involvement in birth and death, their supposed ability to mediate between the real and supernatural world, and their authority in spheres of knowledge closed off to ordinary persons meant that midwives had been regarded with what might be described as awe. While it is impossible to delineate all the explicit connections, the negative campaign of medical personnel may have overlayed existing ambivalent attitudes toward these women. Conversations about midwives, in the present, often evoked a combination of awe and respect, as informants attempted to situate these women (now rendered powerless) within the context of a changed social world. (p.143)

On the other hand, however, a sense of ambivalence, and in some cases shame, emerges as a few of the informants expressed a desire to distance themselves from the history of midwifery:

> ….some actively distanced themselves from the history of midwifery because of its association with backwardness or because it is now considered to have

signified low economic or social status. Admitting to either having knowledge about midwives or having used their services was perceived as somewhat shameful. Some descendants and clients of midwives completely avoided discussing their relatives even when they willingly spoke to me on other matters related to the community's past. In the county, home births attended by midwives came increasingly to be seen by members of the African American community as lower-status care rather than the normative choice of the majority of families. To admit to having used midwives, therefore, hinted at a failed morality on at least two levels. First, it suggested that one's family had been too poor to call a doctor. Second, and perhaps more damning, it implied that even when offered a "better" alternative, some woman and their families had continued to rely on attendants who had been categorized as inferior by medical personnel. (p. 145)

The extensive slandering campaign waged against midwives during the Shepherd-Towner Act era, as discussed in chapter two, was very successful. That is, given the stark history of segregated hospitals and inferior health care black Americans experienced, the rise of physician care and access to hospitals appeared to be a symbol of long-awaited modernization and inclusion. Home remedies, plant therapy, spirits etc. did not match with the authoritative knowledge of medicine. This is not to say, as Fraser takes care to convey, that informants spoke of midwives in a pejorative sense; in fact, they lamented with fond reminiscence of the loss of communal and familial bonds, in which midwives were an integral part.

Instead, these informants understood the younger generation of women and infant's bodies to have experienced fundamental physiological changes. That is, viewing pregnancy and childbirth as having transitioned into a dangerous, risky process, older informants thought midwives, their rituals and treatments, as non-compatible with the needs of the younger generation. This does not mean that they vilified midwives but, rather, perceived the transition from home to hospital childbirth to be necessary and appropriate. Given the history of segregation in the south, it is not particularly surprising that hospitals, which were seen as institutionalized symbols of modernity and upward social mobility, are granted such credence among Fraser's informants. Ironically, Fraser mentions, "the children, grandchildren and great-

grandchildren of the women I interviewed still struggle to gain access to health care resources"

(1998). Fraser wrote that in 1998 and here I am, in 2014, bringing forth much of the same

issues.

In 2014, of course, de jure barriers to hospitals have been eliminated. In fact, the issue is

the *over*medicalization of birth and the negative impact it is having on women and babies,

especially, as is my focus here, on black women and babies. The access to health care resources

points beyond access to hospital births but also to valid, non-biased information on partum and

postpartum care, childbirth options, well-woman care etc. And yet, just like the discussions of

networking among midwives of color, social capital is relevant here also, as Patricia and Zora,

both CPMs, problematize choice:

> We kind of, we as in my generation, have done a disservice I think to your generation. I was active in the civil rights movement, feminist movement, women's health movement and…well, we didn't pass that along to you all. You all reaped the benefit of our work but we did not teach you. I mean….white women have enjoyed the livening of midwifery in the 1960s and 1970s. All of this stuff about reclaiming our bodies, being natural, choice….all of that was something white women embraced. At the same time we're running into the hospital and our babies are dying. This stuff….choice stuff…didn't get to black women. So, I mean, we didn't teach our babies about our history…you know, the history of midwives.
>
> *Patricia*

> See all that coffee on the shelf? [points to a corner shelf in Starbucks stacked with bags of ground coffee] I tell you to pick *anything* you want. Anything. You pick…French vanilla. But I haven't told you about *all* of the coffee available here, nor have I taken you to Caribou Coffee, Panera Bread, Giant, Safeway, Harris Teeter…you get the idea. I did not fully inform you of your choices. That's what's happening with birth now. You think there is only one way. That anything else is risky. All you have to do is watch any woman on TV giving birth and you'll get the idea. Or maybe the state you live in or insurance company you have determines your choice. But that's not choice!
> How can you choose without having knowledge of all your options or without all of your options being equal?
>
> *Zora*

This discussion of choice is powerful. I began the last chapter with a quote from AROM problematizing the white revival of midwifery in the 1960s and 1970s. The historical context is important because while midwifery experienced a revival in the 1960s and 1970s, it was only in 1946 with the passage of the Hill-Burton Act that hospitals were officially segregated as women of color flocked into the hospital-the penultimate symbol of modernity and upward social mobility. As Patricia relates above, this is an important tale about the feminist and women's health movements of the time. Sojourner, the Combahee River Collective, Audre Lorde, Angela Davis, bell hooks and countless other black women and other women of color have well problematized the first and second wave inattentions and reifications of race, class, sexual orientation, ability, religion etc. Yet, is it possible that while great legal and social gains were made, something was lost for future generations? That is, understandings of "choice" and "empowerment," too, were not problematized as race-specific constructs? Did black women and women of color of the time, and subsequent generations, like my own, not receive the message that choice and empowerment, specifically in birth, is our fundamental human right, too? That we, too, are deserving?

The Help and Contemporary Reifications of Black Female Controlling Images

While conducting interviews for this project, the film adaptation of Kathryn Stockett's 2009 novel, *The Help* had recently been released in theatres and, coincidentally, I had just completed the novel and seen the film. Set in Jackson, Mississippi, in the early 1960s, the film depicts the story of a young white journalist, Eugenia "Skeeter" Phelan (Emma Stone), who returns home from college to find that her friends are mothers, wives and employers to black maids, "the help." Skeeter develops a relationship with two of the black maids, Aibileen Clark

(Viola Davis) and Minny Jackson (Octavia Spencer), and in secret collaboration with them, writes a book from their point of view, exposing the racism they experience as they work for varying white families.

Consequently, as I asked midwives to interpret the relative underutilization of midwives among the black community, the hugely popular novel and film were often referenced. I originally anticipated a discussion of the challenges of inconsistencies in private and Medicaid insurance coverage for CPMs, as this seems to be one structural barrier impeding access. Yet, something more visual is at work in their interpretation. Manifestations of legacies of racist and sexist cultural imagery were being highlighted. This imagery that is most problematic in the credential society and my urge for midwives to market skill that I explored in chapter two.

Audre, also framing black birth outcomes within the context of "cellular knowledge" and Phyllis, a CPM with 15-20 years experience, discuss the film's perpetuation of historical imageries of black women and care work:

> The work we do is so powerful, to witness the start of a life…that's powerful. I am honored to do the work I do. But it's messy, too. Blood. Feces. It's messy. And it just registers as something different when I, as a black woman do it, because of this history…of…of…doing care work for white folk. Like…*The Help*. Some of us want so badly to remove ourselves from that history and think of it as bad…or backwards….or just plain embarrassed. And midwives are part of that, too, you know? We ain't much different than the maids, in some folks eyes. The place to start with our people is the teaching that midwives exist, we are educated and we are safe.
>
> *Audre*

> Here is the thing. [long pause] I saw *The Help* with my daughter recently. It was…so hard to watch. It's our history. Subservience and humiliation are part of our history. It's important to remember but it's not our only history. And I'm afraid, because….well, the movie is so popular. It's written, the book is written by a white woman, and the theatre was full of whites when I saw it. I've been talking to a lot of my white friends about it. It's popular, you know? And…well, it just brings back up this image of the subservient, benevolent woman at the service of whites. Even though they are strong women, and Viola Davis and…uh, I can't remember the other lady's name….they played those characters well. But it brings

that image back up for whites…and for blacks. Black people, too, believe those images about other black people. Black people have also internalized these subservient, benevolent…uh…subordinate images, and a lot of times unconsciously. When I think about my work, you know, I have to teach people, more often than not black women, that I am not there only to rub her back and feet….this is important work….but I do more than that. I am capable, I am your provider, you know?

<div align="right">*Phyllis*</div>

I understood their references and also felt uncomfortable with the novel and the film for the reasons they evoke, despite the fact that it is a fictionalized account of a very real period of African-American history.

Viola Davis and Octavia Spencer received much acclaim (Spencer won an Academy Award for Best Supporting Actress) and equal criticism for their roles in the movies. One oft cited review is Toure's (2012) discussion of the film's reification of "the magical negro" trope:

> I don't see any of *The Help*'s journey as pleasurable for anyone: black women are oppressed and fight back in a passive-aggressive way. (Black men are all but invisible in this world.) Whites are mostly evil, or else sheep: soulless and brainless. It's a Lifetime-y simplistic movie, a Disneyfication of segregation, with a gross and unintentionally comical stereotype parade marching through it. There's the ditzy blonde who can't manage to do anything but get dressed. There's the callous ice queen who thinks blacks have special diseases that can be transmitted by sharing a toilet. There's the undeterrable do-gooder. And then there are the blacks who are the latest iteration of that Hollywood staple: the magical negro. They are blacks who arrive in the lives of whites with more knowledge and soul and go on to teach whites about life, thus making white lives better. Magical negroes exist so that the knowledge and spirit that comes from blackness can enlighten or redeem whites who are lost or broken….The magical negro is offensive because despite his or her wisdom, and often, supernatural power, the black character is subordinate to weakened whites. (p. 2)

Much criticism, like Toure's, came from the black community, arguing that films like these only reify images of black women and are "a step back." The midwives here are invoking much of the same criticisms of the film. While *The Help*, and the images of black womanhood that is brought forth, is a modern day depiction of this era, the film and its representational images are situated

in a much longer, complicated history[31]. Even though Davis and Spencer's characters depicted incredible strength and defiance, subservience and the associations of blackness with disease, uncleanliness, and care work remain etched on the brain.

In her opus on black feminist theory, Patricia Hill Collins (2000) theorizes the use of "controlling images" like: mammies (epitome of benevolence and self-sacrifice), matriarchs (dominant black females that emasculate their men), welfare recipients (unwilling to work, "mooching off the system") and hot mommas (embodiment of hypersexuality) as ideological constructions, originating during the slave era[32], are used to justify the oppression of black women. The danger of such images, Collins posits, is the extent to which they are seen and internalized as natural, normal and fundamental to black womanhood. Further, as Patricia Turner notes in *Ceramic Uncles and Celluloid Mammies* (1994), such images have been codified into "ceramic uncle cookie jars, cast-iron jolly nigger piggy banks, ethnic slurs, caricatured performances, and one-dimensional media portrayals…exemplifying the ill will, oppression, and domination of blacks by whites, the merchants of popular culture have used these icons to shackle our psyches as deftly as enslavers once used real chains to shackle our bodies" (p. xv) Images and icons such as that of the faithful, obedient, benevolent, domestic servant, or what Turner calls the "consummate mother," are still present in modern-day midwifery.

Natural Black Hair & Cultures of Resistance

Lost in his discussion of the racist, oppressive and dehumanizing nature of controlling images should not be black women's agency and demonstrations of resistance. During this research process, I noticed that the majority of midwives in my sample--across type, primary

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[31] See Glenn (1992) for an analysis of the historical continuities of the racial division of reproductive labor and care work.

[32] See also Morton (1991) for a discussion of black women's portrayal in American scholarship as a natural, permanent, benevolent slave.

place of practice, region and age--wore natural hairstyles including natural curly/kinky styles,

short afros, dreadlocks or braids. I know this is not by accident. Through wearing their natural

hairstyles, black midwives' demonstrate incredible resistance to the operation of these images in

hospitals, birthing centers and homes.

As a black woman, I have always understood--to some degree--the politics of black hair.

It is not *just* hair. Kuumba and Ajanaku (1998) discuss cultures of resistance, asserting:

> oppositional culture or 'cultures of resistance' to hegemony have been critical to the
> survival of social groupings under the conditions of colonialism, enslavement and
> racial/ethnic expression….culture of resistance is defined as a 'coherent set of values,
> beliefs and practices which mitigates the effects of oppression and reaffirms that
> which is distinct from the majority culture.
>
> (p. 228)

I noticed the ways in which some midwives situated their hair within a long culture of resistance.

Ida (CNM, 35-40 years of experience) recalls her hair causing discomfort to a white preceptor

when she was a student midwife:

> I was looking around for a preceptor. Man, that is so hard for us. Make
> sure you ask about that. But this white woman who I actually had a
> relationship with. I respected her. She…she said, you know basically I
> can't work with you because my clients may not feel comfortable with
> your hair [long dreadlocks]. She did this thing about my hair being
> beautiful but in the same breath told me it was too distracting. Sick. But
> it's me and I will never change it.
>
> *Ida*

Ida does not directly refer to her hair as a form of resistance but her words do relate one of the

challenges some black student midwives may experience in acquiring preceptorships-a

"gatekeeper" I developed in the last chapter. The natural hair growing from her head, and her

styling of it, was perceived as a distraction. Her hair ignited feelings of discomfort and, arguably,

fear on behalf of the white preceptor. Marie (CNM, 20-25 years of experience), however, relates

a very active, conscious expression of resistance to white dominated space.

> You know, I am very conscious about my hair. I mean to say that it is a
> conscious decision. See, I work in the hospital and a very medical
> hospital….you know, trying to push a lot of interventions. And I wear my
> hair proudly as a form of resistance…as a way to maintain me. I mean I
> have been natural [natural curly style] for almost twenty years, before I
> became a midwife, but people respond to you very very differently. It's
> kind of like a statement that I am not going to play by your rules.
>
> *Marie*

Her hair is not only a celebration of her natural hair but also simultaneously challenges whited

dominated notions of female beauty and social acceptability. For her, her hair is a visual

indicator that she will not "play by your rules."

There has been a consider amount of academic and mainstream work on the historical,

symbolic, cultural, political and social meanings of hair. Psychoanalysts, sociologists and

anthropologists have theorized the symbolic meanings of hair (Freud, 1922; Berg, 1951; Leach,

1958; Hallpike, 1972; Obeyesekere, 1981; Cooper, 1971; Weitz, 2004). Work specific to black

hair has also been extensive. Morrow (1973), Patterson (1982) and Mercer (1990) position hair--

arguably mores o than the hue of skin color--as a racial signifier for black Americans. Ingrid

Banks (2000), in *Hair Matters*, discusses Morrrow's understanding of hair and skin color as

racial signification:

> Morrow further argues that once Africans were enslaved, their skin color could be
> 'tolerated by masters,' but not their hair. In fact, the curl of the hair was used to
> justify the subordination of Africans, which initiated the tension between hair and
> people of African descent in the New World. As a result, Morrow argues, the
> comb and other grooming utensils were left behind as symbols that denoted
> culture, tribe affiliation, and adornment. Whereas curly and kinky hair was
> glorified in West African societies, it became a symbol of inferiority once
> enslaved Africans reached American shores. Thus the pride and elegance that
> once symbolized curly and kinky hair immediately became a badge of racial
> inferiority.
>
> (p. 7)

The curl and kink of black hair became a mark of inferiority and servitude.

Morrow, Patterson and Mercer, however, do not specifically address the differential

experiences of black men versus black women in relation to their hair. Grier and Cobbs (1968), Robin Kelley (1997), Maxine Craig (1977) draw attention to the intersections of race and gender arguing that the rise of the Afro and dreadlocks in the 1960s and 1970s, symbolic expressions of alignments with the civil rights and black liberation political movements, were also rejections of dominant white norms of female beauty supported by the massive hair care and cosmetic industries promoting various products like the hot comb or dangerous chemicals in relaxers to straighten the curl and kink of black hair.

More recent academic works have focused on how black women theorize and experience their hair story (Banks 2000; Rosado 2004; Rooks 2006; Tate 2007). Further, the meanings, expressions-even commodification-of black hair have been portrayed in television, music and film, with comedian Chris Rock's (2009) *Good Hair*'s excellent documentary most popularized. Though hair as resistance was not a part of my research design, it was an important observation and, should be situated within a long history of black female resistance.

Epistemic Violence: Mass Media's "Controlling Images"

Invoking Foucault (1973, 1978, 1991), Spivak's 1998 seminal article, "Can The Subaltern Speak," further solidifies epistemic violence as discourses that construct the `Other' as in essentialist, reductionist or inferior terms, despite evidence of counter images or messages. We currently live in a media-saturated, epistemologically violent society. Alongside discussions of access and choice, must also be a discussion of the urgency of reframing problematic media images and messages of pregnancy and childbirth in this country and, relatedly, images of black women and black mothers.

