UVA School of Nursing | GMT20220215-210143_Recording_1760x832

DOMINIQUE TOBBELL: University of Virginia School of Nursing. Thank you for joining us today for today's special roundtable event on the History of Black Midwives. Before we begin, I want to acknowledge the traditional custodians of the land we are on today, the Monacan Indian Nation, and pay our respect to their elders past, present, and emerging. I invite you to join me and reflecting for a moment on our presence in this space, paying respect to the Monacan nation, and contemplating the ongoing struggle for Indigenous rights in our community.

So today's event, which is held in recognition of Black History Month highlights and celebrates the essential role that Black midwives and birth workers have played throughout American history. This is a history that has profound significance in the 21st century. In the US today, Black women and birthing people die from pregnancy related causes at a rate that is at least 3 to 4 times higher than that of white women.

The mortality rate for Black infants is also starkly worse, more than twice that of white children. And such racial disparities have a long history rooted in systemic racism and white supremacy that underpins it. Black midwives, however, have always provided vital care for Black women and birthing people in the US. And it's important that the historical and ongoing work to help establish equitable systems of care is recognized and uplifted.

The Beuran Center is delighted to host this distinguished panel of scholars who work whose work does just that. So the format for this event is as follows. In a few moments, I will introduce each of our presenters who will each have about 20 minutes to share their formal remarks. After all three speakers have presented, we will then open things up for a Q&A and general discussion with you the rest of the audience.

And so now just briefly quick what about logistics. We've all been doing Zoom for a while now, but just as a reminder, please keep yourselves muted until we get to the Q&A portion of the event. And at that time, if you would like to ask a question or make a comment, you can do so either by using the Raise Hand function in Zoom, unmuting yourself and asking your question, or putting your question in the chat at any time and then I will share those questions that appear in the chat.

I'll also touch this note that a recording of this event will be available and posted on our website later this week in case you miss any of this or you want to share this great event with other people. So it's now my privilege to introduce our distinguished panel. Our first speaker will be Doctor Michelle Drew.

Dr. Drew is a practicing nurse midwife, archivist, political activist. She is the executive director of Ubuntu Black Family Wellness Collective and chair of the American College of Midwives Caucus of Black Midwives for Reproductive Justice and Birth Equity. She is a descendant of African-American women healers that dates back more than 250 years to her 7th great grandmother, Sarah, a midwife who was a free Black woman in Surrey County, Virginia.

As a practicing midwife for more than 20 years of clinical experience caring for communities made vulnerable by structural racism, Dr. Drew has attended the birth of 2,700 babies and counting, providing full scope reproductive health services, she walks with people capable of pregnancy through their full health course affirming all their choices of when, where, how, or even if they choose to bear children.

As a student of history and archivist, Dr. Drew uses primary source materials, historical records, and digital databases to document the lives of African-American midwives in the US and the importance of midwifery in Black communities. She has written and lectured on the impact of the public health policy and the regulation and elimination of Black midwives.

Has played on modern maternal health disparities that see Black women and pregnant people anywhere 2 to 14 times more likely to die in childbirth in the United States than their white counterparts. And how structural institutional and interpersonal racism, whether conscious or unconscious contributes to the current lack of diversity in the nursing and midwifery workforce.

Our second speaker will be Dr. Wangui Muigai. Dr. Muigai is assistant professor at Brandeis University in the Department of History, the Department of African-American Studies, and the program in health, science, society, and policy where she teaches courses on the history of medicine and public health. She received her PhD from Princeton University and her AB from Harvard University.

Dr. Muigai's research has been supported by several fellowships, including from the American College of Obstetricians and Gynecologists, and the Barbara based center for the Study of the history of Nursing at the University of Pennsylvania. And she is currently writing a book that traces the history of Black Infant mortality in the United States from the era of slavery to the present day.

Our third speaker will be Dr. Gertrude Fraser. Dr. Fraser is daughter of Gladys Minette who migrated to the US from Jamaica in the late 1960s, and initially worked as a live in domestic and then retired from the New York Civil service. And she is also the granddaughter of Marie Wheatley Barnes, a staunch [INAUDIBLE], politically active, and Cuban anti-Batista and Jamaican independence movements.

Dr. Fraser is UVA faculty member in the Department of Anthropology, and she conducts research in the areas of African-American culture, race, gender, and science, comparative body politics, birth and ethno-history , and health care disparities. Among her published work is *African-American Midwifery in the South-- Dialogues of Birth, Race, and Memory.* She has also served as a consultant in developing culturally competent research methodologies and accrual strategies for breast cancer, mental health, diabetes, genetic, and health policy research.

Dr. Fraser has also held a senior administrative role at UVA as vice provost for faculty affairs, and her career has combined scholarship with action on behalf of strengthening opportunities for women, African-Americans, and other minorities in science, health care, and in higher education. It is such a privilege to have Dr. Drew, Dr. Muigai, and Dr. Fraser join us today. Now, without further ado, I will hand things over to Dr. Drew.

MICHELLE DREW:

Good afternoon. I'm so happy to just be in this space with you, especially in this time that we dedicate to African-American history and say what an honor it is to just share space with all of you, especially people that I've admired from a distance for a very long time like Dr. Fraser and Dr. Muigai who, if I can just take a moment, I lived in Central Africa for many years, and one of the greetings we use to say hello is, [NON-ENGLISH SPEECH], which literally means I kneel at your feet. And so this is my official kneeling at your feet.

I'm just thankful for all of you being here. I have lots of words, but the words that I'm proudest of is saying that I'm the daughter of Mabel and the niece of Francis, the granddaughter of Viola, the great granddaughter of Mabel who was the daughter of Sarah, who was the daughter of Jeanette. And to go back and to know that for as long as my family, as far as we know, have been on this continent, we have been part of the healing tradition of the African-American community.

I am proud to be a descendant of midwives and African midwives. And so I'm a talker. So I don't claim to be a griot, but in that tradition, I'm just here to talk with you a little about and frame the importance of African-American midwives, not only in our community because they certainly were important in our community. And I believe that the loss of a midwife in the community plays a pivotal role in some of the cultural harms that still exist today.

But also we have to acknowledge that since our economy was based on the slave trade and a slave economy, midwives were pivotal to how this country developed, because this country was literally built on stolen land with the blood, sweat, and tears of African slaves that were imported here.

And I also want to acknowledge that all of you are here who aren't of African ancestry or here because you're genuinely interested in this history, and so I want to acknowledge that sometimes hearing about those harms when you are the descendants of slave owners and not the descendants of slaves also may make you feel uncomfortable, but this is a place where you're safe. So we may not be comfortable, but we are safe to hear these stories.

And so when we think about midwifery, and especially when we think about African-American history and midwifery that story, when they're told in traditional textbooks usually speak of midwives being uneducated, perhaps superstitious, all sorts of derogatory words that I want us to all just go ahead and give ourselves permission to erase that from our memory.

And let's first, even go back a step, because the midwifery that was taught and the midwifery that was practiced by my great grandmother and great aunt goes really even further back. It goes back to Africa. And so knowing that so many of the stereotypes of Africans and the African slave trade were rooted in stereotypes of us that were not true and were harmful, but necessary to make it OK for one human to own another, let's reframe that.

So I'd like to start with the fact that I want everyone to realize that the oldest schools of medical education and health education that ever existed were on the African continent, that the oldest languages, the oldest written languages on Earth were 5,000 years ago on the African continent.

And so it stands to reason that our ancestors that arrived here in 1619 didn't come ignorant, they had a language, they had both written and understood, they had an educational system, they were brilliant they were some of the best that the continent had to offer. That's why we were desired here, and that they weren't untrained.

And specifically, when we speak to midwives, we can actually see an historical data that midwifery was a very strong and valued profession historically on the African continent. In the Tomb of the pharaoh or queen [INAUDIBLE], which dates back to the 12th century BCE, you'll see a hieroglyphs if you ever go look at it and it shows the story of one of her children being born.

And so here we see a picture of a queen and there she is with slaves standing behind her, supporting her presumably, and I think of them as the doula. There is another woman kneeling at her feet receiving her baby, and so there is a midwife. And so imagine that if midwives weren't important, why would they be permanently memorialized in the tomb of a pharaoh?

And in the reign of Ptolemy I in 300 BC in Egypt, by then we actually know that there were formal training for midwives in Africa because there is documentation of the physicians that served the queen, his wife, where a physician who also happen to be females job was to train the nurses and midwives who would care for her during her pregnancy and birth, because even then, the male physician of the pharaoh wouldn't be caring for the health and fertility necessarily of a queen.

So we know that when our ancestors came here to the United States in the 17th century, they did so with millennia of history of experience as health care professionals, not only just as baby catchers, but as herbalists, as surgeons, as healers the first cesarean that we know that was documented as being successful, where did it happen on the African continent and done by midwives?

And so long before we came here we had gifts. When we came to the United States, we were barred from speaking our languages, we were barred from writing our languages. And so the midwives that first arrived to the shores in Virginia where you are now, which is also the state of my birth and my ancestry, they had to switch, they had to learn a new language which they were legally barred from being educated in and becoming literate in.

