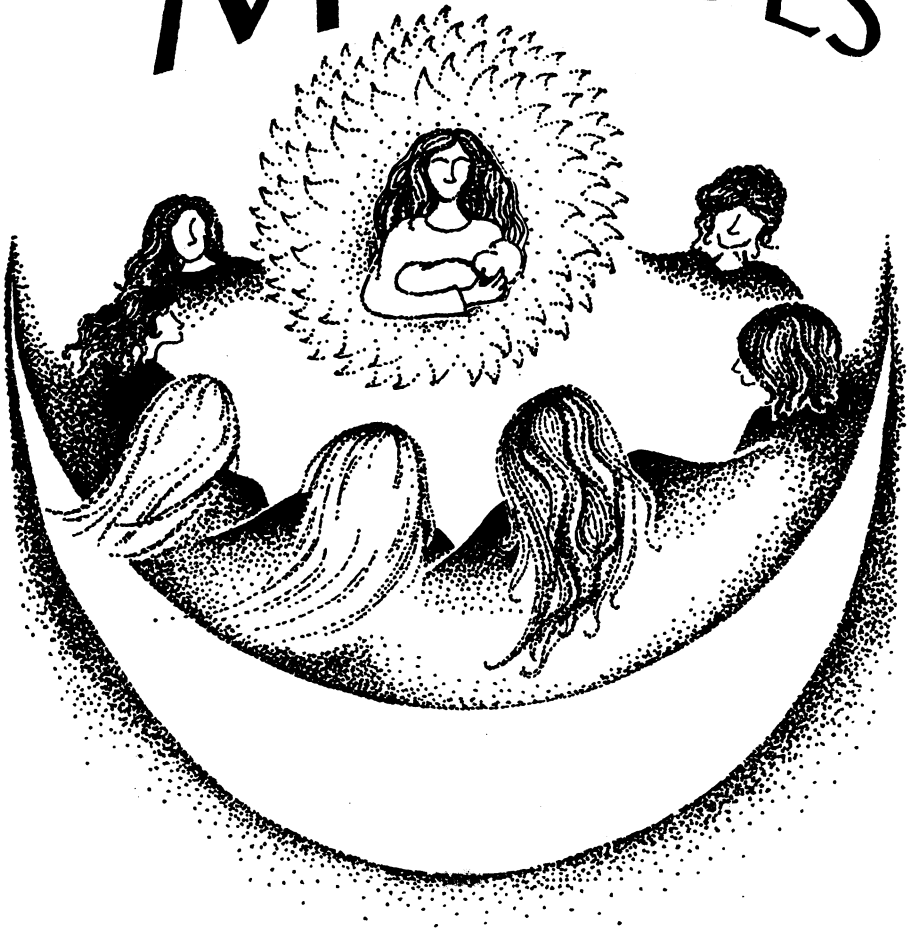
CIRCLE OF MIDWIVES



HILARY SCHLINGER

Circle of Midwives:

Organized Midwifery in North America

by Hilary Schlinger

Preface to the Second Edition

Twenty years have passed since I first set out to write the story of MANA, the Midwives Alliance of North America. During this time, the world entered a new millennium, computers and cell phones replaced typewriters and car phones, the internet went from obscurity to ordinary, the twin towers fell, ten new countries were established, world population grew by 1.6 billion, and more than 80 million babies were born in the US. From 1992 to 2012 the US cesarean rate increased from 22% to 33%, and the maternal mortality rate rose by 5 women per 100,000. Just over 8% of the US babies born this past year came into the hands of midwives, and one-tenth of these midwifery-attended births occurred outside of the hospital, in either a birth center or at home. Yet this was also the year when the World Health Organization and the United Nations came together to declare that "The world needs midwives more than ever," when the first US Homebirth Summit brought together multiple stakeholders to address shared responsibility for the future of homebirth, when Ina May Gaskin received the Right Livelihood Award and Robin Lim was named "CNN Hero of the Year."