The average American over the age of two spends more than 34 hours a week watching

live television, plus another three to six hours watching programs on Digital Video Recorders (DVRs). Our time watching shows from DVRs has doubled, and more of us — 36 million, more or less — are watching some video on smartphones (Hinckley, 2012). Generation M2 found young Americans aged eight to18 years spent an average seven hours and 38 minutes consuming media in a typical day, largely attributed to the widespread use of media-enabled mobile phones, tablets and MP3 devices (Kaiser Family Foundation, 2010). Black and Hispanic youth reportedly consumed three times more media than 'Other' American young people (Kaiser Family Foundation, 2010). A similar pattern follows for adults. A few small companies, six to be exact (Comcast/NBC Universal, News Corporation, The Walt Disney Company, Viacom/CBS Corporation, Time Warner, Sony Corporation of America) own approximately 90% of the U.S. mass media market, wielding immense power in the creation and reflection of our culture, that is in the dismantling or perpetuation of images.

In 2008, Alicia VandeVusse presented a paper, "*A Baby Story* as a Source of Information about Childbirth: The Messages and Their Implications," at the American Sociological Association Annual Conference. Premiering in 1998, *A Baby Story* is a popular reality television show that follows women and couples during the late stages of pregnancy and childbirth. VandeVusse analyzed 40 episodes of the show, identifying all discussions of medical interventions, previous births, and expectations for birth. Noting that the sampled episodes did portray a higher proportion of midwife-attended and home births and a lower proportion of cesarean sections than the current national averages, much of the show's programming centered less on birth options and more on pain:

> Yet the discussions of medical interventions and other birth experiences were largely limited to commentaries regarding birthing women's feelings toward epidurals, a topic closely related to the fear of pain and the desire (or not) for pain relief. By emphasizing the fear of pain and extolling the effectiveness of

epidurals, many episodes portrayed epidurals as a panacea for labor issues. At the same time, many episodes treated epidurals and other medical interventions as matters of due course, noting their occurrence with a brief comment or not at all. The lack of clear information regarding interventions and decision-making during birth has an impact on what viewers can pick up by watching the show. Some interventions are never explicitly discussed or shown, and it is not clarified whether the reason for this omission is the subject's perceived inappropriateness for public display, a failure to make interesting television, a lack of time in the show, a combination of these, or something else entirely. However, the result is a narrow picture of what birth is like for the majority of today's women. Because birth options are not clearly stated and interventions often occur off camera or without comment, in episodes, the medicalized version of birth is enshrined as the normal course of events, while alternatives must be recognized in the small subset of episodes where midwives are the primary birth attendants or the birthing women are particularly "stubborn". In addition, structural aspects of the show (i.e., the brevity of the depicted labors and the discreet camera angles) may give women unrealistic expectations for birth. (pp. 19-20)

Such a narrow focus on pain is a missed opportunity for larger discussions of birthing options and decision-making, thus further dominating the medical model and obscuring understandings of choice and power. It is important to note that VandeVusse's analysis does not address the racial representation of the women featured on the show.

Further analysis has pointed to the ways in which fictionalized representations of midwifery in prime-time television "represented midwives as callous in terms of their personalities. That is, contemporary stigmatizing represented in these shows reduced midwives to mean, uncaring women who in no way enhanced the birth experience and actually detracted from a better birth experience by not providing drugs for pain relief. It is not surprising, then, that the women who chose the midwifery option were quite absurd. What "normal" women would choose to identify with these individuals?" In the episodes of *Dharma & Greg*, *The Gilmore Girls*, and *Girlfriends* (the only show of these three starring African-American characters), the author found that midwives were no longer overtly demonized as ignorant, meandering women, as in decades before, but here characterized as "controlling bitches," forcing

women to suffer in pain, the clear opposite of that typified in the Midwifery Model of Care and found in my data. The women who choose midwives, then, are considered crazy, fringe lunatics, naturally unsupported by their partners and family members for their seemingly irrational choice to birth with a midwife.

In a discussion of the ways in which humorous shows offer an opportunity for negotiation of controversial social issues, Kline (2007) analyzes the effects of framing on such representation. She states that, "fictionalized accounts of social issues function as a means of public argumentation by framing and defining representations to reveal an attitude toward and, thus, implicitly proposing a solution to a given social concern. In other words, frames serve as responses to disruption of the social order and framing choices represent a rhetor's attempt to re-form or repair social fractures." In this way, midwifery plot lines, Kline teaches, are situated in a burlesque frame in which the villain (here midwife) behaves so heinously that they are readily identified as the antagonist who must be banished, most often ridiculed and turned into a caricature. While too much weight may be given to humorous shows' ability to propose a solution or repair social fractures, they do, however, start a conversation, creating entryways for new possibilities (one need only consider popular primetime television shows like *Will & Grace*, *Glee* and *Modern Family* and their impact on public perceptions of homosexuality). The burlesque framing of midwifery plot lines does not serve to fairly introduce midwifery or the Midwives Model of Care to mainstream audiences. Instead, as VandeVusse found with reality television, it serves to solidify the dominant medial model of birth which is ironic given the worsening outcomes. Still, arguably more so than birth outcome data, such images are embedded more so in our culture and on our psyches.

Controlling images of black women promulgated in the mass media further complicate

this. The difficulty, in some cases outrage, expressed in my data and publicly about the reification of the mammy image in *The Help* must be situated in a much larger understanding of the reification of the matriarch, welfare recipient and hot momma controlling images Collins (2000) theorized on, along with what Tyree (2011) refer to as emerging or modern stereotypes of the angry black woman (a contemporary extension of the matriarch), hoochie (a contemporary extension of the hypersexuality frame) and chickenhead (a contemporary extension of both the welfare recipient and hypersexuality frame). Persistent physical and emotional abuse exhibited by black women towards each other in many popular reality television shows perpetuate an ideal that black women have difficulty, at the very least, or are incapable of, at the very worst, being caring, nurturing, loving and supportive towards one another which is absolutely fundamental in the birthing process. The success of such shows rests in their ability to present easily recognizable stereotypes and capitalize upon them for mass media entertainment. This appears natural, normal and, ironically, "real," though much reality programming is just as scripted as situational comedies or dramas.

Consider what all of this means for me, as a young black woman and other women of my cohort. The complexity of this is multi-layered. As my data suggests we as a community, by and large, are not sharing our history with our children, likely because of feelings of indifference, shame, or in some cases, simply lack of awareness. I, too, did not know that my maternal great-grandmother was a midwife or my father was born with a midwife until embarking on this project. Births in the mass media are characterized as risky, dangerous, painful, and thus requiring medical intervention. Midwives and midwifery as a whole is vilified and ridiculed, when represented at all. Black women are portrayed as subservient, overly domineering, hypersexual and/or violent. None of this creates a space for images of normal birth with

competent, credentialed, skilled midwives or black women birthing with the care, love and support of their midwives and partners. More research is needed in this area.

Believing is Seeing

I've had the pleasure of teaching several sections of an Introduction to Women's Studies course and a Sociology of Health, Illness and Health Care course at Lehman College (City University of New York) in Bronx, New York. My students are reflective of Lehman's student population- primarily black and Hispanic females. I always include a unit on the medicalization of childbirth in both courses, usually reading Frances Kobrin's (1966), "The American Midwife Controversy" for historical context on demonization of midwives and subsequent transition from home to hospital birth in the U.S. and viewing the 2008 documentary *The Business of Being Born* produced by Ricki Lake. Consistently, one of the main responses from students is "I did not know midwives still exist." Given the strong history of midwifery in both the black and Hispanic communities, and an active midwifery community in New York City and State, such a consistent response of a lack of awareness of contemporary midwives suggests that these young women (many of them mothers themselves) do not see or know of other women who have birthed with midwives and/or do not see images of midwives in the media to even know they still exist. The "safety question" (i.e. "what if something goes wrong?") soon follows, suggesting that it's not only a issue of awareness of existence, but awareness of the *safety* and *efficacy* of midwives' birth outcomes.

As one CPM in my study insightfully remarks, "*The Business of Being Born* did not do anything to help black women. I thought it was well done but it only helped bring awareness to white women" (Audre). While it's difficult to make a direct correlation between the release of

the documentary and midwife attended births for white women, it bears repeating that white women are responsible for the increase we have seen in home birth in this country. Erykah Badu, black R&B, hip-hop and jazz artist, is a doula, midwife and spokesperson for the International Center for Traditional Childbearing in Portland, Oregon. She began studying midwifery after the birth of her oldest son in 1997. When describing her work with mothers, she says she shares her own at-home birthing videos because "It's important they see I did not cry and scream….They're amazed they don't have to be afraid." Badu's work, particularly as a pop culture icon for nearly 20 years, presents an exciting possibility. Yet, relying on the work and imagery of this one person is both unrealistic and incomplete.

As I conclude here, I am reminded of Sociology and Women's Studies scholar Judith Lorber's brilliantly titled 1993 article "Believing is Seeing: Biology as Ideology." Essentially, Lorber theorizes the ways in which Western biology constructs dichotomies or binaries (male/female; man/woman; masculine/feminine) to perpetuate the "naturalness" of gendered divisions of labor, behavior and social statuses. This eludes the social construction of such binaries and subsequent "naturalness." What we believe, Lorber says, is what we see: two sexes producing two genders.

The same, I believe, applies to images of the incredibly skilled, amazing black midwives I interviewed and black women's birthing with midwives. Believing is seeing.

Chapter Four

"Diversity is Performance Art for White People": Towards the Production of Inclusive Space, Reclaiming Midwifery Organizational Power

"*Diversity* is not merely a reformulation of the idea of equal access to social goods; it is also an attempt to redefine the goods themselves."

Peter Wood (2003, p. 12)

Black midwives' experiences and perceptions of diversity initiatives in midwifery professional organizations, was not an initial research question of this study. Yet, early on in my interviews, the "alphabet soup" of midwifery organizations that is primarily the three major ones: American College of Nurse Midwives (ACNM), Midwives Alliance of North America (MANA), and the National Association of Certified Professional Midwives (NACPM)-were continuously mentioned in my interviews. The extent to which midwives of color value, feel valued by, and participate in these organizations is central to the increase and diversification of midwives. That is, these national organizations have (though relative) political (specifically lobbying), financial and social power that is a challenge for individuals or small groups to achieve without a governing body. At the very least, I found midwives hearing and seeing the word "diversity," and subsequently the planning and implementation of diversity trainings by diversity consultants, more than ever before. Uttering the word at least demonstrates some attention is being paid, though the quality, even sincerity, of the attention may be up for debate, which is the subject of this chapter.

Overwhelmingly, and unfortunately, I found the midwives I interviewed to experience a sense of dissatisfaction, disengagement and/or mistrust with these professional organizations. In fact, the six resigning midwives of MANA'S Midwives of Color Section assert "these

organizations distract us from our true mission" of improving maternal and infant health outcomes for U.S. women.[33]

Take Zora, a CPM with 10-15 years of experience (though a midwifery advocate who attended meetings prior to official licensure) and Angela, an experienced CNM with 35-40 years of experience, who each question the benefit of participation and membership.

> Over the years, I have noticed less and less of us at the midwifery meetings. All of them. I stopped going, too, because I just didn't think it benefited me anymore.
> *Zora*

> I don't participate in the organizations any more. Why give my dues when I don't sense a commitment to communities of color?
>
> *Angela*

Ida, like Angela, a CNM with 35-40 years of experience acknowledges more recently hearing the word "diversity" more often saying, "So I have to say that I've heard them use the word a lot more and that's a good thing. But using the word is very different from action. Otherwise, it's a joke." Utterance is qualitatively different from identifiable action steps. Toni, a CPM with 20-25 years of experience, independently qualifies Ida's understanding of the joke, saying, "The joke is in the….like the celebration. Everyone is great. Let's be tolerant. Let's…celebrate. And what is that? That is what makes diversity a joke. This celebration stuff."

A history of the word itself provides helpful context and Peter Wood's *Diversity: The Invention of a Concept* (2003) is an excellent resource. Wood teaches us that the word, diversity, has historically had rather negative connotations-a far cry from its contemporary use to convey "celebration". Geoffrey Chaucer's "The Man of Law's Tale" in 1386, William Caxton's *The History of Reynard the Fox* in 1481, poet Henry Bradshaw in 1513, Sir Thomas Brown in *Religio*

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[33] See Appendix A for the complete May 2012 Midwives Alliance of North America (MANA) Letter to All Membership re: the Resignation Letter of 6 Members of the Midwives of Color section.

Medici in 1643, as examples, framed diversity in their literary works as "unwelcome conflict and conditions rife with malice" (p. 117). Interestingly, Wood argues that the 1859 publication of Charles Darwin's *The Origin of Species by Means of Natural Selection* created an interesting shift. He positioned species diversity not simply as a biological fact but *as crucial to species' adaptability and survival*:

> We are, for better and for worse, the inheritors of this tradition. Through Darwin and his many successors, we have learned to see natural diversity as a tremendously positive aspect of our world. When contemporary Americans talk about diversity, of course, very few of us are thinking about Darwin or Wallace; but we are thinking *by means* of their ideas about who and what we are. If we see ourselves as having some responsibility to respect diversity, it is because we have learned from them and their scientific successors that diversity is a deeply creative principle in nature. The big of *magic* in the word *diversity* is this association with a powerful scientific idea. Diversity in nature turns out to be crucial to the health of individuals, the well-being and adaptability of species, and the course of evolutionary change. The contemporary appropriation of the word 'diversity' refers to matters logically and substantially quite different from what the old biologists had in mind, but even so, it borrows some of their heft and prestige.
>
> (Wood, pp. 120-121)

The contemporary appropriations Wood speaks of often begin with the historic case of *University of California v. Bakke* in 1978. Bakke, a white applicant, twice denied admission to the medical school, brought suit in state court and the California Supreme Court ruled that the school's affirmative action program was a violation of the 14th amendment guaranteeing equal protection under the law and ordered Bakke admitted. When the case researched the United States Supreme Court, Justice Lewis Powell ruled that the goal of a diverse student body is a constitutionally permissible reason to allow racial preferences in medical school admissions.

At various points, I have shared Wood's history (specifically the quote above) and discussed *Bakke-* a landmark case of which many are already familiar-with representatives of MANA, ACNM and NACPM in conversations about my midwives' perceptions of diversity efforts. The conversations have been interesting and insightful because the implications are

powerful. If, in the scientific tradition Wood describes, a commitment to and respect for diversity is imperative to adaptability, survival and evolutionary change, why do contemporary discussions of diversity efforts resonate as "a joke" when midwifery is actually in great need of such adaptability, survival and evolutionary change? I found that it is precisely a result of the *substance*-or lack thereof-of contemporary usages of the word and subsequent diversity efforts:

> The favored metaphors of rainbows, quilts, stews, crayons and arks are easily visualized images of manyness in unity, but they fail in one key way: All of them smuggle in the underlying commonality that the doctrine of diversity usually attacks. The parts of the rainbow are all spectra of visible light; the quilt is stitched from swatches of fabric; the stew comprises edible foodstuffs; the crayons are part of a palate of colors; and the ark has on board the fauna that will inhabit the postdiluvian earth. What's missing is the radical separateness of each of the parts: the color that does not *want* to be part of the rainbow, the fabric that dangles outside the quilt.
>
> (Wood, p. 134)

An emphasis on favored metaphors and celebration, or even Wood's characterization of the "magic," evades deeply entrenched social inequality, especially in terms of race.

In speaking with midwives, I noticed something else--seemingly subtle but powerful in effect--my mention of the word "diversity" often resulted in a sigh, a snicker or a full burst of laughter:

> Diversity is performance art for white people. If I hear one more white woman or diversity consultant come and tell me how great everyone is and we should hold hands or something. Kumbaya, you know? I will scream. It's almost as bad as…you know that TV show? With Steve Carell? What does that do for birth?
>
> *Audre*

Interestingly, Dorothy, a CNM with 5-10 years of experience, also referenced the episode asking, before laughing, " Have you ever seen that diversity episode of *The Office*? With the index cards? Diversity is hilarious. I always think about that episode when I hear the word."

Hilarious is certainly not the first word I would exclaim if I were playing a word association game and someone gave me the word "diversity." Yet for Audre and Dorothy, the

inanity or folly of diversity was not such a leap. Episode two of season one of the hit TV series *The Office* was the "Diversity Day" episode. When they mentioned the episode during their respective interviews, I had in fact seen it and it *is* hilarious, largely for its absurd parody on diversity trainings. The sitcom centers on the happenings of office employees in the Scranton, Pennsylvania, branch of the fictional Dunder Mifflin Paper Company. In this episode, Michael Scott (Steve Carell), the company's white Regional Manager, reenacts a controversial stand-up comedy routine of black comedian and actor Chris Rock. In it, Rock essentially parodies and, ultimately, reifies stereotypes in the black community. Offended by Michael's reenactment of the routine, employees file official complaints with the corporate office who then send in a "Diversity Today" consultant to facilitate a racial diversity seminar encouraging everyone to be a H(onest)E(mpathy)R(espect)O(pen-minded) and "celebrate difference". Upon conclusion of the seminar, Michael signs the "Diversity Today Pledge" as Daffy Duck. Seemingly unimpressed with the consultant's efforts, Michael hastily crafts his own training, "Diversity Tomorrow," in which he asks each of the employees to share their racial identities with the group and then, to "mix up the melting pot," assigns each employee an index card with a "race" written on it [Italian, Asian, Jewish, Jamaican, Martin Luther King, Jr., Indian etc.] of which they are to affix to their forehead without reading it first themselves but visible to their colleagues. He urges the group to give each other a series of "clues," essentially terribly racist stereotypes and/or jokes, to "guess their race." Upon conclusion of the activity, Michael suggests bringing in "diverse food" to the office next time (the consumption of diversity is a topic I address in the following section) and promptly dismisses the staff at 5pm. Diversity Day is over. Is it any wonder, then, that diversity is, as Audre and Dorothy say, hilarious or that my mention of the world prompted *The Office* parody?