And so that knowledge and tradition became an oral tradition, and then something that was taught by watching and observation and through apprenticeship. And so the apprenticeship model of midwifery which we still see happening on the continent Africa and which to a certain extent has been adopted in the midwifery tradition of the certified professional midwife, truly has its roots in Africa.

You'll hear the stories that midwives were simply the old slaves that had run out of usefulness, and so they were put to use caring for the sick. And from an economic standpoint, I'd like some of it, like us to even think and challenge that a little bit and love to hear from the expertise that by 1808, when the African slave trade was banned in North America, some of the most important slaves that there were as skilled people were midwives because we have the responsibility to make sure that our fellow slaves were more productive and reproduced greatly.

And because of that, some slaves were valued highly because of their midwifery skills, that may determine your price if you're enslaver was going to barter, buy, sell, or trade you, or if you were being sold in an estate, a midwife might have a higher value price on her even if she was older than another female slave, just as female slaves who had proven their fertility had a higher value than those that did not. So fertility was an actual commodity.

When we think about midwifery restrictions, we think about those as they come later on in the 20th century. But some of the first restrictions around midwifery practice were in the 19th century, were actually around abortion, which is really important, because where we are in our history right now, now more than ever, there is a huge battle, and we will soon sometimes see in this country, probably within the next year, a time when our ability to self-determine the continuation of a pregnancy will be taken away from us at a federal level. And so it will come back to the States.

Many scholars, legal scholars, and political activists do believe that when the *Mississippi case* is reviewed in the summer, that rule will be overturned. So it's important to put that in history and think that at a time when the fertility of the African population on this continent became very important, we suddenly start putting in restrictions and penalties for midwives performing abortions.

Physicians and who worked plantation medicine may be called in if the slaves on a particular plantation weren't fertile enough to check to make sure that the midwife wasn't providing herbs to perform abortions. And so those were some of the first true supervision of midwives. Up until then, our job was respected and pretty much left alone to ourselves, and you would never have heard of a white physician wanting to intervene in the fertility of slaves except to fix them.

We all know the horrible stories of J. Marion Sims whose name barely deserves to be spoken. But I'll speak his name and then also speak the names of Betsy, Anarcha, and Lucy who are the mothers of gynecology, who not only served as his experimental material and his victims, but were also skilled nurses and midwives, and surgical assistants themselves.

And so throughout that time from 1619 and 1808, midwives were trusted to, not only manage births but also to manage health, disease, surgery. They were the health care providers of the slave community. But more than that, we know that by the 19th century and all of the slave-holding states, midwives attended the birth of most white women as well.

And so they served their slave masters, and in many cases, those skilled midwives skills would be a financial commodity that they may use themselves. There's documentation of, for example, George Washington's slave, again, here in Virginia. His primary midwife was the wife of the overseer at Mount Vernon.

And she was allowed on her-- besides the fact that she would attend births at Mount Vernon and at the request of his neighbors, may attend births on other plantations nearby. She was also permitted on her days off to attend birth or to attend to the health care of people within the community, and that was a way that she made money.

And Savannah, Georgia is an interesting city and Atlanta also had it similar in that it was an urban city and there were many physicians who lived there. And one of the slaves that they owned often, even in a city where they primarily only needed health servants, for example, were midwives and nurses who, the physician themselves would never have attended first, because that was far beneath them.

And so another way to commodify and to use African women as a economic earning tool was to train women slaves to be nurses and midwives, and then to have them attend births. But it also was a mobility that, one of the most important things that I remember most especially about my great grandmother as a child was knowing the respect and honor that she had absolutely throughout the community, because she literally touched every family.

As midwives, we were healers. We were comforters. We were arbiters of disputes. We were the wise elders of the community. One of the favorite expressions that I ever heard during the time I was living in Africa was when I met a Somali woman and they have an expression that says, the oldest man in the village and the midwife will never tell all they know, not because they're hoarding secrets, but just because they had so much knowledge that they could go on forever and never ever run out of knowledge to share.

With emancipation, midwives became even more important within the community as a African-Americans were trying to establish things for ourselves and our own communities, whereas we were developing churches, and banks, and getting married, and starting businesses, and forming infrastructure, and early education coming where there began to be opportunities for education, for nursing and medicine, but most of those were few and far between.

But midwives were crucial to the health and welfare of Black communities in the South, because certainly even as medicine began to grow in the United States with formal medical education, few, if any white physicians, would ever care for African-American families. And so a midwife who was skilled and knowledgeable was crucial.

And did great work until 1921 comes the Sheppard Towner Act, which is the beginning of the formal public health infrastructure in the United States, and then to follow in 1925 became the drive to regulate and then eventually eliminate African-American midwives.

And at this time also, we have Joseph Daly, an OB/GYN who gives a speech and publishes in the "Journal of Obstetricians and Gynecologists" what they today call "The Great Journal." where he says that the midwife is an obsolete burden. But what he really meant was obstetricians were poorly trained.

And in fact, in the United States in the early 20th century, women who were under the care of physicians during the time of their pregnancy and birth, which was happening more and more in white communities and in the North had a higher mortality rate than those that were being cared for by midwives. And so in order to improve the quality of obstetric education, we needed to get rid of the midwife so that they just eliminated the competition.

And what's really interesting is if you read the article, and you can still get it if you have a good medical librarian, he actually acknowledged that eliminating midwives would lead to increased mortality in the Black community, especially in the South, but that it was an acceptable loss if it meant that women in urban areas and both in the North and the South had to go to a physician to get their care.

So it's interesting once we were no longer a labor tool, it was OK if our population shrunk. And it speaks to today when we think of African-American women who are having higher rates of mortality even though they're getting care and who report disrespectful care, when we see that our pain needs aren't met and that were dismissed.

And when we have a whole medical specialty that was predicated on the idea that we were somewhat less than human, not deserving of having her pain acknowledged or treated, and that our deaths were acceptable if it advanced the cause of Obstetrics, is there really any wonder that today we don't stand much better in the care of obstetrics than we did honestly 100 years ago?

And then the other thing that happened is the rise of the public health nurse and then the nurse midwife. And nurse midwives were this bridge in the gap. Their job was to help eliminate the midwives that they thought were the most expendable, and to regulate those that were left until we could create a workforce of nurses who had training and obstetrics and public health, because that's what nurse midwives were. And of course, they were primarily white.

And so they had a trust and a relationship with medicine that a Black community midwife would never have because all throughout this time, midwives found a way to resist. We hear about the ideal midwife bag, Dr. Alicia Bonaparte wrote an article about, but we also hear about the two different bags.

You had the bag to show and the bag to go so that you had the bag that you showed the officials so that they could see that your bag was cleaned, and in order, and have the instruments that they required and only the instruments that they required and no tools for abortion and no herbs. And then midwives had their real bag, and that was the bag to go.

But nurse midwives were interesting because rule number 1, they were never really intended to do a great deal of birthing of babies themselves. They were simply there to be a police force, and a supervisor, and a teacher of midwives, but then but they stood ready to stand in the gap and to take their place as they eliminated those midwives.

And the exception to those were the midwives who really truly wanted to form collaborative relationships with the community midwives who wanted to honor them, who wanted to be a support and in a lot of ways a buffer, and many of those were the African-American nurse midwives that came from the programs at Tuskegee and at Dillard University in New Orleans. And then there were the original eight midwives, there were eight midwives between 1932 and 1950 that were trained at the Maternity Center Association in New York City.

But unlike their white counterparts who often wrote very condescending and derogatory letters to public health officials, they found the brilliant ways to collaborate with them, they found ways to help the midwives be able to meet some of the requirements for education, even though perhaps they didn't have the literacy when they needed to teach skills or needed to teach policy and procedure, they made them into songs that were similar to the hymns hung in African-American churches. They organized the midwife clubs. They held monthly meetings to help them.

One of my favorite stories is looking at one of the nurse midwives who worked in Arkansas and even though theoretically about 90% of the midwives in an Arkansas shouldn't have met the standards that they needed in order to let them keep their permits, not only do they keep their permits, but in a space of five years, she reduced infant mortality by 50%.

So she not only proved that the public health measures worked, allowing midwives access to soap and giving them the materials they needed to be able to attend birth safely, she also proved that we were teachable, which was something that had been denied them. So I think and it's always important to honor the nurse midwives who really work to collaborate with both African-American community midwives who gave them respect and who held on for them during the time when they were slowly but surely being eliminated.

In 1910, 90% of the births in the South and 50% of the births overall in the United States were attended by midwives. And by 1950, that was down to less than 15% of births. And also that coincided with the end of World War II and the growth of the medical workforce with improved roads, getting access to hospitals and cities.

And then finally, we moved to the beginning of the Civil Rights Act and the Medicare and Medicaid Act which finally gave African-Americans between anti-discrimination laws and Medicaid, financial support, the ability to have hospitals and births, which is when you really start seeing public health officials even more aggressively retiring and eliminating the midwifery workforce. Oh, I'll get emotional.

One of my earliest memories, but one of my last memories of my great grandmother and my grandmother was when they called my grandmother's house in Prince George's County, she lived in Hopewell, Virginia, and asked her to come to the health department and to bring my great grandmother with her who by then had lost her sight and had never driven, as many African-American women didn't-- she went everywhere on foot-- and going with them because I was one of the smallest children. So I also got to tend a few births with them just because I couldn't be trusted to sit still.

