An Update on Midwifery in Alabama
by SHARON ECONOMIDES CPM, LM, IBCLC

In May 2017, the Alabama legislature passed a bill legalizing Certified Professional Midwives (CPMs) to practice midwifery. Alabama has a rich history of homebirth midwifery, which was systematically dismantled between 1921 and 1975.

To gain a context for the background of Alabama midwifery, I spoke with Shafia Monroe, who is the founder and the first CEO of the International Center for Traditional Childbearing (ICTC), and an organizer of black birth workers and midwives: “African-American granny midwives were the main providers of maternity care from the 1900’s to late 1960; and depending on the area, many midwives continued until the mid-1970’s. Granny midwives served the rural areas of Alabama and wherever black women could not receive maternity care due to segregation law.” Monroe goes on to say, “Many folks in Alabama are only one or two generations away from being caught by a granny midwife at home, most who I have spoken with remember their midwife. Numerous individuals over the years tell me that their mother or grandmother was a midwife, unlike many other areas of the US where the connection to midwifery care and homebirth is more distant” (S. Monroe, telephone interview by the author, June 6, 2017).

The groundwork that made the vibrant practice of granny midwifery illegal in Alabama was initiated by the Sheppard-Towner Promotion of the Welfare and Hygiene of Maternity and Infancy Act of 1921, which was enacted ostensibly to help improve high mortality rates in rural areas. One element of the act involved the requirement that midwives obtain midwifery permits from the state. In order to obtain a permit to practice midwifery legally, midwives had to attend health education trainings and meetings, and be supervised by and have their midwifery supplies inspected by nurses from the health department. The training instituted for the already experienced midwives involved rudimentary skills like hand washing, and dictates to discontinue the use of herbs, teas and other time-honored tools at births. These steps undermined generational cultural wisdom and insight into the natural process of birth (S. Monroe, telephone interview by the author, June 6, 2017).

Community midwives continued to attend births, balancing the public health mandates of modern medicine and the traditional wisdom of midwifery. However, the barriers to obtaining and maintaining current midwifery permits initiated the culling of midwives in Alabama: “Bureau officials had stated their intention to eliminate midwives who were unfit for practice. In brief, midwives who did not closely follow health department regulations would not be granted permits to practice in the state.” These increasingly stringent policies enabled further segregation, created greater barriers to healthcare, and eventually eradicated traditional African-American midwives and homebirth as an option for everyone in Alabama.

The limits on homebirth midwives coincided with the public health efforts to increase the number of births in institutional settings. In the early 1940’s, Tuskegee University created a nurse-midwifery training program, with support from the local health departments, with the rationale that “many of the sharecroppers who cannot afford medical care or hospitalization are left to the dubious care of the ignorant granny midwives, and it was hoped that the maternal deaths could be reduced by providing better care during confinement. The most practical plan seemed to be to train nurses to be midwives.” In 1975, the Ala-
By 2014, just 29 of Alabama’s 67 counties had a hospital that offers obstetrical services. What results is mothers having to drive over 50 miles in labor and sometimes to forgo regular prenatal visits because the time off work, fuel, and childcare costs simply aren’t economically feasible. Rurally disadvantaged mothers may choose to schedule medically unnecessary inductions or surgical deliveries in order to avoid unassisted spontaneous vaginal delivery en-route to the hospital.5

In Alabama for 2015, the overall infant mortality rate of 8.3/1,000 was higher than the national average of 5.8/1,000. By 2014, just 29 of Alabama’s 67 counties had a hospital that offers obstetrical services. What results is mothers having to drive over 50 miles in labor and sometimes to forgo regular prenatal visits because the time off work, fuel, and childcare costs simply aren’t economically feasible. Rurally disadvantaged mothers may choose to schedule medically unnecessary inductions or surgical deliveries in order to avoid unassisted spontaneous vaginal delivery en-route to the hospital.5

Jennifer states, “We introduced two bills for the 2017 session: a licensure bill and a simple decriminalization bill. The decriminalization bill is what sailed through the House. It was amended with the language from the licensure bill on the Senate floor on the last day of the 2017 session” (J. Crook, email interview by the author, September 26, 2017). The bill created a State Board of Midwifery which will regulate licensing and will include 4 CPMs selected by the Alabama Birth Coalition, 2 Certified Registered Nurse Practitioners, Certified Nurse-Midwives or Registered Nurses nominated by the State Board of Nursing, and 1 consumer of midwifery care nominated by the Alabama Birth Coalition.6

“Alabama is my paternal home,” says Monroe. “Since a baby, I have spent my summers there. This bill is a dream come true. It re-establishes the practice of community-based midwifery in the African American community.” Her future goal is to build an Ancestral Midwifery Learning Institute. She envisions a place where women will learn midwifery and reclaim the traditions and history of midwifery in Alabama.7