To be absolutely clear here, the hilarity referenced is not the ridiculous and terribly

offensive sparring of racist stereotypes evidenced in the episode. Audre, who earlier described

diversity as "performance art for white people," goes on to clarify the hilarity:

> The racist s*** is not what I am saying is hilarious. Don't get me wrong. It's the
> process of someone, in my experience a white woman, coming in and telling us to
> celebrate diversity like we're supposed to pop champagne. If I hear one more
> white woman come in and tell us how great black people are, I'm going to
> scream!
>
> *Audre*

The celebratory, non-substantive nature becomes hilarious and ridiculous, while also frustrating

and offensive, as it trivializes racial hierarchy, inequality and stigma:

> The ideal of diversity is that once individuals of diverse backgrounds are brought
> together, a transformation will take place in people's attitudes-primarily within
> the members of the formerly exclusive group, who will discover the richness of
> the newcomers' cultural backgrounds. Diversity will breed tolerance and respect,
> and, because it increases the pool of skills, will enhance the effectiveness of work
> groups and contribute to economic prosperity.
>
> (Wood, p. 12)

Perhaps this is the "magic" but the illusion minimizes the difficult, substantive work required to

provide opportunity, access and resources for historically disadvantaged groups. And yet, a

massive diversity industry has been created and greatly profits from such celebrations; of which

midwifery organizations have more recently become clients.

A History of Diversity Training in the United States

Diversity workshops and trainings, though certainly (hopefully) more structured and

organized than that satirized in *The Office*, have a long and checkered history with most recent

estimates reporting it to be an 8 billion dollar industry (Hansen, 2003). Anand and Winters

(2008) divide the history of diversity into four distinct phases, which are helpful in

understanding contemporary manifestations of diversity work.

The first phase begins in the 1960s and 1970s. Such efforts took an organizational focus on anti-discrimination compliance in the wake of the passage of Title VII of the Civil Rights Act of 1964. In response to lawsuits filed with the Equal Employment Opportunity Commission (EEOC), organizations focused on debunking the Act's requirements and sanctions, usually via a one-time, certificate-granting event. By the early 1980s, in phase two, compliance-focused training continued but President Ronald Reagan ushered in an era of deregulation, i.e. placing the onus on organizations themselves-as opposed to intense federal monitoring-to be responsible for their anti-discrimination policies. These phases interpreted diversity as synonymous with anti-discrimination legislation compliance, specifically against women and minority groups.

Anand and Winters (2008), argue that the late 1980s spawned our phase three contemporary understandings of diversity, first with the rise of "managing diversity" and then into what they call the "decade of fostering sensitivity" from the late 1980s to the late 1990s. This seems to be the type of training satirized in *The Office* episode. An emphasis on "sensitivity," "raising awareness" and "celebrating differences," squeezed into one-time sessions reminiscent of post Civil Rights Act trainings, often have, in my mind, two responses. First, such work may promote fear of "the Other." Dorothy had a really interesting perspective and helped to frame my thinking here: "In all of my years, I have found that talking about race…or difference…sometimes makes whites even afraid to mention race for fear of being called racist. What good is that?" Yes, what is the good in that? Dorothy's perspective here is supported by Anand and Winters (2008): "The authors report "many left confused, angry, or with some animosity toward differences" (p. 361). This is precisely because of the perpetuation of color-blind racism Bonilla-Silva (2010) aptly discusses in *Racism without Racists*.

Second, and at the other extreme, may be to fetishize difference demonstrated through consumption patterns. Consider Alice's remarks: "I've seen the gamut. White women wearing kenti cloth or romanticizing third world art…you know? But my thing is…what are you doing for midwives of color while you are wearing or buying that stuff" (CPM, 05-10 years of experience). Much like the inanity of "celebrating difference," so too is the consumption of difference. This seems to be one of the grave consequences of capitalism (Hochschild, 2003; Taylor, 2004). A dominant means of expressing value is through the purchase and consumption of commodities. If I adorn "ethnic" commodities, eat "ethnic" food, or display "ethnic art" does that translate into a commitment to systematically addressing racial inequality?

> The transformation of *diversity* into a consumer good has been a generally benign event for American culture.…We are richer in every sense for being able to purchase African textiles, Central American vegetables and Balinese jewelry.…By emphasizing the make-believe and put-on qualities of diversity, by defining *diversity* as a taste for exotic food, unusual clothes and off-beat tourist destinations, our consumerist impulses steer us away from the non-negotiable demands and seething ethnic resentments that the *diversity* movement encourages in political contexts.
>
> (Wood, p. 368)

The consumption of "ethnic" artifacts, art, food and "celebrations" not only fetishizes and romanticizes people of color but also infantilizes their experiences with and in racist structures.

Returning to Anand and Winters (2008), who argue we are, at this time, in phase five: New Millennium Paradigms for Diversity Learning; the paradigms I have found in my research may be framed, diversity as competency or as skill, diversity as "good business", and diversity as experience. The authors discussed here confirm my findings, asserting that diversity is now framed as a cultural competency, not simply to value differences in a multiculturalist frame but as an important "business skill." Being or demonstrating diversity is a "skill." And there is another consumerist, profit-driven dimension at play. In 1987, Arnold Packer and William

Johnston released the Workforce 2000 report urging that because the U.S. economy will expand

and create new jobs alongside growing more ethnically diverse, reaching a projected tipping

point in 2000, "good business" requires greater efforts to recruit people of color. A more diverse

workplace will earn more. Diversity is "good business" (Wood, 2003). In schools, specifically

colleges, Wood (2003) found that sales brochures "market" diversity primarily to white students,

offering diversity as romance, as experience, as a "thrilling" opportunity to encounter genuine

difference.

In business, organizations and schools alike, the trend is now to establish organizational

responsibility for such efforts including affirmative action plans, diversity staff and diversity task

forces, often through the efforts of "diversity consultants". However, sociologists Alexandra

Kalev, Frank Dobbin and Erin Kelley (2006) find that the effectiveness of such programming is

questionable, particularly for African-Americans who are poorly represented to begin with.

Tracing the history of the word "diversity" and the evolution of diversity training and

consulting is helpful background in understanding the manifestations of diversity work I

observed because, while doing my research, I, too, experienced a timely trajectory in the many

manifestations of this work.

Toward Inclusive Democracy & Justice

In March of 2012, the National Association of Certified Professional Midwives (NACPM)

and The Association of Midwifery Educators (AME) cohosted the first Certified Professional

Midwives (CPM) Symposium in Washington, D.C. Again, CPMs are legally eligible in only 26

states and are eligible for Medicaid reimbursement in only 12 of those states[34] (NACPM). Great

work is to be done in securing increased scope of practice for the CPM credential as both

primary care providers and midwifery educators. Publicly, the symposium was deemed a

success:

> Together at the Symposium, we heard from leaders in education, public policy, and legislation about national and global trends that form the context for CPM practice and education, and we heard from our peers in states across the country whose successes and challenges reflect our experiences and influence our thinking about the future of the profession. Together, we experienced the palpable excitement of the momentum that is growing for Certified Professional Midwifery, while also experiencing the frustrations and discomfort that come from breaking open typical discussions in the search for new solutions. Together we took the brave step of working with facilitators and new social technologies being used in forums all over the world to find new ways forward, to grapple with our challenges and difficult issues, and to seek out and learn a new style of effectiveness. *With this facilitation and new methodologies, one hundred and fifty people were able to work together to identify themes and issues that most need our shared attention, create work groups to addresses these topics, and develop action plans for moving these issues forward.*
>
> (http://cpmsymposium.com/about/)

A couple of the "big" questions, and identified challenges the symposium sought to address and

consider, are these: How can we create diversity in the CPM workforce that reflects the diversity

of our country? What will success for the profession look like if the CPM workforce reflects the

racial and cultural diversity in the U.S. population? Relatedly, what will success for the

profession look like if CPMs serve underserved and vulnerable populations? The symposium

resulted in 11 identified themes: access, consumers, disparities, racism, funding, education,

payment, collaboration, unity, and public relations. Race and racism are, of course, entrenched in

each of the themes above. Disparities in birth outcomes are raced; access to educational

institutions and programs, in terms of admission and funding support, reflect sharp racial

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[34] As a result of the passage of the Affordable Care Act in March 2010, and thanks to the successful lobbying on the American Association of Birth Center and the support of Senator Marie Cantwell's (D-WA), licensed Certified Professional Midwives practicing in birth centers are eligible for provider fee reimbursement through Medicaid.

disparities; successful academic completion and a positive psychosocial experience in those institutions and programs also reflect sharp racial disparities.

The breadth of topics addressed at the CPM symposium appear extensive and impressive, particularly on issues of diversity: "Maternal Mortality in the United States: Taking Action to Eliminate Disparities in Maternal Health Outcomes" by Camille Sealy, MPH, Med; "Attracting, Training and Retaining Women of Color in Midwifery" by Shafia Monroe; "New Mexico: A Consumer Perspective for CPMs on Serving the Hispanic Community" by Micaela Cadena; "Cultural Safety in Training First Nations/American Indian/Alaska Native Midwives" by Sherrill Katsi Cook Barreiro and Anti-Racism and Anti-Oppression Work in Midwifery (AROM), amongst others.

I was not able to attend the Symposium so I followed up with a few people whom I knew were in attendance, some of whom reached out to me knowing my research. The first was a white program administrator and educator of a selective midwifery program whom I will call Cassondra. We spoke just days after the conclusion of the Symposium. I asked her "what efforts is your program employing to increase the admission and retention of midwives of color?"

> Let me just tell you this story. This weekend, the conversations got very very passionate…around the lack of ethnic diversity and the experience of MoC…midwives of color. On the night of the first day, there were some exchanges that left people feeling very unsettled….the race issues are going to dominate this conference and we're not going to get to the business issues…all we're going to do is talk about race people said. At night, in the pub and at breakfast….the convening committee that I was on….we all got together with the convening committee…we'll stick with our program for day two but pick this back up in the evening part…which is kind of a synthesis of the day. One of the midwives of color came to the facilitators and offered herself as a voice for people that couldn't speak for people for fear or safety of whatever. She was so amazing, articulate, eloquent….put things into context that the white women could hear it.

I asked, "What was the reaction in the room?" Cassondra said:

[long pause] It was silent. I was really hoping we leave on her words, we sit quietly, we let her words resonate. This white woman stands up and says….more than 2,000 years ago our Lord God sent His son to save our sins and women's voices were taken from them and we all lost our voices and we are all oppressed. And one young woman from California stood up and said that is inappropriate, you do not get to assert yourself. And then the next day, things really shifted. I think that was amazing growth in our own community. We have to really work on cleaning "our house" though. There is more anti-racism work to be done and it is ongoing. But this was huge.

Interestingly, "the race issues are going to dominate this conference and we're not going to get to the business issues" comment again supports Anand and Winter's (2003) third phase of diversity training-the confusion, anger, and the animosity. Race and racialized experience, it seems, is thought to be a solitary, peripheral conversation and not integral to the very issues the Symposium was designed to address. "Race issues" and "business issues" are separate issues though birth outcome data and certainly the qualitative data herein certainly say otherwise. And this is precisely the problem with color blind ideology-perpetuating a frame of egalitarianism or sameness ("we are all oppressed") positions discussions of difference, here race, as a divergence and an annoyance.

One irony that I must point out is Cassondra's description of the midwife of color as "articulate" or "eloquent." When I realized that perceptions of midwifery professional organizations' diversity efforts was a key theme of this study, I signed up for electronic newsletters of a couple of organizations providing diversity trainings. A message titled "10 Things NEVER to Say to a Black" got my attention for it's number one "no-no": "You're so articulate" (Diversity Inc.) I, too, have been told this on so many occasions and though it is meant as a compliment, it lands as condescension because the implicit assumption is that being articulate (or eloquent) is antithetical to blackness or, more generally, being a person of color.

Even as Cassondra, a program administrator and educator, relates a story for which she is quite proud, she reifies stereotypes of blackness.

Her recounting of this story stuck with me, gnawed at me, even unsettled me. I wondered if the woman felt the need, the burden, and the responsibility to "teach" the white women in the room? Refer again to Peggy McIntosh's 1990 "White Privilege" article in which she lists ways in which she recognizes herself as benefitting from white privilege: # 21: "I am never asked to speak for all the people of my racial group." Three months later, the MANA Midwives of Color Committee resignation letter appeared in my inbox. The word "suffering" in reference to the CPM Symposium, naturally, struck me:

> Having suffered through the CPM Symposium, we Sisters have spent too many days trying to help MANA, its leadership and the leadership of the other AMOs "get it". And they still do not. ! ! ! !We have committed ourselves to our local and global communities we serve first and foremost, doing the best we can with dignity and character knowing that our communities and our children are watching.
> *MANA Midwives of Color Section Resignation Letter*
> (pp. 3-4)

How can this be? Cassondra described the symposium with such joy, pride and elation, all while being very transparent that there is more work to be done. And yet, the six midwives of color relate the experience as one of suffering. This is a powerful gap in perception.

But the letter's suffering preceded the CPM Symposium. I know this because, as I previously stated, midwifery diversity initiatives were not an original object of this study but were nonetheless an emergent theme. This letter, though, gave further historical background:

> In the last three years the position of MOC Chair has been held by three different Midwives of Color – Sheila Simms Watson, Michele Peixinho, and Jennie Joseph – it is now held by Darynée Blount. A question to be asked - if the MOC Chair is a 3-year term, how come all of the recent Chairs resigned after roughly one year into the term? What about MANA and its leadership, the MOC membership (or lack of membership involvement) and their relationship, that such firmly committed, hardworking, bright women relinquish this position?

> The answer lies in examining MANA, both the organization and the individuals in leadership positions, interaction with the MOC. It is clear to us that MANA's ethos of their unearned entitlement that continues to dis-value and ignore us as a group and as individuals. At best we are an afterthought.
> *MANA Midwives of Color Section Resignation Letter* (p. 1)

By this time, the majority of my interviews were completed and I had come to so immensely respect and adore the women who spoke with me. So, to hear of such pain, such suffering, resonating so powerfully from my computer screen warranted further elaboration. When I asked Hattie, a CPM with 35-40 years of experience, about the letter she actually asked me "What did you think was going to happen?" She explains, "This is 100% tokenism. So, we'll put some black people for show, give them a little bit of money, no power and stir the pot."

And yet, Martha, a CNM with 30-35 years of experience, clarifies that this "issue" is not one solely with MANA:

> This is not just a MANA issue. This is an ACNM issue, too. You have people trying to do a lot of good things….matching preceptors, tutoring for students and scholarships. These are the things that we need. But how do you that when the organization doesn't take you seriously? Only put you there cause it looks good. So…it just so happens that these midwives spoke but it's not just a MANA issue.

She goes on to say " I don't necessarily agree with the way they went about it but I understand it. Tokenism is real." Martha's perspective about the generalizable nature of the resigning midwives' experience is particularly poignant because she pointed me to a 2011 publication called "Into the Light of Day: Reflections on the History of Midwives of Color Within the American College of Nurse-Midwives" written by Linda Janet Holmes. The report is a fascinating account of the resistance and struggle nurse midwives of color endured from 1972-1992 as they sought to solidify a Nurse Midwives of Color Committee within ACNM. Most relevant to my study is Holmes's discussion of a 1981 editorial written by Betty Watts Carrington in which she was critical of ACNM's perceived lack of substantive efforts to make

the recruitment of minority nurse-midwives a priority. 25 years later, in 2006, Kennedy, Erickson-Owens and Davis (2006) conducted a qualitative study of diversity initiatives within ACNM and, "concluded that little progress was being made in recruiting nurse-midwives of color into the profession" (Holmes, 2011, p. 31). Clearly, Martha is right, this is not just a MANA issue; it is a persistent midwifery issue.