But going with them and-- I'm sorry, having a young physician and a nurse midwife who was probably younger than both my parents take my great grandmother and my grandmother's parents away from them and telling them that they weren't needed anymore because the hospital, John Randolph that still exists in that town which had previously been segregated, that I couldn't have been born into had I wanted to because unless there was some complication that my granny could convince a physician to take you there.

My mother wouldn't have been admitted to the hospital to give birth. But now that there was the roads, and now that there is Medicaid, and now that poor Black women and poor white women has to be clear, my granny delivered plenty of white women. But now that they have access to the hospital and there were roads everywhere and everyone had the ability to get health care within an affordable cost, they were obsolete.

And so imagine coming in and thinking perhaps you're just going to go through your usual inspection and then having someone-- when's the last time you went into work and thought everything was going well and somebody said, turns out you're fired. So today, in the United-- it's 2021. In 1921, there were probably 100,000 midwives in the United States and 90% of those were Black women.

Today in 2021, the count's not perfect, but there's only around 13,000 midwives. When in 1921, 50% of those would have been African-American and the other 50% would have been immigrant women, Jewish, Irish, Russian, those who provided the cultural care in their communities that was so needed.

Today, 90% of midwives in the United States of that 13,000 are white women, most of whom are intergenerational wealth. Those of you that are students, you know how much tuition you're paying just to have the relative privilege of being able to say that I'm going to go somewhere, I'm going to not work for two years, I'm going to get a graduate education.

If I don't have the ability to pay for it or just don't want to, I'm going to take out six figures in loans and then I'm going to compete for a job in a workforce that's 90% white and I'm going to have the relative assurance that I'm going to get a job, because I know that everyone on the panel that's looking to hire me will say I'm a good fit.

So when we think about today when there's less than 1,000 Black midwives in the United States and maybe as few as 100 Native American midwives, Indigenous midwives in the United States, but the births that are attended by midwives in the United States, nearly half of them are to low-income women who are Black, Latinx, or Indigenous, the Indian Health Service and disproportionate share hospitals, or Black and Brown serving institutions is the place where most midwives work, yet we make up less than 10% of the workforce.

And yet we think of how white supremacy and the drive to eliminate midwives that were Black and Brown and minority ethnic immigrants, you can see that even today, white supremacy plays a huge role in who is caring for women. And so as we go forward, the way we have to change that is at the community level, at the grassroots level, as we seek to reclaim our rights to be pregnant when we want to be pregnant, to choose to not be pregnant if we don't want to be, even if that means ending a pregnancy when it's not the right time.

And the right to have healers that look like us, that listen to us, that have walked our lived experience, and who respect us who we are as humans, as being wholly human without living with a preconceived notions that my blackness does somehow makes me less than you is critically important. And so I just want to thank you for having me here at this time. And thank you for wanting to hear the stories of our grandmothers.

DOMINIQUE TOBBELL: Thank you Dr. Drew for those powerful and provocative remarks. You've given us a tremendous amount to think about, and I'm sure we'll have many questions in the discussion period for you. So now we turn things over to Dr. Muigai, over to you.

WANGUI MUIGAI: OK, thank you. Thank you so much for the invitation to be part of this roundtable discussion. It's really an honor to be in conversation with Dr. Drew and Dr. Fraser whose work I admire so deeply, and has shaped my thinking on Black women healers. So I'm really thankful for all of you to joining virtually this afternoon.

So my talk this afternoon really draws from my current work, my current book project on the long history of Black Infant mortality in the US, and I think really richly complements the material that Dr. Drew just walked us through. And this is a history that I trace from the period of slavery through to our present day.

And as part of my research, I've looked through old medical journals, public health reports, and really the range of documents that Black parents have left behind testifying to their experiences of birthing and losing a young child. And one of the most striking things when focusing specifically on the Black experience is that, as you know, long before the government and the medical profession took a vested interest in the lives of Black babies, it was midwives who carried out this work, who paid attention, and who mothers relied on to see them and their baby safely through childbirth.

And so my talk really just reflects on the pivotal but underappreciated role midwives have played in ensuring Black maternal and infant health, that's the larger context. I'll go ahead and share my screen. I just have a couple of images to help ground my remarks. Let's see. Hopefully that works. Can you see my images?

DOMINIQUE TOBBELL: No, not yet.

WANGUI MUIGAI: OK, well, I'll just keep going. So my title for today really focuses on these themes of trust, training, and tradition. And I want to suggest that these are really critical for understanding this history from how we move from a place where Black women midwives, or Black women are the majority of midwives practicing in the US to now where they make up a small share of current practitioners as Dr. Drew explained.

And these themes of trust, of training, and tradition are also important issues for understanding Black women's health care and birthing experiences more broadly. So I want to start by just giving a brief sketch of what health care looked like for Black Americans in the early to mid 20th century period that I'm focusing on.

The reasons why Black women turned to midwives for care and how health officials viewed them, and the legacies of this early 20th century moment in the history of Black midwifery. So to really understand why we are still grappling with the kinds of disparities we see in birth outcomes, it really requires looking at the structures that have shaped our medical system.

And during the era of Jim Crow racial segregation that stretched from the 1870s through to the 1960s, a series of laws worked to define Black Americans as second class citizens, and this was in all aspects of life, including health care. American hospitals segregated patients by race. The American Red Cross separated the blood it collected from Black donors from all other donors. And many white doctors and nurses refused to treat Black patients.

And to really ground this and give you a sense of just how harmful, how humiliating the system of racially segregated health care was, I'll offer one example that I found in the Black medical journal, "The journal of the National Medical Association," and it describes this really vivid scene in Birmingham, Alabama in the mid 1930s of a Black mother who found herself in the early stages of labor and went to the nearest hospital seeking admission to deliver.

And the hospital staff refused to let her in because she was Black. And she was already in the early stages of labor. She was forced to give birth on the sidewalk and a crowd very quickly surrounded her. It was only when a granny midwife stepped forward to deliver the newborn that the group of onlookers basically woke up and spurred into action.

And this ends up being the rallying cry to both contribute and help establish a small local hospital in Birmingham for other Black people and for the larger Black community, but this incident wasn't unique, these stories, these sidewalk stories of mothers being forced to give birth outdoors in public in broad view because they're denied admission, this happened whether the nearest hospital was a block away or hundreds of miles away.

Black women in need of maternity care were routinely turned away. And in many tragic instances, this made the difference between mother they and their babies lived or died, to say nothing of what kind of experience that was. And this is what health care looked like for most of the 20th century when racial segregation and racism was a defining feature of the American health care system.

For those who manage to gain admittance into a hospital, they were placed in Black-only wards that were often overcrowded, understaffed, outfitted with old equipment. So the ability to access a hospital and be attended by a physician was still no guarantee that Black woman would have a decent birth experience or even survive.

And when we look to the leading medical and public health journals, "The American Public Health Association's Journal," in 1937, there's a piece that reports that the medical care given to colored patients is quote inferior to that for the white, and this has contributed to the higher death rate. And this article, this 1937 piece goes on, that errors in judgment and technique and neglect on the part of physicians were 50% more frequent among colored mothers.

So here we have this really clear acknowledgment of physicians recognizing and really laying out in print that they are actually contributing to the maternal and infant deaths in Black communities, but doctors really work to absolve themselves of this blame by arguing that Black women were biologically different than white women, especially when it came to the skeletal structure of the pelvis, through the birth canal, and that because of these racial deficiencies, Black births required the use of risky procedures like cesarean sections.

Now, I just want to note here that the present day echoes of this are striking and really disturbing because today Black women have the highest rates of C-sections in the US. This is a major surgical procedure that places them in their babies at greater risk for severe postnatal complications and death.

So we can think about the kinds of medical claims that have been used to justify excessive intervention, excessive reproductive surgeries on Black women. This includes C-sections, sterilizations to treat gynecological conditions as Deirdre Cooper Owens really beautifully lays out her work, *Medical Bondage.* So there's a longer story that we can trace on that.

But to really return to this earlier period I'm walking through, we see that in this early 20th century moment, doctors were less willing, really reluctant, refused to serve poor Black communities. And the midwife, Annie Lee Logan, described that in the parts of Alabama where she lived and where she worked, doctors were only occasional sites. They appeared every now and then.

And she writes in her memoir quote, when you call on one, even if you call on a doctor today, he might come tomorrow, he might come tomorrow. It was the midwife or nothing. And we get more evidence of the barriers that took care that Black families experience when we look to the account of Dr. Haley Tanner Dillon Johnson. She was one of the first Black women physicians to practice in the state of Alabama.

And she noted that in the rural areas where she practiced, white doctors would charge Black families for every mile that they had to travel in order to reach patients. And they would demand their payment in cash upfront before they did any attending. Now, for Black sharecropping families, having access to this kind of cash was just not possible. It was not an option. It really writes out this type of care.

So for a number of reasons, Black women avoided hospitals and doctors, or didn't even consider them to be safe, reliable, or an accessible option. The reality was that Black midwives were the main providers of maternal and infant care in their communities. And they attended more than half of all Black births. And in really rural parts of the South, Black families would call on midwives eight times out of 10. In the eyes of the woman they cared for, Black midwives were reliable, experienced practitioners who skillfully manage the uncertainties and pains of childbirth.