REFERENCES
In 2008, after many years of discussion leading to a consensus among the Maine midwives, the Maine Association of Certified Professional Midwives (MACPM) was formed expressly to bring forward a bill to license Certified Professional Midwives (CPMs) in the state. The 2008 bill gained bipartisan sponsorship, and passed through the House by a wide margin. The State House was full of families eager to talk with legislators about their choice of midwives and home birth. Similarly, the phone lines were humming with calls from constituents across the state expressing support for the bill. Then, in the 11th hour, the phone lines were shut down and families were turned away from the State House on the day the bill came to the Senate. Lobbyists for the insurance industry, the Maine Medical Association (MMA), and other medical groups came forward to question whether CPMs could determine whether a woman’s blood pressure contraindicated administration of an anti-hemorrhagic, or whether giving CPMs the right to administer intramuscular vitamin K to a baby might result in injuries to the femur. In a few short minutes, the exhaustive work of more than a year was undone, and the bill was defeated.

Three years later, on the national level, CPMs and CNMs came together to begin to imagine what a unified profession of midwifery might look like, with midwives practicing side by side in all care settings, guided by the educational and practice standards set by the International Confederation of Midwives (ICM). That conversation inspired the formation of US Midwifery Education, Regulation, and Association (US MERA). Over 3 years of meetings with leadership from the accrediting and certification bodies and associations for CPMs, CNMs, and CMs, US MERA reached critical agreements on educational and legislative priorities for midwifery that are in line with the ICM Standards. By building a consensus framework for CPM practice and education, these agreements significantly altered the landscape for licensing efforts across the United States.

Late in 2015, MACPM began to discuss the idea of introducing another bill for licensure. During the early steps of meeting with the Maine chapter of ACNM and the Maine Medical Association, MACPM struck upon the concept of writing the bill collaboratively. These organizations began meeting and soon had invited more stakeholders to the table, including the Association of Women’s Health, Obstetric, and Neonatal Nurses (AWHONN Maine) and the Maine Section of ACOG, in addition to Maine ACNM and the MMA. This collaborative, called the Maine Home Birth Collaborative (HBC), worked tirelessly with a facilitator for a year to write a licensing bill using consensus decision making. Meeting twice a month for many hours, these groups learned a tremendous amount about each other and about the maternity care system in Maine. At a mid-point in the process, the collaborative hosted a symposium, and invited 80 diverse stakeholders from every aspect of maternity care, including insurers and hospital administrators, to spend a day together learning about what the Maine Home Birth Collaborative had been doing and what they hoped to achieve. A wider conversation was begun.

The bill to license all midwives in Maine, including both CPMs and CMs, gained broad legislative support and passed easily. During the last days of deliberation, a pushback from some midwives began to be felt, stimulated in part by some of the compromises concerning multiples, breechesis, and vaginal birth after caesarean (VBAC) made within the statute itself.

The HBC sees its purpose drawing to a close as licensure gains momentum. Nonetheless, the bill passed. The summer of 2016 passed with no movement in the direction of enactment of the bill. Soon it became clear that nothing would be done to enact the bill and allow midwives to actually become licensed because the bill had no fiscal note to pay for it. Another bill was submitted in the winter of 2017, specifically for funding the implementation of the license. It passed into law in July, 2017.

As the HBC continues to work on identifying nominees for the Board and writing the Rules and Regulations for the license, it has embarked in another more far-reaching direction. The HBC sees its purpose drawing to a close as licensure gets funded and enacted, but recognizes a new, broader vision of the needs of mothers and babies in Maine. It is clear that families are choosing birth in many different settings, from home to birth center to hospital, and using a broad range of care providers. The HBC has grappled with complex issues of women’s bodily rights, informed choice, and mutual decision making. The Collaborative realizes that the question is not whether any choice is better or worse, but how can safety and access to care be best provided for all Maine families, regardless of their choices?

The new Maine Perinatal Quality Collaborative (PQC) was formed in response to this challenge, launching at a symposium on October 21, 2017. The PQC draws from the experience of several other states that are engaged in similar collaborations. It will have broad membership of organizations and individuals from every aspect of maternal and infant care, including licensed midwives from every care setting, both governmental and non-governmental agencies, for profit and non-profit groups, and consumers. The Maine PQC has developed a Vision, Mission, and Goals that will carry forward the aspirational vision of the HBC by creating an evidence-based system of maternity care for all Maine families based on data collection and analysis, peer-reviewed practice recommendations, integrated quality measures, and seamless consultation and collaboration, with respect for all family’s choices.

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