Prior to my conversations with Hattie and Martha, I had always understood tokenism-perfunctory gestures of "including," moreso somatically representing, women and/or minority groups in predominantly male and/or white spaces-as an individual experience, i.e. "the token." Yet, these midwives helped me to understand tokenism as not solely an individual experience but can we also consider, from their words, committees designated for midwives of color as acts of tokenism, too? Rosabeth Moss Kanter's (1977) seminal work has most influenced my thinking here. She theorizes skewed groups (certainly the case with contemporary black midwives) as those in which there is disproportionate representation of one "type"-here race-over another. The numerically dominant in the group are the owners and operators of the space and the entrance of the numerically non-dominant is offered as "proof" of anti-discrimination, a commitment to diversity: "People's treatment, then, is not automatically fixed by inflexible characteristics but depends on their numbers in a particular situation" (p. 395) They are tokens-symbols-rather than individuals. It is *proportion* that colors (pun intended) experience. The experience of the token is qualitatively different than the experience of the dominant. *This* is the suffering that the resigning members of the Midwives of Color Section expressed.

In skewed groups, Kanter (1977) argues, there are three perceptual tendencies: (1) *visibility* in which the sheer presence of the token(s) "captures a larger awareness share" and thereby experience "performance pressures," (2) *polarization* or exaggeration of differences

among the dominant and the token often leading to negative relations and (3) *assimilation* or the reification of stereotypes and controlling images. I wish to expand on Kanter's (1977) discussion of assimilation because though her work is focused solely on gender ("The numerical distributions of men and women at the upper reaches created strikingly different interaction context for women than for men" p. 381), feminist theory, in which this study is grounded, has taught us the complexities of identity. Being a black woman is a qualitatively different experience than that of being a white woman or Latina woman, as examples. Kanter says there are "stereotyped informal roles" of which tokens "fit" because they are roles for which dominants have familiar frameworks for and corresponding patterns of interaction. Collin's (2000) controlling images and Tyree's (2011) emerging or modern stereotypes discussed in the last chapter, for example, are present in interactions. To re-engage Blumer's (1986) symbolic interactionism, the main theoretical and methodological framework for this work, humans act toward things on the basis of the meanings they ascribe to those things and the meaning of such things is derived from, or arises out of, the social interaction that one has with others and the society.

For example, one of Kanter's theorized roles is that of "the pet."[35] Though I cringe at the thought of any human-independent of race or gender-being labeled as pet, the implications certainly resonate in my data analysis. The pet, though we may love and adore, remains an accessory, on the fringe. Again, I return to the letter's language noted above: "…disvalue and ignore us as a group and as individuals. At best we are an afterthought" (MANA MoC Section Resignation Letter, 2012, p. 1). My data also supports this. Remarkably, Audre connects our discussion of the images portrayed in *The Help* and their perceived impact on black women's

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[35] See Rothman (2005) for a discussion of histories of white families adopting black children ("the pet") and this role operation in familial contexts.

underutilization of midwives to the experiences of the resigning members of the Midwives of

Color Committee:

> Remember our conversation about *The Help*? Grunt work and tasks were
> assigned on "black issues" during Black History Month of course….asked to work on
> things for the conference focused on racial disparities that was never incorporated or
> considered. It's sick.

The resigning midwives actually referenced and expounded upon this in the citing that such

experiences amount to "The Help-2012 Version."

Just as Kanter (1977) expressed, minority groups experience performance pressures and

have to "prove" ability, arguably worth, to participate in *all* aspects of organizational activities.

Kanter's work is supported by Hattie as she says "There's this perception…you know, that

you're not smart enough…that you have to prove yourself more just because you are black. I can

speak on the 'black' matters but not on the organizational matters." Tokens are *there*, but not

really there: "I feel like the spook who sat at the door…in but not really in…there to make white

people feel better" (Ida). I once again turn to one of McIntosh's statements that is quite relevant

here: "27. I can go home from most meetings of organizations I belong to feeling somewhat tied

in, rather than isolated, out-of-place, outnumbered, unheard, held at a distance or feared."

Toni, a leader[36] in a national midwifery organization, reflects on her role:

> I'm in this weird spot because I am a leader in [national midwifery organization] and it's
> been a real challenge for me because while I may sit at the table, I don't really sit at the
> table. My value is that I am a black woman…good for show and…well, to speak on
> matters related to women and babies of color but I can't do that for all, right? So…it's a
> strange position to be in.
>
> *Toni*

Her words here should also be situated within the fact that leadership positions, specifically

board and committee positions, are appointments and are therefore not subject to democratic

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[36] I have not specified Toni's title or the organization to protect her anonymity.

processes. The same, too, applies for midwifery's accrediting boards. This is an enormous

contributing factor to feelings of mistrust that black midwives, and midwives of color at large,

have expressed. Audre relates this well:

> How do we have an organization that claims to represents us without a vote? It is arrogant, undemocratic and non-transparent. They do not practice representational government. How in the world can this be when they spout wanting to increase the number of midwives of color?
>
> *Audre*

At this point in my interview with Audre, she began to cry and it is an experience I will never

forget. It is painful, especially given the histories of people of color being denied the right to vote

altogether, and even a June 2013 Supreme Court ruling by a 5-to-4 vote, freeing nine states,

mostly in the South, to change their election laws without advance federal approval. Lost in the

"celebration" of difference and diversity is a commitment to democracy and justice.

My Master of Arts in Women's Studies thesis was an analysis of the South African Truth

and Reconciliation Commission's Women's Hearings transcripts using feminist scholar Iris

Marion Young's (2000) pillars of inclusive political communication in a communicative

democracy: greeting, rhetoric and narrative. A bit of background is required here. Young

highlights and takes issue with the fact that individuals and groups often claim that deliberative

democratic processes are defined and dominated by the interests and perspectives of the most

powerful in the given society. Particularly, Young argues, democratic theorists have not

sufficiently attended to the ways in which actual processes of discussion and decision making

often marginalize individuals and groups because the norms of political communication are

biased against some forms of expression. In an effort to counter norms of exclusionary political

communication, Young advocates greeting or the public acknowledgement of all participants in a

discussion or democratic decision making process to recognize them as particular subjects

important to and for the discussion. Further, she recognizes the significance of rhetorical appeals (demonstration, protests, figures of speech) and political narrative as forms of inclusive political communication that help to get issues on the agenda that may not otherwise be heard. Collectively, she argues, greeting, rhetoric, and narrative help to achieve the ideal of inclusion that democracy is founded upon. Focusing on inclusive political communication, she describes her democratic theory as communicative democracy.

The ultimate realization of democracy demands that participants are equally included in its public discussions or decision making processes. It further demands that all participants be held accountable to and for the discussion or process's outcome. Given that democracy is a governance structure that values the interests and opinions of the individual as opposed to the collective, democratic discussions and processes are only legitimate to the extent that they are inclusive of all, or the greatest number of, individuals. In other words, the extent to which democracy maximizes its level of inclusiveness, its other ideals of equality, publicity, and accountably are also maximized.

Her work has again become valuable to me as I listened to the stories of the midwives in this study. I return to her work here to espouse the importance of inclusion, transparency and democracy. In many ways, my aim here is to present experiences and perceptions as political narrative-"I tell the story not primarily to entertain or reveal myself, but to make a point-to demonstrate, describe, explain, or justify something to others in an ongoing political discussion"-, one of Young's pillars of inclusive political communication, toward the quality of democracy she theorizes and the quality of which midwifery currently demands (p. 72). She argues political narrative contributes to understanding the experience of others and countering pre-understandings:

Storytelling is often the only vehicle for understanding the particular experiences of those in particular social situations, experiences not shared by those situated differently, but which they must understand in order to do justice….perhaps more often people come to a situation of political discussion with a stock of empty generalities, false assumptions, or incomplete and biased pictures of the needs, aspirations, and histories of others with whom or about whom they communicate.

(pp. 73-74)

Political narrative, then, is a public and political evocation of situated knowledge. Narrative and situated knowledge, especially from an underrepresented and marginalized group, speaks volumes about the efficiencies or inefficiencies of the dominant group and organizations.

The fact is that national midwifery organizations have the political, financial and social power required to advance midwifery in this country. Granted, midwifery at large is struggling for power-it is relative, though all the more reason for a collective. There is power in the collective; there is strength in numbers. Yet, if the collective is perceived as racist, non-transparent, non-representational and non-democratic, how does that foster inclusion or diversity? How does this foster the "social justice" regularly mentioned in midwifery organizational documents, at conferences and in meetings?

The 2012 resigning midwives of color directly address these questions in their letter:

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

With MANA's frequently changing leadership there is a constant need to educate, sensitize, and re-educate a new cadre of young and older women who "do not get it". Since MANA lacks an organizational vision and mission statement (with an accompanying detailed and concrete action plan to accomplish these) that clearly defines MANA's position on such issues as social justice, privilege and entitlement, racial disparities, increasing the number of midwives and MOCs, we must address and re-address these issues each year, over and over again.

(MANA MoC Section Resignation Letter, p. 1)

Their words seem to highlight the inanity and non-sustainability of a public attention to social justice ("canned responses") without consistent, substantive resources-diversity in leadership and funding-to support such efforts.

June 1 (five days later), the Executive Director, President and Board of Directors posted an overview of MANA's Social Justice Plan (later described as an agenda), divided into "a description of tasks and activities that were accomplished in 2010 and 2011, as well as items on the drawing board for 2012," on a public Facebook forum.

Before launching into such tasks and activities, they ground the intention of the agenda: "The Midwives Alliance's Social Justice Agenda must be founded in actions that go beyond mere awareness of the impact that social inequities have on maternal child healthcare. It must directly address the integration of this knowledge into our work by enriching decision-making and organizational operations and communications" (Post-Resignation Facebook Forum). This appears to be a direct response to the suffering expressed by the Midwives of Color Section and, further, the precise inanity of hereto social justice initiatives.

The document includes 13 activities and accomplishments in 2010 and 2011 and 4 activities planned for 2012 focused on: (1) MANA leadership training on anti-racism, anti-oppression and decolonization and, (2) the creation of a strategic work plan and action steps for implementation of a Social Justice framework. I wish to highlight five 2010 and 2011 items because they directly pertain to the Midwives of Color Committee and/or diversity efforts. They are as follows:

> Formed a MANA Social Justice Standing Committee within the MANA board.
>
> Endorsed the Midwives of Color Section's document entitled Points of Unity as a core and significant MANA document.
>
> Appointed a 'Social Justice Watchdog' within the Board of Directors to monitor

every aspect of MANA's conferences, meetings conference calls, and decision-making in order to raise awareness and encourage behavior change related to social justice consciousness and action

Recruited a significant number of new members to the Midwives of Color Section through a focused membership drive

Provided $6000 in conference scholarships for Midwives of Color

(Post-Resignation Facebook Forum)

Though these items appear factual in nature, as in they simply happened or not, they sparked

debate in a series of public posts that followed with one of the resigning MoC members saying,

"I have to question a few points contained in this latest MANA release. As a former MANA

member and former MOC member, I do not think all of the information in this release is

factually correct. No, a few points may be a different perspective, but some of the information is

factually incorrect" (Claudia Booker, 06.03.12).

She cites the perceived infrequency (two of three scheduled conference calls occurring in a

four month time span) and inefficiency ("none of the conversations resulted in actions or

outcomes relevant to maternity care or health disparities") of the Social Justice Standing

Committee and questions MANA's formal endorsement of the Points of Unity and the

appointment of a Social Justice Watchdog ("Would you please list the name of MANA's Social

Justice Watchdog? When was this person appointed?"). She notes a perceived inequity in the

voting privileges associated with the focused membership drive citing above saying "Yes, under

Jennie Joseph's leadership, and in an effort to increase membership in the MOC section, MANA

offered a reduced rate membership for MOC members. However, the reduced rate of $50.00

came with the proviso that MOCs who took this reduced rate could not vote in any MANA

elections, thereby denying these women full active participation in MANA. This May when a

reduced membership rate was offer to the general MANA membership ($75.00), people who

took advantage of the reduced rate did not forfeit the ability to vote and thereby full participate in

MANA" (Claudia Booker, 06.03.12). Finally, she addresses the actual targeted group of the

$6,000 conference scholarships saying that they were not limited to women of color but to any

student or midwife in need.

Much like the polarized perceptions of the CPM Symposium, the same issue applies here

with MANA's Social Justice Plan. These items sparked continued debate with MANA

responding in another official statement. For the purposes of this discussion, the specificities are

less important than the larger message: The subsequent posts exist on a continuum from a

watershed of painful experiences from midwives, student midwives of color, and apologetic

whites to defensiveness:

> The tone of all of MANA's communications recently has been open but there has been a
> lot of-what we've done and what we're doing.
> And not a lot of, we were wrong, we are sorry.
>
> (Janelle Allyn Lucido-Conate, 06.03.12)

> As my years of experience in MANA increase, my hope lessens. I see a consistent
> unwillingness to compromise. I hear many variations of this theme: I want to be the kind
> of midwife I want to be and I am not going to change my perspective; I will not allow
> you or anyone else to speak for me; and if you want me to change, you must be evil.
> These voices are few but pervasive and loud. Until a majority of MANA members are
> willing to make the compromises and changes necessary for MANA to be an
> organization that speaks for a people, it will always be a loose collection of individuals -
> a club. That might be nice, but it is not an entity that will make the changes necessary to
> meet its goals.
>
> (Patricia Ross, 06.01.12)

> To the MANA Board, slow and steady is one thing, lack of acknowledgement is another.
> Be still and listen for once, maybe even let someone else speak and not just your chosen
> Women of Color spokespersons. The loss of the MOC leadership from MANA's board is
> tragic, and predictable. The lack of commitment to clear goals created the environment
> where attempts to meet the goals fail. When an organization has clear goals toward equity
> and excellence, and offers effective representation of the best of what midwifery can
> offer, many midwives will rally round. And some won't. MANA has to be willing to wish

those folks Godspeed, and focus on continuing to improve the profession of midwifery for women of all backgrounds.

<div align="right">(Jessica Roach, 05.26.12)</div>

I want to be clear that every time I have discussed this resignation with midwifery leaders-Presidents of professional organizations or leaders of midwifery education programs-everyone has expressed sadness at the resignation but simultaneously openness and a commitment diversifying and bettering the midwifery community. Nonetheless, I am not a midwife and have not been member of the professional organizations. Their first-hand, more long-term experiences hold tremendous value.

It is midwifery leadership's responsibility to ensure the inclusion, political equality, reasonableness and publicity democracy demands. The predictability that Jessica Roach speaks of could not be more true as it speaks to, independent of good intentions, the failures of tokenism, non-substantive "social justice" and celebratory diversity. Wood (2003) theorizes a satisfactory image or metaphor of diversity:

> To get all the way to a satisfactory image of diversity, we would have to construct some metaphor in which each component possesses its own autonomy and insists on its own importance, and the whole would be overseen by a *power who simultaneously credits and ignores each part's claim to precedence*.

<div align="right">(p. 134 my emphasis)</div>

Pushing toward a satisfactory image, for me, is less important than the necessary power Wood speaks of. The midwives I spoke to seem to be asking-even demanding-the same. Where is the power? Historical and contemporary experiences with racism are manifesting themselves in birth disparities and yet, midwives of color at large, are expressing experiencing racism in their very professional organizations that should be leading the charge in supporting and

developing midwives of color and addressing birth disparities. Pushing beyond fear, consumption, tokenism, "canned responses" is imperative to the *power* that diversity work demands. And, as Martha identifies, this is not just a "MANA issue." This is an issue that must be at the forefront if midwifery, as a collective, is to advance in this country.

I began this chapter with expressing the importance of organizational power. I know of various efforts on the part of MANA, NACPM and ACNM, respectively, to join forces with the American College of Obstetrics and Gynecology (ACOG) to create more opportunities for midwives and obstetricians to form collaborative care partnerships or lobby Congress to amend the Social Security Act to allow all midwives to receive Medicaid reimbursement. These are incredibly important initiatives that have national implications for increasing midwives' scope of practice. These kinds of initiatives, though, can only happen with the collective power of organizations. Yet, if even just my sample of midwives overwhelmingly report dissatisfaction, disengagement and/or mistrust and are demonstrating this by withdrawing membership-I suspect this may be a generalizable sentiment-it begs some questions: *who* is the alliance of MANA, *who* is the association of NACPM, *who* is the association of the college?

Just recently in April of 2014, I was invited to present my research at the second annual meeting of the United States Midwifery Education, Regulation and Association (US MERA) Workgroup. This workgroup is comprised of seven national mainstream midwifery professional organizations and accreditation boards seeking to establish "common ground" on baseline midwifery education, education pathways and credentials. I was thrilled at the opportunity and was inspired by the collaborative conversations and actions taking place. I was one of less than a handful of people of color in a room of over thirty of midwifery's national leaders.