In 1924, a group of nurses who are working for the federal agency, the US Children's Bureau, interviewed a number of Black and Latina mothers about their birthing experiences. And they found that Black mothers preferred having a midwife and really expressed and articulated a number of well-considered reasons for why they called on midwives to attend on them, through pregnancy, through birth, and through the postpartum period.

And for these mothers, tradition and training mattered. Black mothers valued that midwives relied on knowledge that they quote, said, had been handed down from slavery time. And as Dr. Drew so beautifully covered in her presentation that we just heard, this is a tradition that we can trace back with deep roots in Africa, form of knowledge, and skilled labor that was passed down across generations.

And the women interviewed in 1924, they said that they trusted midwives. They shared that they quote, the midwife does more for you, she helps with her hands. And one of the mothers described having such a traumatic experience when she was cared for by a doctor. She swore to never have him again. And she made clear that in the future, she would only call on a midwife as she told the person interviewing her, granny helps in your misery.

Others explain that they appreciated midwives could help manage household tasks like laundry and cooking, basic functions, the ones that are too demanding for women to carry out in the initial days when they're still recovering from giving birth. So when we look across all these reasons, we see how Black women made informed choices with the limited choices that they had.

Their responses reflected economic, emotional, epistemological concerns about the kinds of knowledge and care that they valued. And its sources like this survey that allow us to hear Black women sharing their own words, what they envision for their births, the multiple ways midwives met those needs, and how they articulated their desire and right to determine where and under what conditions they would bring their children into the world.

But unfortunately, at the turn of the 20th century, few government health officials took into account Black women's reasons for preferring midwives. They considered mothers who relied on midwives to be uninformed and negligent with their prenatal care and with their pregnancies. And rather than recognizing midwives as the trusted, valued, and indispensable health practitioners that they were, many doctors and nurses blamed midwives for deaths during childbirth.

They went so far as to argue that eliminating the practice of midwifery was the only way to address the nation's high rates of Black maternal and infant mortality. And physicians really campaigned quite aggressively for state laws to regulate midwives whom they regarded, and who they painted, and described in their journals as ignorant, and as diseased, and primitive. They claimed midwives use unscientific and unsanitary, and therefore unsafe techniques to assist birthing women.

And this campaign of course, was just one manifestation of a longer history of rendering women's labor invisible and discounting it as unskilled. And there's also a larger genealogy of stigmatizing Black women in particular by portraying them as ignorant, by portraying them as dangerous and harmful to children.

So this early 20th century argument that midwives were the cause of maternal and infant deaths, this becomes a key reason that physicians rely on to essentially remove their main source of competition. Under increasing pressure from physicians in the professional organizations, states across the country passed laws that place stringent regulations and requirements on the practice of midwifery.

So by the 1920s, you see that midwives have to take a number of exams to demonstrate their competency. They are to attend classes often taught by public health nurses, comply with having their equipment, their bodies, and their homes regularly inspected to ensure that they were following sanitary measures. And they had to do all of this in order to receive a license to legally practice.

So it's worth noting that this kind of surveillance did not exist to the same degree for doctors and nurses. But for Black midwives who did not have the economic and the political power to organize and collectively push back, they couldn't push back against the way that they were being unfairly policed and targeted.

And so it's through these lessons and through these classes that midwives are really explicitly taught the limits in terms of what they can and cannot do when attending to women, when attending and assisting in births, things like that they must report the birth, they must require or call on a doctor if any complications arise, they must promptly report the birth and fill out a birth certificate with lots of monetary fines, even threats of jail and imprisonment if midwives do not keep up with the compliance and with these regulations.

And there's a real emphasis on hygiene that we see as well, this idea that the new midwife, this midwife who's gone through this kind of training, who's legally licensed to practice, she must be clean. And cleanliness, of course, is a major issue and a major concern in public health campaigns across the country at this moment.

But the levels of meaning in terms of what physicians, and what public health nurses, and what government health officials are saying about Black women, Black midwives being required to be clean and all the ways in which they are being surveyed, and inspected, and examined to prove their cleanliness just brings on additional layers of intimidation and assumptions about the bodies of those who are providing this kind of indispensable care.

Now, of course, the roles that midwives were called to attend to were also not the kinds of sterile environments that you see in hospitals and delivery rooms that doctors were used to working in. Midwives did what they could. But in the rural areas where they worked, these are spaces that lacked basic infrastructure like clean running water, that make it very difficult to carry out these kinds of techniques and measures in the ways that health officials envision and place them expectations on.

By the mid 1940s, many midwives who are really part of this first generation of having their practice regulated had grown increasingly frustrated by the frequent inspections, the frequent surveillance. And this is a scrutiny that can intensify if health officials sought to push out an elderly midwife out of practice.

In her memoir, *Listen To Me Good,* the midwife, Margaret Charles Smith, remembered a particular incident where she overheard another midwife informing the public health nurse who supervise them, I think I'll bring my bag in and give it to you all because you all are not there when this labor is going on.

You don't know how it goes, rubbing helps and teas help. If I can't give them teas which I know which will help, I just will ought to give up. So as this exasperated midwife was really making clear, the constraints on which she was allowed to do what she was allowed to use during labor really left her with little room to provide the care her patients wanted.

CAROL WANYO: Because are connected, I had this.

WANGUI MUIGAI: Women called on her because of her skills, managing pain and putting them at ease during a moment of uncertainty. And in this sense, adapting to state laws was hard for midwives, but it was also hard for the pregnant women who expected their deliveries and their transition to motherhood to be similar to the experiences of their own mothers, their relatives, and their friends.

So as much that midwives had to negotiate between complying with these new regulations and being receptive to the kind of care that women asked for. And breaking from years of experience wasn't easy. Midwives struggle to maintain control over their practice, but also their professional identities, with some finding that the only suitable solution was really an outright rejection.

But still, some midwives found ways to continue providing the skilled care Black mothers needed in spite of this intense surveillance and in the face of the continued reluctance of public health officials to invest in addressing the structural factors that placed Black Americans at greater risk for premature death.

And we see this really beautifully illustrated in the life and the work of Mary Coley, who is a midwife who practiced in rural Georgia. She was well-respected by white and Black families who called on her, as well as the health officials in her area. And in the 1950s, Mary Coley really gained the respect and admiration of communities beyond her small town in Georgia when she starred in this film, this public health training film called *All My Babies-- A Midwife's On Story.*

And this was a training film that was created to be used in the midwife teaching classes that I just talked about that occurred across the South. But pretty soon after it debuted, the film was also used to teach medical students, to teach nursing students. It was shown to expectant parents across the country in order to help prepare them for birth. It was shown to emergency responders, police and firefighters to sort of give them a sense of how to adapt and how to be resourceful if they're called to deliver a baby regardless of where the circumstances were.

And this film was screened around the world, winning numerous awards along the way. If you haven't heard of it or seen it, I encourage you can do so. You can watch it on YouTube, but you can also see clips of it in the National Museum of African-American history and culture in DC. It's just really one testament of how important this cultural piece is to Black History, to public health history.

And part of the reason why so many different audiences were drawn to this film, drawn to this narrative, really drawn to Mary Coley was because of the way that she braids together this tradition and training, the way she presents the central role midwives have in their communities. The medical roles, the civic and social roles, the emotional support that they provide, and the resourceful ways midwives continue to carry out their work.

And she not only starred in this film, she really had a key presence in terms of shaping it behind in a sort of off camera, in a way that really forced the wider health care profession, including federal government health officials to reckon with the living and the birthing conditions that existed in the Black South in the mid 20th century. So I really see this film as just one example of the kind of activism that Black health practitioners have really engaged in in order to fight for better and more health care resources and care in their communities.

And these issues, these tensions in the history of midwifery, especially when we're thinking in the context of Black maternal and infant care, they continue to resonate today, especially as we still grapple with racial disparities and birth outcomes, with Black mothers and babies facing greater likelihood of dying during childbirth.

But recently, there has been a renewed attention and interest in the beneficial role of midwives who are associated with improved birth outcomes, with lower rates of infant death, and that Black pregnant women report greater satisfaction with the care they receive from midwives than from physicians.

And this rediscovery, this renewed attention to midwives is important and so too is being aware of the reasons and the context that pushed midwives, particularly Black midwives out of their work in the first place, to really remember these lessons, the broader circumstances and to recognize them as they prop up maybe in more subtle and less explicit ways. But they do creep up when we're discussing what the outcomes and what the experiences of birth look like today in the US, and why this country as a country we really struggled to ensure the lives and livelihoods of Black mothers, of Black women and their babies.

And I just want to suggest that really holding these historical moments and really thinking through the long journeys that we've been through and not that this is just a new moment is really important if we're truly committed to honoring the choices, the values, and the visions of birthing people and continuing in that work. So I'll conclude there and I'm really looking forward to our discussion. Thank you again for your time.

DOMINIQUE TOBBELL: Thank you, Dr. Muigai for a wonderful presentation. Again, you've given us a lot to think about. And so we now go to our final presenter, Dr. Gertrude Fraser. So over to you.

GERTRUDE JACINTA FRASER: Hello, everyone. I'm going to try to share my screen. Let's see if it works. I also sent the PowerPoint in case-- can you see it?