Notably missing at the meeting, for me, was Ms. Shafia Monroe, founder of the International Center for Traditional Childbearing in Portland, Oregon. ICTC is a "non-profit infant mortality prevention, breastfeeding support, and midwife training organization, comprised of women and men who want to improve birth outcomes and provide training opportunities in their communities" (International Center for Traditional Childbearing). Ms. Monroe annually organizes a conference that "brings midwives and healers together to find solutions to improve birth outcomes, increase breast feeding, and mentor persons aspiring to become midwives" (International Center for Traditional Childbearing). Ms. Monroe was an excellent resource for me as I began this project and I have had the opportunity to visit her headquarters and attend an annual conference. I learned that in addition to providing great training and educational opportunities, she has formed a national community of midwives, *especially* midwives of color, which is active during the annual conference and throughout the year. She has ongoing insight into the educational experiences, both the amazing possibilities and surmountable challenges, of midwives throughout the country. And yet, ICTC is not a member organization of the US MERA Workgroup.

This concerns me greatly, especially because I know of publicized and non-publicized efforts to hire *external* "diversity consultants" when midwives of color are asking to be heard or consulted with. Again, the diversity industry is big business at a reported 8 billion a year but it appears quite circular in nature, a concept that Wood (2003) helped me to visualize:

> *Diversity* advocates create the problems that *diversity* consultants are then hired to ameliorate. *Diversity* amelioration causes more problems, for which diversity experts propose the answer: more *diversity*. *Diversity* in the workplace is supposed to make the company more agile, better equipped to reach out to new markets, and more creative in solving problems because, compared to the old, undiverse company, it has access to more styles of thinking. The diverse company is the company that has escaped from the rut of taken-for-granted ways. It is poised for creativity. So goes *diversity* management theory. But there is a little rub. Not everyone is "comfortable"

with diversity….Enter the *diversit*y trainers.

For midwifery, this may or may not be an issue of comfort. I do know that national midwifery leaders have generally well received my research-my presentation of political narratives, according to Young's (2000) understanding of inclusive political communication-and desire to incorporate the findings into future work. I also know that some have felt very puzzled or defensive about the findings. Either way, perhaps it is easier to hear it from the consultant, the supposed expert, than hearing from the midwives themselves who are, in my mind, the real experts.

But the MANA resignation letter and subsequent Facebook posts reveal this is a deeply painful, though enlightening process. Leading this charge requires the power Wood speaks of. The work begins with acknowledging the current state of midwifery "space." In this way, I appreciate the words of Mary who recounted the Symposium story above: "We have to really work on cleaning "our house" though. There is more anti-racism work to be done and it is ongoing." Nirmal Puwar's (2004) is a great contribution to my understanding of space. In fact, while at the recent US MERA Workgroup meeting, I wrote the word "space" in big box letters because it was quite jarring. Puwar defines social space in this way:

> ….social spaces are not blank and open for any body to occupy. There is a connection between bodies and space, which is built, repeated and contested over time. While all can, in theory, enter, it is certain types of bodies that are tacitly designated as being the 'natural' occupants of specific positions. Some bodies are deemed as having the right to belong, while others are marked out as trespassers, who are, in accordance with how both spaces and bodies are imagined (politically, historically and conceptually), circumscribed as being 'out of place.' Not being the somatic norm, they are space invaders.
>
> (p. 8)

In midwifery's history, the "natural occupants" and "space invaders" have certainly shifted over time and in place. Once the natural occupants were immigrant and women of color and with the

"white revival" of midwifery in the 1960s and 1970s those roles-rights of "ownership"-have oddly shifted and are reified in educational institutions, professional organizations, accrediting agencies and national workgroups.

Puwar's (2004) theory of space invasion is in conversation with Kanter's (1977) proportional experience in that midwifery's "invader" also brings with her, here specifically, socially constructed, controlling images of blackness. For those who are granted access to the space, their very presence challenges the ways in which racialized bodies have been categorized and fixed. She argues that invaders unconsciously register as trespassers and often experience a series of "markings," or reminders, of their status. In this story, such markings, I imagine, led to the resigning midwives saying they are "The Help-2012 Version" or Ida saying "feels like the spook who sat at the door." Puwar's thesis asks "….what happens when those bodies not expected to occupy certain places do so. And most specifically it is concerned to ask what happens when women and racialised minorities take up 'privilieged' positions which have not been reserved for them, for which, they are not, in short, the somatic norm? What are terms of coexistence?" (p. 1) The terms of coexistence are, at best, challenging.

I posit one final caveat to complicate this further because identity is, after all, complicated. After a recent presentation of my work to a predominantly white audience, a white woman addressed me after to tell me about "her African-American friend." She relayed that her friend hates and is offended by any discussions of race, inequality and achievement because she has worked hard and has succeeded without race being a barrier. I expressed that I do not in any way deny the presence and importance of individual agency. Structurally, however, achievement and access are granted or denied in our highly stratified society. We had a great, non-academic discussion of Bourdieu's social and cultural capital-cumulative effects of non-financial assets

such as social networks; education, enrichment and exposure opportunities; speech patterns; style of dress; physical appearance etc.-after which she thanked me for my "interesting perspective."

I relay this story here because midwifery's "space work" that I suggest is not a call for add black, Latina, Asian and/or other midwives of color and stir into the proverbial melting pot. Class, capital and political identity matter. In 1956, C. Wright Mills examined the social, educational and occupational backgrounds of those that occupy the dominant positions in the military, economic and political institutions in *The Power Elite*. In 2006, Richard Zweigenhaft, reexamining the power elite, found that though this cohort demonstrates increased diversity as compared to the 1950s, its core group continued to be "wealthy white Christian males, most of whom are still from the upper third of the social ladder….the new diversity within the power elite is transcended by common values and a sense of hard-earned class privilege. The newcomers to the power elite have found ways to signal that they will call for no more than relatively minor adjustments, if that." Though my study solely investigates the operation of race (and certainly has been the most salient part of my midwives' identity in midwifery) I do not presume they are all the same as this would only reify notions of tokenism I seek to strongly critique.

Still, I ask, where is the power? Focusing on those underrepresented and underserved reveals the most about organizational values, processes and level of inclusive space. Listening, *really* listening to and *acting upon*, the words, experiences and perceptions of my sample of black midwives and midwives of color at-large weaves a key political narrative that cannot be so neatly addressed with celebrations, magic, performance art, "canned responses," the token person or committee or the external consultant. Like birth itself, this work is far more messy. And it maybe as painful. But it is perhaps the work that is most worthy of celebration.

Chapter Five

**"Sick and Tired of Being Sick and Tired": Situating Midwifery within a
Womanist Ethic of Caring Justice**

All my life I've been sick and tired. Now I'm sick and tired of being sick and tired.
-Fannie Lou Hamer

Earlier in this manuscript, I have discussed women of color's experiences of exclusion within and from feminism and mainstream feminist organizations. Beginning with Sojourner Truth in 1851 asking "ain't I a woman?" at the Women's Convention in Akron, Ohio, women of color have challenged agendas that narrowly focus on sexism without focus on the educational and economic development, political rights advancement and social services access crucial to women of color for survival and empowerment. Feminism and feminist mainstream organizations, assert Caraway (1991) and Collins (2001), have historically been and continue to be viewed "by both blacks and whites as the cultural property of white women" and attempts to address race and racism are "sapped by understanding and celebrating difference" (Collins, 2001). This is curiously familiar to my sample's reported experiences with mainstream midwifery professional organizations. Again, in Puar's (2004) terms, elaborated on in the last chapter, space is not neutral but instead maintains "natural occupants" and, those who are not so are "space invaders." In midwifery's space, it is precisely the problem of rightful occupancy that I have framed the contemporary midwife problem which, I will argue here, must be situated within a womanist ethic of caring justice to affect positive social change. The point of departure for the womanist ethic of caring justice is the body and lived experience of black women. Acknowledging a history of institutional racism and controlling images that continue to systematically impact the lived experience of black women, the womanist ethic of caring justice

demands liberty, equality and freedom-demonstrated in policy and in practice-to support and

empower black women as women, mothers, partners, sisters and friends.

Midwifery as a Womanist Issue

      I wish to revisit and expand upon womanism; to simultaneously position both the

recruitment and retention of black midwives *and* black access to and awareness of midwifery

care as womanist issues. Layla Phillips (2006), building on the interdisciplinary works of

womanist theorists, offers an important distinction between womanism and feminism and the

relationship between the two:

> ….womanism does not emphasize or privilege gender or sexism; rather, it
> elevates all sites and forms of oppression, whether they are based on social-
> address categories like gender, race, or class, to a level of equal concern and
> action. Womanism's link to gender is the fact the historically produced
> race/class/gender matrix that is Black womanhood serves as the origin point for a
> speaking position that freely and autonomously addresses any topic or problem.
> Because Black women experience sexism, and womanism is concerned with
> sexism, feminism is confluent with the expression of womanism, but feminism
> and womanism cannot be conflated, not can it be said that womanism is a
> 'version' of feminism.
>
>   (pp. xx-xxi)

Phillips typifies womanism as having five key characteristics: (1) antioppressionist (aligned with

liberationist projects against *all* forms of oppression); (2) vernacular (grounded in "the

everyday"); (3) nonideological (focused on developing decentralized structures of inclusion and

positive interrelations); (4) communitarian (aimed towards the collective well-being of all

people, specifically with black men); and (5) spiritualized (rooted in spiritual beliefs and

practices) (Phillips, 2006, p. xxiv). My data demonstrates that "the everyday" speaks volumes

about individuals and institutions of power and that it is only through inclusion-working toward

Iris Marion Young's (2002) communicative democracy specified in the last chapter-that a representative midwifery collective can be built.

In chapter two, I presented Alice's (CPM, 5-10 years of experience) reflections on a "white girls network": "I think it's hard for all midwives but I think there is a ' good ol' white girls network…' they look out for each other and we need to do the same." At first, the "we" she refers to is black women. Later in the interview, she says "You know, this is a midwives of color issue. We have such sad but beautiful histories and we need to and can do better together more than apart. And I mean this for all women-black, white, Latino. All women."

Not only is building a strong, cohesive midwifery collective an important womanist issue, so too is black women's awareness of and access to midwifery care. Audre (CPM, 10-15 years of experience) reflects:

> Black women….we, we are the example of just how bad birth is. And there is a long history of abuse to black women bodies and at the same time a distancing from midwives. It could be they don't want midwives or just don't know! That's the problem.

Audre connects poor black birth outcomes to a long history of horrifically abusive medical research and practices endured by black people. As vast as such abusive medical research and practices have been, so, too, is there a long history of black health activism (A. Nelson, 2011; J. Nelson, 2003). Access to and awareness of midwifery care must become a priority for the contemporary black health activist agenda.

The black women's health movement, for example, is said to have begun with Fannie Lou Hamer's proclamation "we're sick and tired of being sick and tired" at the 1983 gathering of 1,500 black women at Spelman College in Atlanta, Georgia, for the National Conference on Black Women's Health. At that conference, the National Black Women's Health Project, now the Black Women's Health Imperative, was founded by Byllye Avery. The mission of the

Imperative is "devoted solely to advancing the health and wellness of America's 20 million Black women and girls through advocacy and public policy, health education, research and leadership development" through a framework of reproductive justice (Black Women's Health Imperative). The Imperative, alongside SisterSong, a women of color reproductive justice collective, are the nation's leaders in reproductive justice for all. This agenda seeks to expand the narrowly focused rhetoric of "choice" expressive of the pro-life/pro-choice debate of reproductive rights movement and instead focus on the physical, mental, spiritual, political, economic and social well-being of women and girls.

Much like Bonilla-Silva's (2009) critique of "choice" in the abstract liberalism frame of color-blind racism, reproductive justice activists problematize the very nature of "choice"-to have a child, or not have a child-as it assumes that all options are freely and widely available. "Choice" rests on notions of individualism that masks the social, economic and political conditions that frame that which is available. (Solinger, 2001; Smith, 2005). Liberty has also been proffered within the same paradigm of choice. I particularly align with Dorothy Roberts's (1997a) discussion of liberty: "Liberty protects all citizens' choices from the most direct and egregious abuses of government power, but it does nothing to dismantle social arrangements that make it impossible for some people to make a choice in the first place. Liberty guards against government intrusion, it does not guarantee social justice" (p. 294)

For black women, understanding the gravity of social *injustice* and the urgent need for reproductive *justice* must be situated in a thwarted legacy of racist, capitalist and criminalist denigrations of black childbearing, including state-mandated sterilization in exchange for public assistance and corporate-sponsored research of dangerous oral contraceptives and hormonal implants using black women as subjects, often without informed consent (Roberts, 1997a; Smith,

2005). The demands for justice are for the right to safe contraception and abortion, a safe, healthy and caring birth and the right to social, economic and political demonstrations of value for black women and black children (Rothman, 2005; Spar, 2006; Taylor, 2004). Just as Audre instructs us that "black women are the example of how bad black birth is," black women's struggles in childbirth and childrearing then and now, are an important place to begin developing the womanist ethic of caring justice for women, children and families.

Toward the Womanist Ethic of Caring Justice

The ethics of care represents a cluster of philosophical ethical theories first developed during the feminist and womanist movements (Collins, 2001; Gilligan, 1982; Held, 2006; Jaggar, 1983; Jaggar, 1984; Kittay, 1999; Noddings, 1984; Noddings, 1992; Ruddick, 1995). The ethics of care ultimately begins with the premise that people are relational and interdependent. This is a fundamental difference from the premise of abstract liberalism, specifically problematic notions of individualism and choice, which I have earlier addressed. Theories of ethics beginning from these premises--an ethics of justice--focus on issues of freedom, equality, independence and *individual* rights.

In contrast, ethicists of care lead from the premise that we begin our lives dependent on others to provide us with physical and emotional care and will depend on others for care throughout our lives, when we may be ill, temporarily or permanently disabled or just the everyday forms of care and nurturance essential to our survival. Ethicists of care not only position interdependency as fundamental to identity and social relations, but also demand *value* for "attentiveness, trust, responsiveness to need, narrative nuance, and cultivating caring relations" (Held, 2006, p. 15). Distinguishing between an ethics of justice and an ethics of care,

Held (2006) says "whereas an ethic of justice seeks a fair solution between competing individual interests and rights, an ethic of care sees the interests of carers and cared-for as importantly intertwined rather than simply competing. Whereas justice protects equality and freedom, care fosters social bonds and cooperation" (p. 15).

Ultimately, the ethics of care and ethics of justice should work in tandem. Care, though, must be the fundamental value; a value that is supported in practice and policy. Held (2006) argues that there *can* be care without justice. Midwives, for instance, have and continue to provide care in an unjust U.S. society that has historically abused and devalued black women and their bodies. Black birth outcomes reflect such injustices. But justice *cannot* exist without care. Without care, there are no individuals, families or societies to make equal or free. Care, then, is the primary value from which to achieve social justice:

> The ethics of care clearly implies that society must recognize its responsibilities to its children and others who are dependent, enabling the best possible bringing up and educating of its future generations, appropriate responses to its members in need of health care, and assistance with the care of dependents.
>
> (Held, 2006, p. 159)

Our social, economic, legal and political structures must make a commitment to individuals, families and societies beyond individual rights. This is the positive notion of liberty that Dorothy Roberts (1997) speaks of; there is a drastic difference between freedom *from* government intrusion and an entitlement *to* caring, just governmental policies.

It follows that a caring, just society places primary values on government-subsidized early childhood and higher education; high quality elementary and secondary education that is equally resourced in economic and human capital; environmentally just neighborhoods[37]; food

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[37] The United States Environmental Protection Agency (EPA) defines environmental justice as "the fair treatment and meaningful involvement of all people regardless of race, color, national origin, or income with respect to the development, implementation, and enforcement of environmental laws, regulations, and policies. EPA has this goal for all communities and persons across this Nation. It will be achieved when everyone enjoys the same degree of

security[38] and other social service programs. Specific to birth, I also posit that policies should include equal and fair access to midwifery practice in homes, freestanding birth centers and in hospitals. It is not beholden to the lobbying power of medical professional organizations. It does not perpetuate the dominance of military power or the economic interests of the corporate sector. Collectively, such policies are a demonstration of the womanist ethic of caring justice I theorize here.

I first qualify the ethic as womanist because womanism is, as Phillips (2006) teaches us, antioppressionist and communitarian. Though the physical act of birth is the labor and experience of a woman, she is a partner, mother, sister, and friend. Birth is as much about the flow of oxytocin, the "love hormone," between mother and baby released during and after birth as much as it is a celebratory event of life and welcome for everyone related to--biologically and socially--mother and baby. It should be the ultimate expression of warmth, nurturance, love and humanity.

I second qualify the ethic as womanist because, and a clear distinction from feminism, birth is expressed by midwives-*all* midwives-as a spiritual process and event (Gaskin, 1977). The call to birth work was mentioned, in some form, in all interviews. Below I recount some of its most memorable expressions:

> [tears] To witness the start of life….the very start. It is amazing. I am doing God's work. I know this. Some are called to teach, some are called to preach, I was called to witness and aid the process of birth. Just like we need to value our teachers more. We need to value our midwives more. We are doing God's work.
> *Patricia* (CPM, 20-25 years of experience)

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protection from environmental and health hazards and equal access to the decision-making process to have a healthy environment in which to live, learn, and work." (United States Environmental Protection Agency)

[38] The U.S. Department of Agriculture (UDA) defines food security as "access by all people at all times to enough food for an active, healthy life."

> I treat pregnancy, childbirth, breastfeeding and all relations between mama and baby as beautiful, spiritual. It's a job…but this is more than that. I was put there to do this work. I had to find my way, you know, but this is my life's purpose. Even through the pain cause it [birth] hurts like hell, there is an element of the spiritual there. It is an experience. I bring my skills, my love, my care to it but there is something happening in that room that is far greater than the people in it. It's real.
>
> *Zora* (CPM, 10-15 years of experience)

The U.S. medical model of pregnancy and childbirth's values of systematization, management, efficiency and control does not reflect the interdependency indicative of the ethic of care. Where is the woman in the body? Where is the woman in the technocratic cascade of medical interventions? What emotional connections between mother and baby are disrupted? To me, how we as a society primarily treat birth reflects our very value of human life. The womb is the baby's first environment. The baby's transition from the womb to the world--the birthing process, setting and people present--is our first demonstration of care, love and value for baby, mother and family. When, where and how we enter, even what we enter *into*, matters. Birth, the subsequent growth and development of children, the raising of a younger generation, with all of the familial, communal and social resources required, is a universal aspect of human existence. It is the tie that binds us all and should serve as the nucleus around which to develop a womanist ethic of caring justice.

The Life Course Perspective and the Womanist Ethic of Caring Justice

Understandings of birth and birth work are often narrowly defined to pregnancy, childbirth and postpartum care. Yet, the ethic demands demonstrations of value for and attention to black women, and all women, throughout their life course. The life course perspective on women's health and birth outcomes, as theorized by Lu and Hafron (2003), is an important

public health contribution to the ethic and may serve to positively impact health care in this country. The perspective is said to be a synthesis of the early programming model and cumulative pathways model. In 1990, the early programming model, developed by David Barker, a physician and researcher, contends that exposures and experiences during "sensitive developmental periods" in utero and in early life programs the hard drive-our organs and systems-and has a long term impact on future reproductive potential, health and disease. Systematic differences in these experiences and exposures, specifically by socioeconomic status and race/ethnicity, manifest themselves in birth disparities. In many ways, this seems to be the "cellular knowledge" that Mary and Kimberlee reported in chapter three.

The cumulative pathways model reflects Brian McEwen's (1998) discussion of allostatic load. Allostatis, again, is the body's attempts to maintain stability during and after exposure to stressful experiences. If the body consistently and continuously is exposed to prolonged periods of allostasis, it reaches a limit or allostastatic load. This load represents the body's inability to recover from the effects of prolonged wear and tear on the system. This load ultimately has a "weathering effect" and gradually declines reproductive health, increases the likelihood of experiencing poor birth outcomes and/or developing a chronic disease.

The life course perspective, then, synthesizes these two models by addressing the biological programming of early life and the cumulative effects of allostatic load and weathering throughout the life course. Lu and Halfron (2003) describe this perspective in this way:

> ….it provides a longitudinal account of the interplay of biological, behavioral, psychological and social protective and risk factors in producing adverse birth outcomes. Disparities in birth outcomes result from differential development trajectories over the life course, as depicted in figure 1. The black-white gap in reproductive potential (product of her developmental trajectory over the life course) widens in utero and early life, and possibly during puberty, pregnancy and other sensitive periods of development. Outside of these sensitive periods, the gap continues to widen as a result of differential cumulative exposures to protective

and risk factors. Thus the lower reproductive potential of black women, relative to white women, results from (1) lower starting point due to intergenerational effect, (2) smaller acceleration and greater deceleration in their developmental trajectory during sensitive periods, and/or (3) exposures to more risk factors and less protective factors across their life span.

(p. 19)

This perceptive is in line with my samples' perceptions of black birth outcomes in three ways.

First, it supports their perceptions of the *intergenerational* effects of differential development

trajectories over the life course. Efforts to eliminate racial disparities in birth outcomes would

ultimately require targeted interventions during sensitive development periods (e.g. in utero

development, early childhood, puberty, pregnancy) and greater access to and quality of women's

health care throughout the life course. Closing the gap in one generation is the only hope of

giving the next generation an equal start.

Second, the perspective's conceptualization of differential accelerations and decelerations

in reproductive potential throughout the life course reflect my sample's discussions of racism

and microaggressions. Again, Anna (CNM, 40-45 years of experience) reflects:

> I know how it feels to be a black woman in this world…walking down the street, at work. Stupid stuff people say. The way stuff makes you feel. That small stuff. I also know what it feels like to be a black mother in this world. I know what we been through as people and what that mean for her and her baby. We are a strong, smart, prideful people but it's hard.

It is black women's cumulative exposure to more risk factors and less protective factors, relative

to white women, which is a strong explanatory factor of disparities in birth outcomes. This was a

key finding in my data.

Third, the perspective's conceptualization of not only differential exposure to biological,

social and environmental risk factors but also differential exposure to *protective* factors is also

reflected in my data. June (CNM, 35-40 years of experience) reflects on her emotional,

protective labor:

I'll be honest. When I am working with a black woman, I love on her hard. When she comes to me for prenatal or at birth, I rub her back, ask about her babies, make sure she is doped up on vitamins [laughs], make sure she is exercising and also eating healthy. I always have healthy fruits and vegetables in my office. "Take it. Love for you and baby." I have even made meals. There is so much love in food. And it's important to get her family in here, especially if she is a teenager.

Anna, a CNM (also the oldest in my sample) expands upon the importance of loving community, of protective factors:

We have to work with, collaborate with, our black men. Our men of color. Get them involved in all aspects of pregnancy, childbirth and raising the baby. They are oppressed, too. In different ways than us but they are oppressed. We midwives once brought families and communities together. Bound them, you know? We need our men."

June and Anna's descriptions of their work seems to align with what Fraser (1998), Lee (1996), Logan (1991), Smith & Holmes (1996), and others producing works on the grand midwives of the south. That is, black midwives have historically done more than simply "catchin' babies" but have served as community figures and emotional laborers; an important tradition which has not been eradicated, but drastically has decreased. The ethic I theorize here seeks to restore, in policy and practice, midwives as such important womanist, and caring providers.

On Relationality and the Life Course Perspective

Building upon foundational ecological models (Brofenbrenner, 1979; Stokols, 1996; Evans & Stoddart, 1990) and social determinants theory, more public health research is being grounded in the concept of relationality. In *Maternal Nutrition and Infant Mortality in the Context of Relationality*, a report produced by the Joint Center for Political and Economic Studies Health Policy Institute, Lu & Lu (2007) contend: "Relationships are constitutive of what it means to be human. The central role of relationships and their associated effects upon maternal

and infant well-being have generated a new understanding of the infant mortality challenge" (p. v). This language is certainly reflective of care language and the centrality of relationality is not a new concept for midwives or midwifery researchers. It does, however, suggest an important direction in public health research. June and Anna, in their discussion of protective risk factors for black women, as listed above, relate the value and importance of familial and communal relationships. Lu and Lu (2007), offer black women's "broken relationships" as an explanatory factor for birth disparities. Though I'd argue the phrasing is poor in design because it reifies unfortunate stereotypes of black women and families, the substance of it is important. They contend that it is black women's poor relationship with--specifically in terms of quality and access--health, economic, political, social and legal resources that is broken, causing high stress and low support.

At present, access to high quality care, including emotional labor, demands economic capital, cultural capital and social capital. Jones et al. (2010) have coined the term "reproductive social capital," or networks, norms and social trust that facilitate optimal reproductive health, based on the One Hundred Intentional Acts of Kindness toward a Pregnant Woman community-based program in south and central Los Angeles, California. Developed by the Healthy African – American families project, focus groups were conducted with local pregnancy women to determine acts of kindness that families, friends and strangers might do to support, emotionally and otherwise, local pregnant women. 100 Acts encourages and engages active participation from family and community members in promoting healthy pregnancies, i.e. maximizing women's reproductive social capital.

Though ambitious in scope and profound in impact, 100 Acts is but one program, in one state, in one city. What about the other millions of black women and girls throughout the United

States? Again, how we treat birth reflects our very value of human life. Though the Affordable

Care Act does increase access to preventative services for women covered by insurance

companies, there is an incredible amount of additional work to be done. Based on my data and

midwifery, social science and public health research, I conclude that caring, just policies during

pregnancy should include greater government-subsidized support for community-based prenatal

care models like Centering Pregnancy,[39] community-based doula programs[40], breastfeeding

support and inter-conception care. I here list, in addition to the caring, just policies and practices

I mentioned in the "Toward The Womanist Ethic of Caring Justice" section of this chapter, a

series policies and practices to be institutionalized throughout the life course. There must be

government-subsidized support for

- increasing access to and the affordability of a healthy, nutritious diet and general well-being by eliminating the placement of harmful chemicals in food and household products;
- privileging the health of families as opposed to the financial and proprietary interests of major food suppliers and distributors by regulating the availability and marketing of junk food to adults and children of color and/or adults and children of low income;
- funding equally school and community-based comprehensive versus abstinence-only sex education programs,
- continuing to support and strengthen Women, Infant and Children (WIC) programs;
- increasing access to mental health services for women and reducing the stigma attached to receiving care; and

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[39] The Centering Healthcare Institute describes Centering Pregnancy as "a multifaceted model of group care that integrates the three major components of care: *health assessment*, *education*, and *support*, into a unified program within a group setting. Eight to twelve women with similar gestational ages meet together, learning care skills, participating in a facilitated discussion, and developing a support network with other group members. Each Pregnancy group meets for a total of 10 sessions throughout pregnancy and early postpartum." (Centering Healthcare Institute) See Ickovics et al. (2003).

[40] The International Center for Traditional Childbearing offers a Full Center Doula Training program. ICTC describes the training as " a 29 hour birth companion training program that includes cultural awareness and sensitivity, infant mortality prevention, high risk pregnancies, medical terminology, prenatal support, labor and birth management, postpartum and breastfeeding support, nutrition, relaxation techniques, HIPPA, lead prevention, professional business development, traditional and spiritual birthing practices, and much more. Graduates receive a provisional certificate and ongoing support (including business development) for full certification." (International Center for Traditional Childbearing) ICTC offers trainings in cities throughout the country.

- removing disincentives for partner/father involvement in "TANF[41] (e.g, elimination the distinction between single and two-parent families for eligibility determination), EITC[42] (e.g., allowing a second-earner deduction), and child support families (e.g., establishing amnesty programming; allowing greater 'pass-through' of child support payments to children and extending TANF, EITC and other social support services to non-custodial fathers who pay child support" (Lu & Lu 2007, p. 62).

There is good news in this story. Our country's midwives are already doing much of this work in homes, in freestanding birth centers, in clinics, and in hospitals. They are doing this work well, safely and cost-effectively. They are doing this work within a country that does not systematically value or support its midwives. Black midwives are serving as "othermothers"-though different in scale-than their grand counterparts of the 17th century. They are doing this despite negative images of midwifery and controlling images of black women and midwives reified in the popular media that do not reflect the depth, breadth or efficacy of their work (Collins, 2000; Kline, 2007; Tyree, 2011). And yet, arguably because of this, 7% of in-hospital black births are attended by midwives and less than 1% of black births occur outside of the hospital (Martin, Osterman, Hamilton, Curtin & Matthews 2013).

Despite increasing mainstream critiques of the medical model like former 1990s talk show host Ricki Lake's 2008 documentary film *The Business of Being Born* or Christy Turlington's 2010 documentary film *No Woman, No Cry*, these poor black birth statistics still persist. And, again, though the 1% of national births occurring outside of the hospital is slowly increasing, 90% of the increase is attributable to increased use of midwives by non-Hispanic white women (MacDorman, Mathews & Declerq, 2012). When I asked Audre (CPM, 10-15 years of experience) if she noticed an increase in black women seeking her care after the Lake and Turlington's documentaries were released, she said "*The Business of Being Born* didn't help

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[41] TANF is the federal public assistance program Temporary Assistance to Needy Families.

[42] EIC is the earned income tax credit.

black women. Are we watching it? Do we know it exists? I feel like it stayed in one circle. Most of our women will be reached in schools and in communities, you know? They need to know we are here. We are waiting. We are here to support you."

Recommendations

In this section, I offer recommendations for the general midwifery community.

Clarity of Credentials

The April 11-13, 2014 United States Midwifery Education, Regulation and Association Workgroup meeting that I have mentioned throughout this manuscript was set with one of the intended goals to align all U.S. midwifery education programs and pathways with the International Confederation of Midwives (ICM) Global Standards. ICM is an accredited non-governmental organization that includes the World Health Organization and other United National Agencies, global professional health care organizations, non-governmental organizations, bilateral and civil society groups (International Confederation of Midwives, "Who We Are, "http://www.internationalmidwives.org/who-we-are, n.d./). ICM "supports, represents and works to strengthen professional associations of midwives throughout the world. There are currently 116 Midwives Associations, representing 102 countries across every continent. ICM is organized into four regions: Africa, the Americas, Asia Pacific and Europe. Together these associations represent more than 300,000 midwives globally groups (International Confederation of Midwives, "Who We Are, "http://www.internationalmidwives.org/who-we-are, n.d./). In

2008, ICM developed global standards for midwifery education, essential competencies for basic

midwifery practice and curriculum guidelines for professional midwifery education[43].

The first day of the US MERA Workgroup meeting was called the "Learning Day." The

first half of the day included presentations by leaders of the American College of Nurse

Midwives (ACNM), the National Association of Certified Professional Midwives (NACPM) and

the Midwives Alliance of North America (MANA) on trends in the state of U.S. midwifery.

Leaders of ACNM and NACPM (and their corresponding accrediting agencies) presented a very

detailed overview and discussion of the varying education programs and pathways. Prior to the

meeting, the respective organizations presented handouts on how the CNM credential and CPM

credential midwifery education program aligned with ICM Global Standards for midwifery

education and practice[44]. During the presentations, I was really struck by the fact that among the

nation's midwifery leaders, there was an incredible amount of mystification and confusion about

the varying midwifery education programs pathways; I, and would venture to say, everyone in

the room benefited from what I experienced to be excellent, thorough, clarifying, demystifying

presentations.

This mystification and confusion is also present within the larger midwifery community, as

evidenced by my data. That is, my sample of midwives drew rather informed conclusions about

the requirements leading to midwifery credentials other than their own. Similarly, some drew

rather uninformed conclusions about the day-to-day experiences of midwives with credentials

other than their own, specifically the clients they serve. My discussion of "real midwifery" in

chapter two is evidence of this.

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[43] See http://www.internationalmidwives.org/what-we-do/global-standards-competencies-and-tools.html for ICM's
Core Documents: ICM Global Standards for Midwifery Education, ICM Essential Competencies for Basic
Midwifery Practice, ICM Standard Equipment List for Competency-Based Skills Training and ICM Model
Curriculum Guidelines for Professional Midwifery Education.

To me, this is not a poor reflection of my research participants. Rather, it speaks to the need for greater collaboration amongst the major national midwifery organizations and educational institutions. Leadership, after all, sets the tone. Furthermore, given the very small network of black midwives, there is little room for mystification or non-collaboration. Too many black women and babies suffer from devastatingly poor outcomes and can benefit from race-concordant execution of the Midwives Model of Care.

Institutional Validation of Midwifery Credentials in the Credential Society

In chapter two, I discussed the credentialism thesis espoused in the work of Max Weber (1948) and Randall Collins (1979). I sought to expand upon and complicate the thesis by offering three premises: (a) credentials are steeped in power relations but are also deeply raced and classed; (b) the process of acquiring credentials, i.e. experiences in in education programs, is a raced experience; and (c) credentials' power is predicated on deliberately marketing the *value* of skills and services. In April of 2014, the US MERA determined that, by 2020, all new applicants for midwifery licensure, i.e. taking the national certification exam, must have successfully completed an education process *accredited* by two of the national midwifery accreditation agencies. This is a grand and important shift because this is presently not the case.

This is also a grand and important shift toward the institutional validation that the credential society demands. Institutions validate professional knowledge, secure professional boundaries and, ultimately, aid in the professions' power to make jurisdictional claims. Weber(1949) and Collins(1979) teach us that this often stands in opposition to the possession or development of skill but credentials allow professions to "sit at the table" or, as Abbott (1979) would say, to make jurisdictional claims. Further, U.S. midwifery's move toward the

standardization of accreditation is quite relevant to my sample's discussion of the important of the *kind* of credentials for midwives of color. The advancement of midwifery, I believe, depends on continued demonstrations of the cost-effectiveness of the Midwives Model of Care *and* a demonstration of midwives as skilled and institutionally validated primary maternity care providers.