DOMINIQUE TOBBELL: Yes.

GERTRUDE JACINTA FRASER: All right. So you know who I am. I'm daughter of Gladys or GB as she was called Gladys Barnes. She was a teacher in Jamaica and then she came up on a living domestic visa, special visa program in about 1967. And then three years later, she sponsored my two siblings and my father, three people, four people, to come up to the US in 1970.

And the woman, the first night, December, it was so freezing cold I'd never felt cold like that in my life. She was in a room like she had rented a room from a far off relative we all clustered in that room, and it was so close. It was just so exciting. And then I think the week later, she moved us all into the brownstone she had bought in Brooklyn. So the woman was phenomenal.

And then I got my degree with an anthropologist at Hopkins, and I joined UVA in 1990, '91, I think. And so the book that connects me to African-American midwifery, in my field work on family memories of midwives. Well, what I wanted to talk about today is I want us to have a conversation about work that drawing on, which is Jennifer Christie Nash's work.

And she is-- let me hold on, let me get to it. She hype me to this set of issues which I should have been attending to more directly. But it's an article published in 2019 called *Birth* in *Black mothers-- Birth Work and the Making of Black Maternal Political Subjects,* and it's in the Women's Studies Quarterly, volume 47.

And she's really calling her attention, and I think as we rightly valorize, bring attention to the history of African-American midwifery, I think we have to-- and this is what Jennifer Nash is doing attend to the present moment when, I think particularly doulas, but I think African-American midwives in general are subject to what I would call super forms of exploitation and appropriation of their cultural traditions in another form of unpaid reproductive labor.

And they often do it lovingly, but they also do it at the expense of their families and their own children, just like my mom did when she was [INAUDIBLE] domestic. Remember, she came up with a domestic, that mean she left us down there Jamaica suffer at the hands of very evil relatives.

Jennifer raised this point about at what cost do American doulas take on the burden of African-American maternal and infant mortality and morbidity, and how it is up there, how it is that there-- and I don't think it's unrecognized by those who take them, put them in this place for taking on the burdens of almost 13 times in some instances, mortality rates for African-American women. And as our colleague just pointed out, the high levels of cesarean section, et cetera. So I wanted to play-- let me see if it'll work. I don't know that it will, but let's see. Hold on, let's see if it'll work. Can you hear it?

DOMINIQUE TOBBELL: No, you might have to share your other screen.

GERTRUDE JACINTA FRASER: Oh, OK, hold on.

[VIDEO PLAYBACK]

- A doula is someone who is trained to be with pregnant women. They are trained to provide physical, emotional, educational support. We help the client speak for themselves, helping them find their voice so that they could advocate for themselves and say, I'm not going to allow this. You're not going to treat me with disrespect and abuse.

- [INAUDIBLE] labor has worked for you and me. So what you're doing by going up the stairs sideways is you're opening up your--

- The doulas that I have they're both Black women and are really trying to change the conversation around Black maternal health. So it's very reassuring to know that their concerns are the same as mine, and they've studied and done way more research than I have. And knowing that they are like, no, putting my foot down, you don't have to do this, this is what this means,

- And that cover pressure helps relieve a little bit of that--

[END PLAYBACK]

So I want to recognize the important work that doulas do in pre-part and postpartum and during birthing for their clients who have access to them or can afford them. But the thing that Jennifer Nash points out that I wanted to call attention to is what I call a substitution praxis, maybe a different way to call it, but check it out.

[VIDEO PLAYBACK]

- Women should die in childbirth because of complications.

- If you're worried about finances, if you have housing insecurity, if you have all these other things that are going on in the back of your mind plus compounded with the fact that you're pregnant and you're carrying another living human being inside of you, come on. And that weighs on a person, that weighs on their body, that reason their spirit. I think that this work is especially important because we act as a defense system.

- Thank you, senator.

- As a Black woman and a mother of six children.

[END PLAYBACK]

Oh, let's see. So that's a substitution move if you didn't notice it where the senator introduces a problem and then the Black doula steps in to present herself both with regard to the lived experience of being a mother, but also to the work reproductive work and maternal care she takes on behalf of the state.

And this is the issue that Jennifer Nash points out, and she says that it's a form of superexploitation of African-American doulas. And I was telling my daughter about this issue. And she said, hey, mom, that's like when you're a diversity expert, diversity inclusion expert at a company, let me just-- even at the University of Virginia, and people expect you to solve 200, 300 years of inequality and lack of diversity of students or faculty members and you get all of the substitution moves.

You get to be the face of the diversity solution. You get to be the voice just as these doulas do with maternal mortality. And in some ways, you come to become the physical embodiment of the University's efforts. But behind the scenes, you don't have any resources. Maybe you're not even the vice president, I think we have one now. You don't have any resources, you don't have any power, but you take on the visible image of the organizational strategy to solve the problem.

And of course, you can't. And of course then, you often get vilified for your inability to solve the problem and perhaps also get vilified for being the stand in for the woman senator who can happily slip away from the stage and the press now has the duel of front and center. And this is the work that, and I think it's extremely important political work that Jennifer Nash is doing, and I wanted to tell you about her.

She is the Jean Fox O'Barr professor of gender, sexuality, and family studies at Duke University. She got her PhD at Harvard University and her JD at Harvard Law School. And she does work at the intersection of Black feminist theory and sexual politics and Black motherhood. And the study that she used to talk about, the burden placed on African doulas is work she did in Chicago, in the state of Illinois that amounted an initiative to solve the problem of high maternal mortality in Illinois and specifically in Chicago.

And the way she sets up her article is to say that, what she really wants is to understand how Black women seem to come into political view to their proximity to death. And the proximity of death is not only the African-American birthing mother, but the doula. In this case, she's focusing on doulas, but I think also the Black midwife, particularly the Black midwife that practices ably outside of the birthing care system.

So what Nash said is that the Black-- in the configuration that brings a doula to solve the institutional processes of hundreds of years of Black maternal neglect, the Black doula now is the visible manifestation of the Black Women's body and its abjectness in terms of the state's responsibility. And I think it places African-American doulas, and I would say midwives too, but what Nash focus on doulas and I think I understand why as the embodiment of the problem that they cannot solve, they can help individual women often, but they cannot solve.

And the reason that Nash's work is so important to me is because when I wrote my book on African-American midwives, I really focused on the way that they and their descendants talked about the fact that they were doing this care because it's a deep spiritual commitment, because of their sense of themselves as both having book knowledge, yes, but also what they call mother wit, a deep intuitive sense of what to do and how to do it.

And I think African-American doulas draw on those traditions, and I focus on them because in many ways, they operate within this tradition, almost a tradition of a commitment to care at the cost of their own selves, their own lives, et cetera, because they get paid so little. And I couldn't find any specific data on the income that African-American doulas make. But on average, doulas overall make 15,000 to $30,000 a year.

And what I could find which is mostly anecdotal qualitative stories. African-American doulas often make much less than that. They doula work is like a third shift work because they have to have paying jobs, because they have children they have families, they are head of households, and then they do doula work in the interstices. And if not unpaid, super low remuneration.

The other information that I could find is that often those who have access to African-American doulas tend to be middle class women, African-American women and middle and upper class white women. But even then, as many doulas report in the literature that I could find, they often feel that people treat them and expect them to work as if they were quote unquote domestic performers, domestic servants of domestic labor, and didn't recognize the deep knowledge and qualities they brought.

And so I think what Nash is suggesting that I would like for us to just take into account as we look at the history of African-American, the longest of African-American midwives is the costs that go along with it. And what Nash says in her article is that women of color do less take on the state work of equitable reproductive care, but for free or low wages.

And what you saw in Illinois and what I pointed out to you in that clip from New York is that under the auspices of reproductive justice, women of color doulas are recruited by y-based doula programs to transform the birthing experiences of Black women. And then what happens as a result of that is that when the states start to pay attention to the crisis, the deep crisis of Black maternal mortality, instead of investing real doulas, instead of making commitments to ongoing long term transformational investment in Black women's health.

They go the cheap way, so to speak, of using doulas to attend to birthing women, African-American women. There's nothing inherently wrong with that. I know from the literature that boomers can make the difference between good and poor health outcomes. But what not in terms of all of the preexisting conditions under which Black women have had to give birth. And so what the state has now, this convenient way to point to the fact that they're not only delivering good maternal health care, but they're doing it in culturally appropriate ways.

And I think it's a form of cynicism and it's a way that states opt out of making the deep investments that really need to be made. And so that's really what Nash's work got me thinking about. And she talks about the way that the state used doulas at a very low cost, almost as miracle workers, and then don't actually have a way of tracking the long term impact of the doula interventions.

And so I think it's just this pernicious problem that we need to be thinking about in the context of the work we're doing to raise the profile, the historical profile of African-American midwifery, because I think if we don't do that, then we are contributing to this problem of this substitution by proxy that relieves local health care agencies, relieves hospital, relieves physicians, relieve the health care system for taking Black women's health and death seriously. So that's what I wanted to bring to the conversation.

I think also, and then I'll stop so we can open it up to the question and answer. I think the other thing too is that with regard to doula professionalization, and I put a quotation marks around it, there is a real racial divide, because white doulas have taken up the very obviously successful set of professionalization practices that white midwives had way back since the '80s and '90s in creating organizations, in this case, pro-doula, I think in the name of the network.