I suspect that discussions of a Bachelor's degree as the minimum qualification to sit for the CPM credential will occur in the near future and, I believe, is important to the advance of midwifery, and its jurisdictional claims-making, in this country.

Toward a National Midwifery Association

The second half of the first day of the US MERA meeting began with a presentation of the ICM global standards and competencies by Deborah Lewis, Vice President of Global Operations. Interestingly, throughout her presentation and even during the Question and Answer section when the U.S. leaders asked clarifying questions about their respective credentials, Lewis consistently remarked about the "unique case" of the U.S. in that there are so many types (and corresponding agendas) of midwives.

I wondered then, and now, about the benefits of developing a National Midwifery Association (or some variation on the name) that really consolidates efforts. In the school board world, the other area I know best, there is a National School Boards Association (NSBA) that represents all state school boards associations and their more than 90,000 local school board members. Can midwifery follow the same model? Can we, for example, take the pressing need to amend the Social Security Act to grant CPMs mandated provider status for Medicaid

reimbursement eligibility[45] *and* the need to expand the scope of practice-*true* recognition as independent, primary care providers as opposed to working under physicians-for CNMs, and situate those as priority national midwifery issues to which organizations can collectively fund lobbyists and other national policy efforts?

I know that NACPM, ACPM and MANA are working on these issues as individual organizations but are there not strength and power in numbers? This speaks to the interdependency of the ethic of care. Just as I found no significant differences by type of midwife, age and/or years of experience in my data, so, too, I find national midwifery organizations to be more similar than different. In many ways, I envision the current US MERA group serving in this capacity. The wheel doesn't need to be reinvented, only tinkered with.

Financial Support for Midwives of Color

Raising the minimum qualifications for entrance into midwifery, i.e. a Bachelors degree, begs the obvious question about financing such increasingly expensive educational endeavors. According to the National Center for Education Statistics, "for the 2011–12 academic year, annual current dollar prices for undergraduate tuition, room, and board were estimated to be $14,300 at public institutions, $37,800 at private nonprofit institutions, and $23,300 at private for-profit institutions. Between 2001–02 and 2011–12, prices for undergraduate tuition, room, and board at public institutions rose 40 percent, and prices at private nonprofit institutions rose 28 percent, after adjustment for inflation" (National Center for Education Statistics Fast Facts, http://nces.ed.gov/fastfacts/display.asp?id=76, n.d.).

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[45] Both Medicare and state Medicaid plans are mandated by federal law to include the services of CNMs and most state plans have done so since 1988.

The increase and diversification of midwives demands the development of systematic funding for midwives of color administered by educational institutions and professional organizations. Again, as I have argued throughout, money is the primary means of demonstrating value and providing support for what MANA's resigning midwives of color described as "canned responses."

Equally important are loan repayment programs, especially for long-term recruitment and retention efforts. Certified Nurse Midwives, for example, are eligible for the National Health Service Corps (NHSC) program, which offers financial and other support to primary care medical, dental, mental and behavioral health providers in exchange for a two-year service commitment to underserved communities. Corp members may receive $30,000-$50,000 toward loan repayment. Of the Certified Nurse Midwives represented in this study, 5 specifically mentioned grants like NHSC as reasons for pursuing nurse-midwifery as opposed to the Certified Professional Midwife credential. Brokering relationships with the National Health Service Corps program and other service-loan repayment programs, will likely increase and diversify the nation's corp of midwives.

Representative Leadership and Democracy

If diversifying midwifery is a stated organizational goal, as it has been for MANA, NACPM and ACNM alike, organizational leadership should reflect such a commitment. Greater efforts to institute women of color into organizational leadership *outside* of designated spaces (Midwives of Color Section (MANA) and the Midwives of Color Committee (ACNM))) and into professional organization Board of Directors or seats on accrediting boards will speak volumes to those stated goals.

Further, the relationship between those organizational "designated spaces" for midwives of color-, i.e. MANA's Midwives of Color Section and ACNM's Midwives of Color Committee-to the larger professional organizations themselves-MANA, ACNM etc.-is a huge area of concern. The 2012 MANA Midwives of Color Section resignation letter and even Carrington (1981) and Kennedy, Erickson-Owens and Davis (2006)'s critique of ACNM's diversity efforts are evidence of this. Much like my above discussion of credentials, there is a lack of clarity about the placement of such sections or committees within the organizational structure, specifically around voting privileges for the section or committee chair and financial support for the section of committee itself. These sections and committees have incredible opportunities for important programming to recruit and retain midwives of color. One programming opportunity that emerged in my data, for example, is the need for mentoring and tutoring programs. I am aware of ACNM's Midwives of Color Committee's efforts to formalize such a mentoring and tutoring program. This speaks to the need for greater networking among black midwives, and all midwives of color, reported in chapter two. Again, these efforts are not sustainable without organizational and financial support.

"Playing the Game": More Research Publications in Non-Midwifery Journals

Abbot (1979) argues that academic publications are one of the main ways in which professions are empowered to make jurisdictional claims and police professional boundaries. Much of the midwifery research reporting data supporting the health and economic benefits of the Midwives Model of Care is published in midwifery journals, primarily the *Journal of Midwifery and Women's Health* which, in many ways, is preaching to the choir. Greater dissemination of such research in Public Health and social science journals may allow for greater

power to make jurisdictional claims, particularly for CPMs still vying for legality and Medicaid reimbursement in all 50 states. Furthermore, and most salient in my research, greater attention to race concordant midwifery care among black midwives will be invaluable to the midwifery community to aid in understanding its benefits. Such data can also be used to make policy claims for financial support of midwifery, particularly on those issues most pressing for CPMs.

A Hopeful Look Forward

In this section, I review exciting doula training and midwifery education programs that are a hopeful look forward to diversifying birth work in this country.

International Center for Traditional Childbearing Doula Training Program

When I began this project, Shafia Monroe's International Center for Traditional Childbearing (ICTC) in Portland, Oregon, was incredibly inspirational to me largely because of its grassroots approach to mentoring and developing midwives, community leaders and doulas by and for all, though with special attention to communities of color.

I was particularly struck by ICTC's "No First Birthday" awareness campaign during September's national Infant Mortality Awareness Month. Monroe translates the horrific national infant mortality statistics into an experience-the loss of a child's year of life, love and celebration:

> You can observe 'No First Birthday' by placing and lighting candles on a large sheet cake for each baby who died before age one, in your state or community. In their memory, we will call out one name per candle as the candle is blown out. This is in recognition of all babies who had 'No First Birthday' due to infant mortality causes. In place of the happy birthday song, we will have a moment of silence and reflection. The cake is not to be eaten but will receive a burial instead.
> (International Center for Traditional Childbearing)

ICTC's Full Circle Doulas Training with regular offerings throughout the United States is creating a corp of doulas committed to ending infant mortality (and subsequently the experience of "No First Birthday") and providing support to laboring women. Doulas provide continuous physical, emotional and informational support to mothers before, during and after birth. I continue to admire the increasing amount of black women becoming doulas through ICTC's training program and others like it. ICTC has become a well-respected organization committed to empowering birth workers and women of color. I am aware of several collaborative efforts between ICTC and the national midwifery organizations. Yet, the collaborative possibilities appear to only have scratched the surface. Again, I am curious as to why ICTC is not a member organization of US MERA, *especially* because of its training of doulas and incredible network of birth workers of color. It is a tremendous opportunity to recruit midwives of color and positively impact midwifery education. ICTC should be incorporated into the National Midwifery Association I theorized above.

Midwifery Associates Degree programs

I am aware of three Associates degree programs specifying in midwifery: an 83 credit-hour Associate of Applied Sciences in Midwifery program at South Louisiana Community College, a 81 credit-hour Associate of Science in Midwifery program at the Midwives College of Utah, and a 68 credit-hour Associate in Direct Entry Midwifery program as Southwest Wisconsin Technical College. The Louisiana program aims to prepare students to meet the criteria for the North American Registry of Midwives (NARM) exam to satisfy the requirements for Certified Professional Midwife (CPM) and/or state licensure. The Wisconsin program aims to train professional midwives who will quality for certification and licensure in Wisconsin. The Utah

program is, of the three, the only MEAC accredited Associate degree program and requires students successfully pass the NARM exam.

These programs offer exciting possibilities for midwifery because President Obama, as part of his American Graduation Initiative education platform, set two national goals: by 2020, America will once again have the highest proportion of college graduates in the world, and community colleges will produce an additional 5 million graduates (*Building American Skills Through Community Colleges*). The Health Care and Education Reconciliation Act of 2010 includes $2 billion over four years for community college and career training (*Building American Skills Through Community Colleges*). The benefits of community colleges are many: tailored training programs, affordable tuition, flexible course schedules, convenient locations, open admissions policies and economic and human capital gains for the student (especially women) and their children (Attewell & Lavin, 2009). Christopher Mullin (2012) of the American Association of Community Colleges reports that community colleges have historically enrolled approximately half of all undergraduate students of color. In 1965, community colleges enrolled just 6% of undergraduate fall enrollment; by 2009, they enrolled 38%. Mullin reports, however, that this number may underestimate the actual enrollment:

> For institutions that enroll students year-round, however, more students access higher education than is commonly realized. At community colleges, for example, referencing unduplicated year-round enrollments increases the number of students accessing higher education by 56%. The magnitude of access is increased even further when noncredit students are included.
>
> (p. 4)

My excitement about this possibility is tempered against the raced and class nature of credentials I reported in chapter two. Understanding perceptions of midwifery Associate degree programs was not part of the research design of this study as I only learned of them later in the research process.

I did, however, later ask five of the midwives about these programs and I will share

Gwendolyn's (CNM, 20-25 years of experience) thoughts:

> I am excited about anything that will diversity our folks. I know lots of people go into community colleges. People talk bad about them but they provide a lot of access for us. I do think it is tricky…and I think a lot of my sister midwives will agree with me…it's tricky because trying to make it in this country, especially if you are black, requires more than an Associates. We *are* trying to advance midwifery BUT I say open the doors and we can work on validating the credential, you know, socially later.

I intend to investigate these programs in future research.

Master of Arts in Maternal-Child Health Systems program

One of the most amazing things about this research process has been the opportunity to

share my work with midwifery educators. During this journey, I had the pleasure of meeting

Suzy Myers who in 1978 founded the Seattle Midwifery School (SMS) to prepare Licensed

Midwives (LMs)[46] in Seattle, Washington. In 2009, SMS merged with Bastyr University-

offering unique programs in natural medicine, in Kenmore, Washington. Bastyr's direct-entry

midwifery education clinical training program is the first and only program in North America to

provide a Master of Science degree in Clinical Midwifery from a regionally accredited

university.

In June of 2013, envisioning a program for experienced midwives and other maternity and

infant care professionals, Suzy invited me and a team of a dozen midwives, midwifery educators

and researchers for a workgroup meeting of a new, interdisciplinary 45-47 credit-hour (45

required, additional 2 are optional) Master of Arts degree program in Maternal-Child Health

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[46] Washington state law requires licensed midwives to complete 3 years in a state-approved midwifery educational program, which includes participation in 100 or more births and verification of clinical skills and didactic course work. To attain licensure, all LMs must pass an examination provided to the state by the North American Registry of Midwives (NARM).

Systems. The program is not designed to be a clinical training program[47], but instead is intended to prepare, grounded in the Midwives Model of Care, leaders in midwifery education, research, policymaking and advocacy. That is, graduates of the program will expand their expertise in maternal-child health beyond personal service delivery to a *systems*-based perspective by investigating best health care system designs (including collaborative care models mentioned in chapter one), developing skills in data analysis and evaluation, research design and the policy-making process. This program is currently under review for regional accreditation by the Northwest Commission on Colleges and Universities.

Doctorate in Midwifery program

The State University of New York Downstate campus is developing, under the direction of Ronnie Lichtman and in collaboration with midwifery educators and researchers around the globe, a 30 credit-hour Doctorate in Midwifery. This program, also grounded in the Midwives Model of Care, is designed to prepare candidates for academic, administrative, clinical, professional and/or research positions in institutions or organizations. Students will learn and develop skills in midwifery theory and praxis; midwifery research design, scholarship and publication; best practices in midwifery education, design and implementation, including clinical skills; best practices in clinical skills practice; independent midwifery practice organizational design; midwifery practice ethics; sociological theory of health, health care; and policy evaluation. There is incredible value in training and developing expertise in midwifery of this kind. Graduates will create and support midwifery scholarship; design and support midwifery

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[47] A minimum of 2 full-time years of practical experience as a midwife, doula, childbirth educator, or lactation specialist is required.

education programs; lead professional organizations and positively impact midwifery policy in this country. The program is currently under university review.

Limitations & Future Research

A Statement of Study Limitations

I observe three limitations of this study. First, the majority of the interviews were conducted throughout 2010 and 2011, prior to the resignation of six members of MANA's Midwives of Color section. Since then, MANA, NACPM, ACNM and many midwifery education programs have developed and/or intensified anti-racism and diversity initiatives. A systematic investigation into black midwives' perceptions of more recent initiatives are not captured herein.

Second, with a sample size of 22 U.S black midwives, the results may not be generalizable. Therefore, these qualitative data could be enhanced by quantitative data. Such data will ideally capture a larger sample of generalizable data on black midwives' (and black student midwives) practice in addition to experiences in and perceptions of midwifery education programs and pathways and professional organizations. The exact number of practicing black midwives in the U.S., however, remains unknown because of non-affiliation with professional organizations who maintain demographic data. Non-affiliation may be the result of similar feelings of dissatisfaction, disengagement or mistrust midwives reported in chapter two, feelings of risk or danger if practicing illegally or some midwives' desire to not report their race or identity as black. Nonetheless, the available data will likely offer important findings.

Third, the perspective of midwifery educators would potentially add interesting insight into the education data reported in chapter two. That is, further information on recruitment and

retention efforts, the implementation of culturally responsive pedagogy, perceptions of school climate, amongst other topics, may help to improve the overall experience of midwives of color. It should be noted that I have already begun this work in a rather informal manner but, thus far, I am confident these data will be an important contribution to the design and implementation of midwifery education programs and pathways in the future.

Future Research

I envision four key areas for future research. First, building upon the second identified limitation of this study, I would like to conduct descriptive and inferential statistical analyses using the available organizational data on black midwives. For a comparative analysis, it would be interesting to compare such data to that available on black female physicians. Though U.S. black admission into medical school has slowly increased since the passage of the Civil Rights Act in 1965, this cohort represents only slightly more than 8% of first year medical students (Hinton et al., 2007, p. 117). Further, Hinton et al. (2007) report that "blacks still receive advanced training in the health sciences at rates far below their population share of about 15.4 percent" (p. 117). Ultimately, this limits the availability of black physicians for black patients.

Second, building upon the third identified limitation of this study, I would like to more systematically interview midwifery program educators and administrators preparing CNMs and direct-entry midwives. I am particularly interested in a longitudinal analysis of black student recruitment, retention and post-degree placement of black students in the midwifery Associate, Master and Doctorate degree programs I mentioned above.

Third, I would like to see more research on existing programs and social supports for black women that positively impact black birth outcomes. There is incredible value in fostering

networks of trust, support, community and solidarity (Bourdieu, 1986; Putnam, Leonardi & Nanetti, 1993). I am inspired by the 100 Acts program in Los Angeles; the International Center for Traditional Childbearing's (ICTC) full-circle doula training program with regular offerings throughout the United States; ICTC's Birth Works for Black Women: Afrocentric Pregnancy Fair; the Commonsense Childbirth School of Midwifery, founded by black midwife Jennie Joseph, offering programming in midwifery, perinatal education, childbirth education, lactation education, and doula training and the other formal and informal programs I became aware of in my research. I am wondering, too, about the work of churches, civic organizations, schools, workplace programs or community health organizations that provide support to and for black women and families. Is there a differential impact when the caregiver or supporter is race-concordant with black women? I strongly believe the work is being done. It is just a matter of finding out about 'the what and the how'. In future research, I aspire to produce scholarship in this area.

Fourth, more research and support should be generated toward the production of positive images of black women, mothers and midwives to combat epistemological violence-solidified in controlling images. Relatedly, I seek to more systematically investigate black women's wearing of natural hairstyle as resistance to white-dominated midwifery.

Listen to Your Midwives

Nationally, we are living in incredible and opportune times. A shift in cultural understandings of and desires for birth and birthing options are burgeoning in the mass media. Alongside the passage of the Affordable Care Act is also the impending obstetrics and gynecology shortage and the possibilities of collaborative care. Midwifery is making great

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strides toward becoming stronger stakeholders in international and national health care policy. Internally, midwives are reflecting and acting upon the cancer of racism, the contemporary midwife problem. Just as larger society should demonstrate the ethic of womanist caring justice I have theorized within, the hope and promise of midwifery's future, too, depends on a substantive demonstration, in words, action *and* policy, of a commitment to recruiting and retaining black midwives and increasing awareness of and access to the Midwives Model of Care for black women and all women.

Just at ICTC's "No First Birthday" campaign has brought increased awareness to the experiential loss of infant mortality, the very same level of care and intention must be paid to the loss of midwives of color. One loss of a midwife of color, too, is an experience, whether from an education program for not feeling an ethos of trust, respect and caring in the program's climate or from a professional organization for institutional racism. It is one less midwife of color's experiences and perceptions to inform, better and advance midwifery's power. It is potentially one less mother, child and family experiencing and benefiting from the Midwives Model of Care. It is potentially one less black woman experiencing not only the survival of her child-first birthdays and beyond-but an amazing sense of empowerment maximized in midwifery-attended birth. In this world of birth, such a loss must be understood as a crippling death, as another equally horrific statistic warranting attention and change-within people *and* institutions.

To my knowledge, this is the first study to systematically investigate the experiences and perceptions of contemporary black midwives. Though the black midwifery community is small, there are more than the 22 represented herein. They are in doula training programs questioning an entrance into midwifery, they are students in midwifery education programs and professional organizations, they are black midwives practicing for one year and for 40 years. They are there.

To the larger midwifery community, listen to your midwives of color. The future of midwifery and positively impacting birth and birthing options for *all* women in this country depends on it.

Appendices

To the MANA Community,

On Monday morning, May 21, MANA's Midwives of Color (MOC) Section Chair Darynée Blount publicly and unexpectedly presented a letter of formal resignation to the MANA Board of Directors. Her signature was accompanied by those of five midwives and students who have comprised her Inner Council leadership team.

This has been a tumultuous week of emotional and intellectual discourse, with elements of both despair and hope. The MANA Board of Directors would like to provide a summary of some of the issues and concerns that were named this week and some solutions that are in the works.

The resignation letter identified multiple areas of distress, including the difficulty MOC section chairs have had with the position, pointing to the fact that the last three section chairs have resigned prior to the completion of their terms. It is their belief that these situations, and other concerns expressed in the letter, are the direct result of institutional racism in MANA's ethos, priorities, structure, and decision-making processes.

In essence, it was stated by the signatories that repeated exposure to discrimination and racist attitudes-whether intentional or out of ignorance-is oppressive and not good for them mentally, physically, emotionally, and psychologically. It distracts them from their true mission of addressing maternal and infant health care, increasing the number of midwives of color, and better serving their communities. We've posted their letter here.

The MANA Board is trying to fully understand these concerns and challenges; we have been deeply reflecting on the letter and our losses; and we are taking the statements made by the six MOC members very seriously. We hear the deep pain, frustration, and anger being expressed, even as we struggle to understand the reasons and ways in which such emotions have come to be. These women are our sister midwives and our friends; to know that we may be the cause of such hurt is difficult and heartbreaking.

We have purposefully posted the letter so our entire community can both understand the scope of our troubles and help us identify ways to build a better future. We have created a space here on MANA's Facebook page for the MOC and other members of the midwifery community to air grievances and have meaningful and public conversations. We have also posted statements on our website here. We welcome your comments, emails, calls, and posts.

The listening process has challenged us all. Just as our community is made of many voices, we are hearing many perspectives. Some are feeling hurt and angry that we have not done enough work to combat institutional racism in our community. Others are feeling hurt and upset because they feel under attack. And yet others feel that the events of this week are distracting from the mission of MANA.

At the week's end, we feel it is appropriate to respond to the questions that have been asked by our community and share the next steps that are emerging as the result of this conversation.

To the midwives in our community who feel the letter has inaccuracies that should be corrected, know that we hear you. While we might dispute some of the letter's facts, to do so publicly

would not serve to bring our community together.

To those who suggest that by detailing what work we have done around social justice, we are making excuses, know we are keenly aware of the thin line between explanation and excuses. By saying we have done some work, we are not proclaiming we have done enough work. We are hearing from community members who want to know what's been done, and it feels appropriate toanswer their questions.

To those who feel that this issue is a distraction from our larger goals, we want to say this: Every member of our community is valued and is important, and we cannot move on if we leave some behind. We can and must pause here to repack our bags and make sure everyone is ready to move on as best we are able. Some of what has been said has elements of truth; we are determined to learn so that we may move forward together.

The issue of race and privilege is complex and doubly confounding for midwifery. We wrestle with race and privilege as we discuss the accessibility of our work and profession, and we live with the issue of racial disparities in maternal and infant outcomes. The two are clearly related.

All midwives in this country struggle, regardless of race. Yet the MANA Board recognizes that the struggles for white women and women of color are not the same. Women of color face additional challenges that white women do not face, in ways that many of us cannot begin to fathom.

We also recognize that our work, our model of care, can literally make a difference between life and death. In a country where black women are nearly four times as likely as white women to die from pregnancy-related causes, where the infant mortality for black infants in our nation's capital is 17.2 deaths per 1,000 live births, we hold among us the key to saving these women and children.

On both fronts, there is no time to spare.

Within the midwifery community and among the national midwifery organizations, MANA has been out front on issues of social justice. Prioritizing social justice is one of our four organizational strategic goals. In the next week, we'll be providing an "inventory" of what we've accomplished and what we have in the works. We have posted a brief update on what we have already done as an organization including new plans we are currently putting into place. We don't expect that it will make this crisis go away. Instead, we offer a public accounting and ask for your comments and feedback.

It is hard work, and we don't always get it right. MANA is a volunteer organization with two part- time employees and a tight budget. We have devoted much time and energy to social justice, disparities in healthcare, seeking funding, partners, opportunities, and alliances. And still, despite good intentions, we see that we have indeed failed to meet some expectations. Our failures and shortcomings are unintentional, but nonetheless ours.

At a personal level, I challenge every member of our community to investigate what she can do

to learn more about how racism impacts our sisters in the MANA community and the women with whom we work. Even those of us who have done extensive personal work on racism have room to grow and do more. Participate in the trainings that MANA offers and find resources and training at your local level.

At the organizational level, I ask for your help. MANA is made of her members, but in reality, she is far more. She is a leader, mentor, companion, and home for many midwives. While we struggle to understand and effectively address racism and social justice, we need your voice and presence. We need to stand together.

As our sister midwives who have left our circle gather their thoughts and intentions, and begin to build what better holds their most impassioned beliefs, we offer our best wishes and continued support.

In peace,

Geradine Simkins, President

Jill Press, 1st Vice President

Christy Tashjian, 2nd Vice President

Sarita Bennett, Secretary

Connie Canada, Treasurer

Adrian Feldhusen, New England Region Representative

Linda McHale, North Atlantic Region Representative

Tamara Taitt, Southeast Region Representative

Jana Studelska, Midwest Region Representative

Marinah V. Farrell, West Region Representative

Colleen Donovan-Batson, Pacific Region Representative

Aza Nedhari, Student Section Chair

Dear MANA Board Member,

Over the last 6 months there have been several troubling interactions and we, the members of the MOC Inner Council would like to take this opportunity to discuss our perspective on our relationship with MANA and the action we are taking.

Currently the MOC Inner Council consists of: Jennie Joseph, Ayesha Ibrahim, Jessica Roach, and Claudia Booker - Michele Peixinho had agreed to return to the Inner Council upon her return from the Philippines. Our goal in creating the Inner Council included being available to assist Darynée, to make decisions for the MOC based on a consensus model, to provide support and advice to her, and to serve as Chair in her stead.

In the last three years the position of MOC Chair has been held by three different Midwives of Color – Sheila Simms Watson, Michele Peixinho, and Jennie Joseph – it is now held by Darynée Blount. A question to be asked - if the MOC Chair is a 3-year term, how come all of the recent Chairs resigned after roughly one year into the term? What about MANA and its leadership, the MOC membership (or lack of membership involvement) and their relationship, that such firmly committed, hardworking, bright women relinquish this position?

The answer lies in examining MANA, both the organization and the individuals in leadership positions, interaction with the MOC. It is clear to us that MANA's ethos of their unearned entitlement that continues to dis-value and ignore us as a group and as individuals. At best we are an afterthought.

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

With MANA's frequently changing leadership there is a constant need to educate, sensitize, and re-educate a new cadre of young and older women who "do not get it". Since MANA lacks an organizational vision and mission statement (with an accompanying detailed and concrete action plan to accomplish these) that clearly defines MANA's position on such issues as social justice, privilege and entitlement, racial disparities, increasing the number of midwives and MOCs, we must address and re-address these issues each year, over and over again.

The Inner Council spent one month this year re-visiting (and soliciting MOC input on whether and how to move forward with the POU) the 2009 Points of Unity, which were written by some of you during an emotionally turbulent conference in Asolimar. With the warrior- like commitment of then MOC Chair Michele, MANA provided 24 scholarships and had the highest attendance of midwives and students of color in its history. But the atmosphere of the conference was so stressful the MOC felt driven to write its Manifesto, a Document of Affirmations. This internal document chronicling this time in MOC history and belongs to the MOC and that group has the unilateral right to decide what to do with that document. The 2009 POU does not belong to MANA or to the Social Justice section of MANA, nor is it available to be used as a campaign

platform for future MANA leadership.

The following year, 2010, MANA provided significantly fewer scholarships to its conference in Nashville. MANA's commitment of increasing students and midwives of color participation at in its conferences was short lived. MANA requested Michele personally raise funds for MOC scholarships if we wanted more MOC attendees. Michele subsequently resigned and Jennie took the Chair. It appears that MANA has a budget of $6,000 for all scholarships, with the 2009 funding being an exception.

For the 2011 Conference in Canada, after much negotiation and hand wringing, MANA agreed to Jennie's request for 12 scholarships; many of these went to students of color, and a suite for us to sleep and meet in. What an oasis for us! We spent sleepless hours sharing, healing ourselves, and developing a plan for utilizing the suite at the 2012 conference as a center for workshops, skills practice, classes, vision board making, movie showing.

In recapping this history my mind keeps shouting, "If MANA is committed to increasing the numbers of midwives and students of color, why is there a need to fight for scholarships to the MANA Conferences year after year? Either MANA is committed or it is nor? What's up with that"? The real issue is simply MANA's commitment - nothing else.

For one year Jennie fought wholeheartedly to keep the issues of racial disparities in healthcare and midwifery and maternal and infant care on the front burner of MANA; to keep us at the center of MANA's decision making; to get the organization to put its time, resources, influence, and money into developing (with the communities of color and the health care providers that serve them); concrete, sustainable strategies for saving mothers in babies. All issues MANA professes to support but has no concrete strategies to achieve. Jennie spent a substantial portion of her time away from her practice, family, clinic, and school (plus her own money) representing MANA and the programs it professes to support across the U.S., while getting little tangible support from MANA.

Keep in mind that in the United States, "Births to Black mothers made up 16% of U.S. births, but 30.4% of US infant deaths in 2008" (The U.S. Infant Mortality Rate: International Comparisons, Underlying Factors, and Federal Programs - Elayne J. Heisler Analyst in Health Services April 4, 2012)

In September 2011 Jennie resigned as the MOC Chair and Darynée Blount agreed to accept the Chair position, with the creation of an Inner Council. Darynée is young, energetic, optimistic, and eager to make the MOC a success and willing to give MANA and its leadership a fresh start. She believes MANA has the potential to become a productive organization, responsive to its members, and concretely working on improving maternal and infant care. Besides being a full-time midwife and a mom, she has a midwifery training program she is dedicated to. She was instrumental in making the recent CAM Conferences a success.

One of the first things she negotiated was the Inner Council's active participation in reviewing proposed abstracts and the agenda for the 2012 MANA Conference. However, our participation was made meaningless. The third week in March we received a 64 page document which was a

disorganized compilation of the various proposed abstracts MANA had received. Several of us spent more the 4 days reviewing the proposed abstracts in detail, writing general comments on them, especially their failure to address the required cultural competency criteria set out by MANA in the abstract application. Next, we compiled a list of about 20 suggested topics for Conference workshops that addressed the multi-cultural world of midwifery in the Americas and health issue of those communities. We submitted our comments to MANA in less than 1 week and were informed that our comments were too late. We have not been involved in the final selection of the abstracts or the agenda for the upcoming Conference.

In response to MANA's request that the MOC submit abstracts for the upcoming Conference, three of us decided to submit an abstract for our "Saving Our Babies, Mothers and Families Then and Now Midwives Save Lives: An Introduction to the Grand Midwives of America A Pictorial History of African-American Midwifery in the United States 1600's – Present" presentation we recently presented at the VIDM. This seems every pertinent after viewing the historically incorrect and scanty time line of midwifery in the U.S posted at the Home Birth Summit and the CPM Symposium. Our abstract was summarily rejected with a comment, "Perhaps next conference". We are withdrawing the presentation from present or future consideration for a MANA Conference. What a missed opportunity to correct history.

A few days before the beginning of February MANA requested the MOC prepare a series of weekly Constant Contact blasts for Black History Month (which is February); we had a few days' notice to plan and prepare. MANA contributed practically nothing to this effort, except a statement from Gera Simkins with an excerpt from her book. Their explanation for not participating was that they felt inadequate to contribute to this effort. Did MANA not know Black History Week was coming and, perhaps, could have spent some time planning some sort of recognition in a timely manner? Another MANA afterthought?

On last Tuesday MANA informed us that the third in the "I Am a Midwife" video series will be launched this Saturday. The topic of this video is health disparities. We were requested to write a blog of between 500 - 1,000 words on the mothering .com blog on the issue of health disparities, with internet links on research and resources and great photos, and to post the blog by Monday. We were not involved in the scripting or development of the video (though it features several midwives of color) nor have we viewed the video. Is this a topic MANA is not familiar with? While the video was being developed, could MANA or its staff have done its research on the topic? No, once again, last minute calls to the MOC to provide substance and validation of this project, without any input in the development or planning. Once again, an act of arrogant entitlement, with the MOC participation as an afterthought.

Meanwhile, the MANA leadership and the leadership of the other Allied Midwifery Organizations (excluding ICTC who was not invited) are in Washington attending a Childbirth Connection event on maternal and infant health. Did MANA or any of the other professed ICTC allies seek an invitation for ICTC?

In the last few weeks the issue of student and midwives of color scholarships to the 2012 Conference has again arisen. In March Darynee submitted a proposal that MANA open its doors to all students and MOCs who want to attend. In the last week the discussion of MOC raising its

own funds to provide for MOC scholarships was again raised. Here we go again – is participation by students and midwives of color important to MANA, yes or no? If so, support your commitment with a sizable financial contribution that could make an impact!
Having suffered through the CPM Symposium, we Sisters have spent too many days trying to help MANA, its leadership and the leadership of the other AMOs "get it". And they still do not.

We have committed ourselves to our local and global communities we serve first and foremost, doing the best we can with dignity and character knowing that our communities and our children are watching.

We can no longer continue to participate in MANA's disrespect of us as a group, a race, as the Women our community respects. We cannot keep our heads held high and take this shit. Our view of ourselves will suffer and eventually the young ones will look at us with less than admiration. We are not "The Help - 2012 Version". This treatment is not good for us, mentally, physically, emotionally and psychologically – this is the stress that's kills us in so many ways, drains our energy and distracts our focus.

These issues and these organizations distract us from our true mission; we have become myopic, focusing on these groups and not exploring global approaches to maternal and infant health care, increasing the number of MOCs, and better serving our communities.

Therefore, I Darynée Blount, am resigning from the position of MOC Chair, the MOC and MANA and we Jennie Joseph, Jessica Roach, Ayesha Ibrahim, Claudia Booker and Michelle Peixinho are hereby formally resigning from the Inner Council, the MOC and MANA.

Darynée Blount, Jennie Joseph, Jessica Roach, Ayesha Ibrahim, Claudia Booker and Michelle Peixinho

Pseudonym	Type of Midwife	Years of Experience	Age
Alice	CPM	05-10	40-45
Angela	CNM	35-40	60-65
Anna	CNM	40-45	75-80
Audre	CPM	10-15	N.R.
bell	CNM	5-10	N.R.
Dorothy	CNM	05-10	35-40
Gwendolyn	CNM	20-25	55-60
Ida	CNM	35-40	65-70
June	CNM	35-40	60-65
Kimberlee	CNM	20-25	50-55
Lorraine	CPM	20-25	50-55
Marie	CNM	20-25	35-40
Mary	CNM	40-45	65-70
Maya	CNM	40-45	60-65
Nikki	CPM	20-25	40-45
Octavia	CPM	15-20	50-55
Patricia	CPM	20-25	55-60
Phyllis	CPM	15-20	65-70
Toni	CPM	20-25	50-55
Zora	CPM	10-15	40-44
Hattie	CPM	35-40	60-65
Martha	CNM	35-40	60-65

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