They provide certification. They provide training. They allow you to document the fact that you've spent so many hours in the doula. And in some senses, they become visible, and so when mothers are looking for certified doulas, they tend to look for women who can show that they have gone through this certification, legitimized program.

African-American doulas who practice in cultural positions that are important to them often don't have the deep resources nor the recognition of their training programs, many of which require many more hours of doula clinical work with mothers. So you create this two-tiered system. And what that means is that African-American doulas who offer their care as a spiritual practice, and I and I'm afraid to say this out loud because I don't want to be misconstrued. But in some senses, by taking this, they monetize their work.

Their work is highly valued spiritually and they do important work. But in a sense, because of the continued expropriation of Black labor, they place themselves in the non-money birthing economy, and are not expected to ask for a living wage. And so to me, that's a real problem. And the other part of the problem that Nash calls attention to is that, doula see themselves as providing voice. They see themselves as working in the cultural tradition of consent, i.e., the African mothers trust them and they give them their consent to speak on their behalf.

However, in the hospital context and even in the home context, doula's voices, particularly when there's a midwife, there are often voices that are silent, that are politically muffled. So even as Nash points out in the context of giving voice to African-American women, because doulas are so-- their value is so misrecognized that their voices aren't amplified, especially in the context where they need to speak on behalf of the birthing mother.

And I think this is a real issue that we need to be talking about, because if we just continue to do this proxy substitution, the problem of maternal infant disparities cannot be solved and will not be solved by African-American women midwives and doulas. It's just it's impossible, but we will take on the burden of that transformation that it's impossible for us to do and we're doing it unwaged, and de-legitimized, and also romanticized at the same time.

And I just think, I encourage you to read Nash's work. I'm sure there's other work looking at this issue. But I wanted to bring it into the space as we recognize the powerful work that African-American midwives have done, both in Africa historically on the slave ships and also in the nation. So I think we cannot bring them back into the story without recognizing the way that we continue to exploit African-American women reproductive labor. And so I thank you and I look forward to the conversation.

DOMINIQUE TOBBELL: Thank you, Dr. Fraser for bringing the experience is complex roles and conflicted status of Black doulas to our conversation today. Again, a very provocative presentation. So I'm excited to say that the floor is now open for questions and discussion.

And just to remind you all, there's a couple of different ways you can do this. You can use the Raise Hand function that you can find at the bottom of the Zoom screen. You can put your question in the chat or if for some reason I don't see you waving your hand, you can unmute yourself and ask your question.

MICHELLE DREW: Hey, Monique, if I may.

DOMINIQUE TOBBELL: Absolutely.

MICHELLE DREW: Thank you for that Dr. Fraser. She put me in mind of, again, when we think of the power structure and how embedded white supremacy is to this. But when we think of Ubuntu, which is my non-profit which also serves as a practice, one of the key markers is that not only do they have a midwife for their care, they also are paired with a doula in their pregnancy as early as possible.

And we built into it by definition that we would pay our doulas a living wage and structured it actually, some of their fee structure around the rate that doulas are paid in Virginia, and wanting to acknowledge Birth in Color RVA, which is an advocacy and group, but also have the doula group that provides amazing care to the Black women in Richmond, Virginia. And the granddaughter of Claudine Curry Smith who was a very well-known and well-respected midwife in Northern Neck Virginia, is the executive director and a future midwife.

But it's interesting to see how Black women have to navigate spaces and how midwives and doulas are perceived. So as a nurse midwife, especially and I'm with a nurse midwife intent because, a lot of which is my grandmother's decision-making on which, of course, I took, whether I became a CPM or CNM, but we have this position of power that is perceived that we have an authority in the room, whereas doulas are often disregarded.

We're viewed as non-threatening. In hospital situations, their visitors, and certainly there's this idea that if you fight too hard or push back, you can be removed. So while we still honor the beautiful tradition of doulas' and their hand skills and their heart skills, and just the incredible work they do to help pregnant women achieve healthy birth, because especially in Black women, we've seen the reduction in preterm labor and in serious birth outcomes just by being with a culturally congruent doula.

We have to acknowledge that some of the reasons why Black doulas lives are acceptable in the birth space whereas we still see so few Black midwives is because of that power dynamic of viewing doulas at a lower subservient role, much the same way that we looked at Black community midwives.

DOMINIQUE TOBBELL: Thank you, Dr. Drew, for that comment. We have a couple of questions in the chat, which I think are for any of our panelists who would like to answer them. So first, Clidy shared a question, since midwives had the knowledge of all aspects of women's health, were they forced to have any role in the eugenics that took place in the first 2/3 of the 20th century?

GERTRUDE JACINTA FRASER: Oh, maybe Dr. Muigai could speak to that. I know that in the work that I looked at William Plecker, I think that was his name. He was a physician and a state director of health statistics in Virginia and later was very much involved in the effort to-- what's the word? To decertify the presence of Indians in Virginia, saying that they were what he called tri-racial isolate, that they were just mulattoes trying to opt out of the Negro category.

His concern was really more around maintaining what he called racial purity. And part of the effort to control and survey midwives was so that they wouldn't slip biracial phenotypically white-looking babies into the White category. So he really saw his work as creating a little the line across which no legitimately not white person would cross. And he thought that midwives were actually a problem for racial hygiene as he called it. But there may be-- I don't know if there are other ways that African midwives participated in medical eugenics.

WANGUI MUIGAI: Yeah, I think that's exactly right. I think to my knowledge where I see midwives really being pulled into this, the reach of the law in terms of policing reproductive lives and really firming up these racial boundaries and gendered boundaries has a lot to do with the kind of reporting that midwives were compelled to do.

When you start to really see the growth of the birth certificate as being a document that every person should have, and that whether it's a midwife or physician who attends the birth, they're required to fill that out in a timely way and to send that up to vital registrars like William Plecker and others that move from the county, to local, to state, to the federal channels that there's a real scrutiny of the ways midwives are filling out those documents and reporting the birth of their attending.

And in a large part, it is to sort of maintain, as Dr. Fraser points out in her remarks and also in her work, these boundaries of hypodescent, of really making sure that white purity is ensconced and protected in birth certificates, but also to look for things like women who have births out of wedlock who then receive social services and welfare support. And there are a number of different ways in which state officials and local officials really start to pay attention and pull out all kinds of information from these documents that become really key to citizenship, but are also used to further eugenic programs.

So that's one place where you definitely see that the ways in which midwives who have that knowledge, who are in those birthing rooms, and they see the women, and they see the partners, and they see the families, they're really called on and called out and forced to report on what they've witnessed. And they have different ways of negotiating that, but that-- it's a very great question and that's where my mind goes in responding to it.

MICHELLE DREW: And I'll say yes and no. And this comes in and to part of thinking of both sides of eugenics and also in thinking that the resistance that Black midwives play, because we certainly see in documentation, in places like Alabama, for example, Macon County, Alabama where there was a hospital that admitted Black women in Tuskegee for that matter, that as many as 50% of Black women who ended up giving birth in the hospital had unconsented sterilizations.

And so one of the ways that Black midwives were part of that resistance may be that when they were providing care and perhaps Virginia, for example, in Alabama might require a pregnant person or midwife to present a pregnant person for an exam to be quote approved for and out of hospital birth, and perhaps you had a mother who had high parity, they were having their seventh, eighth, ninth, 10th baby, and maybe a physician would say, no, she might need to give birth at the hospital because she's at risk for something.

And people heard those stories of women who came into hospitals and then left without a uterus, as many as 50%, again, of women who went into a hospital thinking they were just having a vaginal delivery, but had some sort of risk factor went left with a post-partum hysterectomy. So maybe the midwife ended up having someone who was told they couldn't have a hospital birth, but then the baby just came too fast. So it's like, oh, I know you told me to bring her in, but the baby came. We weren't going to make it.

And then to also think about the role that nurse midwives played in the public health infrastructure. So we know that, for example, the Ralph sisters which is one of the cases that led to why we have to have consent for tubal sterilizations and written informed consent, it was the public health nurses, some of them may have been nurse midwives who actually brought them in to the hospital.

And if you read the account of the one sister who tells the story, they were essentially held prisoner. But then the other side of eugenics is positive eugenics, and we know about Frontier Nursing Service and Mary Breckinridge. But one of the things is that's often not talked about the Frontier Nursing Service and Mary Breckinridge is that she did not approve of birth control for the White women in Leslie County. And she was the final arbiter of who got tubules of women's asked for tubal ligation.

And you put that in the setting of the early 20th century and the positive eugenics movement, is that one of her primary beliefs and why she chose Leslie County, Kentucky in that place was because she believed that population were white Anglo-Saxon Protestants of ideal blood. And so they had this notion that having the right population grow and be fruitful and multiply was essential at a time when people viewed the Great Migration of Blacks to Northern cities and the rise of immigration from Europe as being a threat to the whiteness of America.

So many of you all know, so if there's anyone here of Irish descent, you know and until 1866, you weren't actually viewed as completely white. Any one in this audience who may be Jewish, if they could go and look their family up in the census or look at some of their birth certificates, if they have them under race, they would have been listed as Hebrew.

So there was a large number of people that part of eugenics was keeping unfavorable populations from breeding, but there was also an encouragement for white Anglo-Saxon women to have a duty to give birth, to make sure that immigrants and ethnic minorities, and Black people didn't take over America. And midwives absolutely played a role, nurse midwives absolutely played a role in that.

DOMINIQUE TOBBELL: Thank you. We have several questions. And so let me go back to the chat before we go to, I see Pat has her hand raised. But we have a question in the chat that came in several moments ago. This is from Bree, who referenced Vice President Harris's recent maternal Health Summit at the White House.

And where several spoke about the funding for midwives as a way to increase the numbers in the ranks. And politically, this was tied to a bill that has not passed. So Bree asked, what is next? How do the numbers of Black midwives resurge with the many financial constraints that Dr. Drew mentioned? And how does this pipeline get built?

MICHELLE DREW: In my personal opinion, one of the things that we need most is we need the return of midwifery education to HBCUs in the history of the nurse midwifery educational practice. So far, there have been four, but only two that were really modern, and those were at Meharry and Charles Sturt University. And both of those were successful in graduating more first-time graduates or first time successful passing awards than all of the other predominantly white institutions.

It comes in looking at the midwifery faculty and midwifery directors, because I sit on an admissions committee of a university where-- and I will be honest, and it may be challenging for some of our colleagues that are on here right now who are white nurses who are in academia where we would be looking at graduate students application packages. And I'd hear things like, she doesn't seem to be the right fit, or, will she be able to stand up the rigor of the program?

Hearing graduate students who are applying and being interviewed, especially Black students were being asked questions like, were they married? How many children did they have? Were they single mothers? Would they be able to stand the rigor of staying in a program? And think about the ways that when we are admitting students, do we bring our own interpersonal and institutional racism into it?

And yes, we do need funding. There's the midwives for MOMS Act, but I will tell you there are some inherent flaws in that act, and that it talks about diversifying the workforce but there's nothing measurable and objective that says that any program who receives any of that funding has to admit a single more student of color, especially Black or Indigenous than there are currently.

But there's also the Perinatal Workforce Act, which is part of the omnibus and part of the Build Back Better Act, which is important because if that one was passed, it would have funding, not only for nurse midwives but for obstetricians and gynecologists, doulas, CPMs, for all across the work structure to diversify the workforce.

So we need to-- as Dr. Abraham Candy says, it's not enough to not be racist. It's important to be anti-racist. And that means for those of us that are in nursing education and predominantly white institutions, we have to be conscious of the way our programs disadvantage students of color, especially Black and Indigenous students and our Latinx students, and how are we going to radically reimagine nursing education in order to make it a safe and welcoming space.

DOMINIQUE TOBBELL: Thank you, Dr. Drew. Any of our other panelists want to comment on that question? OK then. Over to you, Pat. You can unmute yourself and ask you a question.

PATRICIA D'ANTONIO: Well, first of all, Dominique I want to thank you and I want to thank all the panelists for just an absolutely fabulous presentation. And one of the things that it's made me do is think more deeply about the kind of work I'm doing right now. I'm looking at nursing in their assistance, CNAs, nursing assistants, and how that whole process was a boundary work that nurses needed to do to kind of define their own place in the health care hierarchy.

I think that's also true of the public health nurses you talked about who were clearly a driving force behind the elimination of the midwife in the earlier 20th century. And I don't know that I can coherently formulate the question, but the discussion about doulas also made me start to think, is this another form of boundary work between nurses and other people who want to claim a place in the health care structure?

And when you look at nursing assistants, I mean they're primarily people of the wrong class racial, religious backgrounds. And I'm wondering if we can think about now this kind of place of doulas might be replicating that same kind of pattern. And this is to anybody on the panel.

MICHELLE DREW: And I'm sure Dr. Fraser with her current work may speak to it. But I do-- and thank you for that, because I do think to a certain extent, you're right. There are ways in which we view-- how you said, how we do see it certified nursing assistants. We view them as being subservient. We view them as being the providers handmaiden, and being delegated to tasks that are either simple or perhaps unimportant or where a nursing workforce who's maybe mostly white women as, back in the day, they say good blood and good breeding, that they were beneath them.

But yet they hold a critical role, if you don't believe it, like don't let the nursing assistants show up to work tonight and we're all in a world of trouble. But I think it's really interesting because I was a doula for a couple of years when I came back to the United States. I got my original midwifery diploma and degree when I was living in the British Commonwealth and couldn't practice when I came here. So needing to earn money, I worked as a doula.

And it was very interesting how those are viewed, and especially how they're viewed depending on who their patients are, especially because I was a midwife, and I was a nurse, and I was skilled, and I have the gift of learning from my grandmother's hands. I took care of patients who were largely financially comfortable, and they paid me a good wage.

I went to doctor's appointments with my patients so that OB/GYN and midwives would see me and know that I was a friendly face, and I coach switched and put on the voice of someone who was college educated and made sure that I was just there to be a help, and I wasn't a threat, and I wasn't going to be at all oppositional.

And when I was with those clients who were doctors, and lawyers, and accountants, and whatever, I was viewed as very welcome. But when I would go into-- and I went to school at Vanderbilt, but when I walked into Meharry, which is the City County Hospital with a mother whose time, I was donating my time, I was viewed as like a suspect, and I was OK as long as I stayed out of the way, and didn't get out of my place, and didn't annoy anyone.

And there was always this underlying threat if I started challenging or questioning what the doctor's decisions were or are encouraging my patients to challenge, then suddenly maybe I was looking a little suspect. So I always had to play this game and role of making sure that any comments and any suggestions that were made were coming from my patient and not from me, and so we learned sign language and how to look at my face so that--

I might point at my wrist even though I'm not wearing a watch so that they would say I'd like some more time, because we had to be very careful when I was caring for Black women who were feeling vulnerable and who are really at risk in this population to make sure that I wasn't getting out of my place.

WANGUI MUIGAI:

I think that's a really great question, Pat. Thank you for raising it. And I think in part, just to build off of the comments, the ways Dr. Drew walked us through how we might want to think about this has to do with the way, on the one hand, doulas are being positioned and the way they position themselves, I think, when we're talking about the politics and really what happens in these spaces, clinical spaces, birthing rooms, delivery rooms.

And I think there is a way in which we can see a utility and usefulness of doulas operating very much on the margins or on these boundaries as both able to critique systems and establishments and position themselves as outside, but with the perspective and with the knowledge to really understand the language, the techniques of what's going on. But as also in an outline and other spaces.

When I'm thinking boundary, I'm actually thinking the boundaries of what? Because I don't think it's just about professional hierarchies. I think it's also about doulas really inserting or being inserted into how we think about it and imagine classically a physician patient relationship, and very much in the interests of that, right in the middle.

And it can be very-- when I read Jennifer Nash and how she's thinking about how Black women are being politically exploited, but also figuring in this space, I think it has to do with exactly the way that they're situated and the way that they're situating themselves and she points out really the danger of these narratives, of Black women being called essentially to save themselves, and how that isn't a complete, a thorough, really an adequate way to address the disparities and the death that we witness.

But that doulas are very much part of those narratives and that self-fashioning. So I think the boundary work is a really rich way to think about it. I think it exists beyond a health care hierarchy. I think it really has to do with all the different kinds of players and people that come together when a birth is about to take place, when a woman is in labor and preparing for delivery. So thank you for bringing that into the conversation.

DOMINIQUE TOBBELL:

We have a question from Birth Sister. So please, unmute yourself and perhaps you can share a little bit about your collective as well as asking your question.

LISA BROWN: Oh, sure. Thank you. I am Lisa Brown, and I am the deputy executive director and co-founder, one of the co-founders, also on the call is Doreen Bonnet who's our executive director. And we are a community-based organization and collective here in Charlottesville, serving in Charlottesville and surrounding counties.

And I really appreciate this conversation, and we are directly on the front lines helping moms at grassroots wise, both [INAUDIBLE] and I or doulas ourselves, as well pushing the conversation upstream and working in the realm of advocacy for this work. And I felt like there were so many great points, but I really appreciated Dr. Fraser's conversation about how doulas are going to be utilized to make a change, to make a difference in birth outcomes for Black women, and how they currently are, and then what that would look like.

And I thought about the changes that are happening in Virginia. In Virginia, we have just committed to Medicaid of being a benefit for women to have a doula, and that is a good thing. But I will say there was some decisions around that, that will change the course of how we do some of our work. So right now, a woman has the autonomy to choose her doula and her birth sister, and she still will.

However, if she has Medicaid. She now has to go to her medical provider or a medical provider, clinician to say, hey, I would like this person involved in my birth and order for Medicaid to pay for that birth, that birth worker, that doula. So when we're talking boundaries, that's really a thing that we deal with day in day out of course. And it does depend on how we are as individual doulas, but also this now bureaucracy that's being inserted. So I just appreciate the conversation, and we'd love to talk more with-- Dr. Drew, I've also met you, I think, before.

MICHELLE DREW: Yeah, good to see you.

LISA BROWN: Good to see you. And yeah, I'm very interested in this conversation.

MICHELLE DREW: Yeah, one of the things I tell people that-- and as we were trying to navigate this space, and first of all, thank you for your work because the work that we're doing now in my home state, which is when I'm in the United States, I'm in Delaware to get doula care reimbursed is modeled after the work that you and Birth in Color RVA did to just get the program in Virginia going through. But I always say there's no remuneration without regulation.

So as whether it's somebody deciding that in order to be reimbursed, your doulas have to be donor-trained, no disrespect to anybody who's a donor-doula, or how much documentation you have to do. Like you said, essentially having to get a physician or midwife's order for a doula in order to get the care reimbursed and even the rate.

It's one of those steps that is really also bringing back, hearkens back to the regulation that community midwives went through especially in the '30s, '40s, and '50s to be able to say if this mother was going to have an out of hospital birth, they had to do x, y, and z, midwives had to present themselves for care.

The mothers had to go to the public health clinic. If you've ever seen all my babies, midwives in Georgia were required to make sure that each one of their patients presented to the public health clinic to get at least one exam to approve them. But it does hearken back a bit to that policing of birthing people and that speaks to it.

And I appreciate so much the work that doulas do, because I live now in two worlds I was a hospital-based midwife for many years, actually at my grandmother's insistence. When I came back to the United States, I very much considered becoming a CPM, and it was at her encouragement and the fact that she and even her children were denied the right to go to college, that she wanted me to become a nurse midwife and not articulating it well, but the power that it afforded me in that space.

But now I do out of hospital birth, but I recognize that there will probably never be a time in my lifetime or in my career when more than a single percentage or 2% or 3% of Black families will choose out-of-hospital birth, and with some of the regulations in place will be eligible to.

For example, in the state of Delaware, a mother has to have a hemoglobin of 10 in order to have a out-of-hospital birth, and we have the genetic preponderance to small red blood cells, which means that even when we're well-fed, and well-nourished, and well-loved, our hemoglobin is lower than their white counterparts.

So it was important for me to be in that space. But what it also means is that respect, that communities respect that my grandmother had may not be there for me as a nurse, and especially with respect to my white nurse midwife colleagues who don't live in their communities. I mean, I literally do. I live next door to my parents.

I live in walking distance to the hospital where my clients come for care. My camera will go off from time to time because when my phone goes off, it's often a client who's trying to reach me or a doula calling me. And literally, I walk through the community and see babies that I've caught and families that I cared for.

But as nurses, as nurse midwives, when we're in this space and we have the badge of authority in that office, doulas play a very important role because they truly are usually their client's contemporaries, their neighbors, and trusted and trusted friends. And as we navigate this space and work to build up the Black workforce of midwives as to what it used to be, I think they play pivotal roles. So thank you very much for the work that you're doing and thank you for the advocacy work that you're doing in Virginia and beyond.

DOMINIQUE TOBBELL: I would like to ask a question about the importance of the sources that each of you is drawing upon to reflect about the experiences of midwives and doulas, and mentioned in the fact that so much of traditional and community midwifery was based on an oral tradition. Doctor Fraser's work doing ethnography and Doctor Muigai, you mentioned the sources of Black parents who had shared about their birth experience that you were able to locate.

So I didn't know if any of you would like to speak further about what role sources play in making sure that we recognize and hold up the important experiential knowledge and incredible role that midwife and doulas have played in history, and how that history is important for informing the present.

GERTRUDE JACINTA FRASER: Well, I could start. I think there are these feminist philosophers who talk about testimonial justice or testimonial importance. Yeah, the importance of testimonial justice and testimonial empathy. I think why it's important to continue to document these histories is because I really think that what a part of what we have to convey and part of what we have to teach is the capacity for the powerful to recognize the testimonies and the stories of the marginalized as legitimate.

So it's not only documenting. It somehow finding ways to have like students in my class listen to these narratives and to be able to have the capacity to actually listen to these testimonies as a form of justice and as a form of deep empathetic justice for the marginalized. And so to me, it has to be it has to be connected. It's not only collecting the stories, but finding ways to have people actually be genuinely listen to these testimonies and think about what that actually means in terms of their own action.

So yeah, it has to go hand in hand and we have to find ways of listening to Dr. Muigai, Dr. Drew tell these stories, these deeply emotional stories and then how can we get people who are in a very different power position to be able to listen in a deeply empathic way.

WANGUI MUIGAI: I couldn't agree more. I think about it a lot in terms of historical empathy and historical justice in the way I [INAUDIBLE] and in my methodological approaches. And I think, particularly when you're looking at Black experiences within medicine, science, public health, it's so often Black bodies are positioned merely as objects of study upon which techniques are performed, observations are made, insights and conclusions are drawn.

And just to repivot and to work from the perspective of not even, first of all, just to recognize that it's not simply a story of exploitation and experimentation that we really do want to center and highlight and also consider the reasons why Black practitioners, Black patients have been marginalized and written out of the way we understand modern health care system, the development of medicine writ large.

But also to recognize and show Black patients, Black physicians, Black nurses, Black midwives, as decision makers, as making choices and not simply acting out of a necessity, out of a lack of choices, but is really thinking through what's available and navigating a changing health care system and changing societal structures in the face of quite explicit and terrifying violence and retribution.

And so the sources that I'm drawn to are where we can excavate that to the extent we can and hear in their own voices. But especially as it concerns issues of loss and death, because I think that as much as it is important to recognize widening statistical disparities and talk about maternal and infant deaths in the realm of statistics, that really covers up the fact that behind each of those numbers is an actual baby that died.

And in a parents, and family, and a community that mourned and witnessed and experience that loss. And whether it's about death or certain kinds of disease and debility, these are human experiences, and to really not get lost in the numbers. As much as they can tell a broad picture, they don't give us a grounded sense of what that looked like over time. And so that's my thinking in terms of what draws me to the particular kinds of archives, and records, and documents that look through.

MICHELLE DREW: Absolutely. And I look to the present work and I look at the work of somebody like Karen Scott who's an OB/GYN and an epidemiologist, and really is reimagining birth for Black birth givers. And the way she's doing that is through a lot of qualitative important work and her sacred birth study of just humanizing birth and humanizing Black families and Black birth givers.

Because as you said, to so many, I work in graduate medical education. And currently in a class of residents, the two classes of residents that I'm responsible for, there are exactly zero Black women, but yet 90% of the women whose births they will attend are Black women with Medicaid. So it's very important for us to see people through their lived experiences and understand why they rightfully don't trust the system.

Like today, I saw a mother, but more importantly, somebody who I didn't see as a patient, but who I know in the community, who according to the ACOG algorithm should have been delivered last week, but wasn't. And she came in for an appointment on a Friday afternoon and they were pressuring her literally to go upstairs to labor and delivery to get a C-section, and she said I'm not doing that until I talked to my midwife.

And I've literally never provided her care, but I see her in the community. I offer her encouragement, and support, and rub her back, and provided resources to her in other ways. But to this woman, I am her midwife, and she was not going to consent to be delivered until she'd spoken to me first, and that she just had someone who heard her, because the only thing she heard from the physician who was very well-meaning is, well, you're this gestational age and you have this preexisting condition and you have to go upstairs.

How did that make her feel as a human being? And one of the reasons I went from history to archives, and I love archives, I love to put my hands on things and then started studying genealogies and trying what I can to find the descendants, especially people who have living memories of the midwives and the community, is to be able to reverse that narrative, that we weren't just the necessary evil. They didn't just go to the midwives because white doctors wouldn't take care of them. As Dr. Muigai pointed out, they chose us. They chose my grandmother. They chose my great grandmother. They trusted her.

I mean, 23 years-- no, I'm sorry, 13 years. It was another 13 years after the hospital in town was desegregated and my great grandmother who by then was nearly completely blind, but who still had the hands, and the nose, and the ears of a midwife was still attending births even though all they had to do was get in the car and travel less than five miles to be attended by the physicians and the nurse midwife or midwifery service to attend their birth.

They chose her, and they chose her daughter, my grandmother and said, we know that we would rather pay these midwives out of our pocket when we can than to go to that hospital and give birth for free, because they are our midwives. And so those stories need to be told and they need to be heard for some of us, especially in the medical industrial complex so that we can appreciate exactly what communities are saying when they're saying that it's important to have a caregiver from their community that looks like them, that values who they are.

And especially as Black and as Indigenous people also lift up the work of changing women initiative. And Nicole Gonzalez in New Mexico who having done things that seem remarkable in her community going to get, not only a bachelor's degree in nursing, but a master's degree and was working in a large hospital in Albuquerque, New Mexico, but who left that structure that was harming her community to be able to reclaim out of hospital birth for Native American communities. And think of how important that is to both of those communities and how this country historically was built.

DOMINIQUE TOBBELL: Thank you. I think that's just an incredible way to end our discussion today. I just want to thank our incredible panel, Dr. Drew, Dr. Muigai, and Dr. Fraser. Please, I know we're all on Zoom, so we can virtually clap. But as you'll see from the comments, this has just been an incredible presentation and I'm so honored and privileged that you joined us and shared your wisdom, your deep historical knowledge with us and to all our audience members for participating in the discussion. So thank you so much. I hope you all have a good evening.

MICHELLE DREW: Thank you for having me. It's a joy to see you all.

WANGUI MUIGAI: Thank you.

SANDRA LEWENSON: Thank you, everybody. Great talks.