In the time since Circle of Midwives was first published, MANA has given birth to multiple allied organizations with their own accomplishments: the Midwifery Education Accreditation Council went on to receive its federal recognition as an accrediting agency from the US Department of Education, the North American Registry of Midwives began granting the CPM credential, the National Association of Certified Professional Midwives was launched, Canadian and Mexican midwives formed their own national midwifery organizations, and the International Center for Traditional Childbearing now is in its twenty-first year. Midwives take part in the Association of Midwifery Educators, the Foundation for the Advancement of Midwifery, and consumers can make their voices heard via Citizens for Midwifery and The Big Push for Midwives. Childbirth Connection brings consumers and professionals together to promote evidence-based maternity care options. CPMs are licensed or

recognized by 27 states. Homebirth has gone from the fringes of society to the pages of the New York Times.

The face of the American College of Nurse Midwives has also changed dramatically. The first edition of this book recounted the conversations between MANA and ACNM representatives under the auspices of the Carnegie Interorganizational Work Group, which were seen as the first steps toward creating alliances and mutual respect between the organizations. One of the culminations of such work was the statement "Midwifery Certification in the United States," endorsed by the boards of both ACNM and MANA in the first months of 1993. The document acknowledged MANA, NARM and MEAC as the appropriate organizations to determine the education and certification of direct-entry midwives in the US. However, ACNM abandoned this position less than a year later, with the creation of its own direct-entry credential, the CM. And whereas the educational requirements for a CNM were an RN plus certificate in the years when MANA was first being organized, by 2011 all CNMs and CMs were required to have a Master's degree to sit the certification exam.

If so much has changed, then why revisit the past? I believe we are at a unique juncture in time, where opportunity abounds for midwifery as a profession, if only we act with thoughtfulness of direction. Furthermore, I believe that charting our future path includes examination of where we have been, of our original dreams and goals, of both the progress and pitfalls we have experienced along the way. The multiple organizational "players" on the field can work at cross-purposes, or with unified action. They can get caught up in a veritable tug-o-war over who is best positioned to lay claim to the title "midwife," can argue over which group holds the corner on the 'best' or 'most legitimate' route for education and certification, can make exclusive alliances which result in the seeming betterment of some, but leave a large number of their sisters out in the cold. Or the organizations and the individuals who comprise both their boards and membership can choose a different path. They can choose the path of unity.

At a recent CPM/midwifery educator symposium, I sat at a table marked 'unity,' where a group of midwives elaborated characteristics they felt must exist in order for midwifery to move forward as a profession in the US. These included respect and support among the allied organizations, allowing for communication, & working collaboratively on projects and initiatives, with an

honoring of the strengths and actions of each organization. They called for practical collaboration within the profession, with shared educational and clinical opportunities, and an articulation of shared values. The group, comprised of all 'flavors' of midwives, felt that basic unity was an essential component in moving midwifery forward in the US. They identified barriers such as lack of understanding, defensive posturing and scarcity mentality which hold midwifery back, but saw the vision of unification as a means for re-establishing trust and building a future that encompasses all certified midwives.

On the plane home, I was left pondering the question of, "How do we get there from here?" I opened my laptop and brought up my pdf of Circle of Midwives. And in those two-decade-old voices, I found answers. Maybe not *all* the answers, but a map set out as goals in 1982. "To educate the American consumer regarding midwifery care." "To develop unity among all midwives in America." "To promote better cooperation between midwives and other health professionals and non-professionals." A philosophy which believed "that cooperation and strength among midwives will assure the future of midwifery as an established profession, thereby improving the quality of health care for women and their families." As I read the passages by midwives I had interviewed, I heard their voices in my ear; I heard Valerie Appleton explaining how she went from fear of being "sold out" to trusting in the process, Mari Patkelly reminding midwives to see themselves as the source of positive energy, Carol Leonard describing the meeting in Boulder as 'where we fell in love.' I realized that those voices are needed *right now* by the US midwifery community – that we need them as we chart our profession's path.

So aside from adding this preface, I have not changed the manuscript. I want you to read the voices from the past, and hope they speak to you as loudly as they do to me. And to paraphrase my own words from 1992: *I hope you join me in continuing to explore new ways of relating to each other, to make sure all our voices are heard and respected. Join me in making MANA the place where all midwives can be at home.*

Hilary Schlinger
Albuquerque, NM
July 2012

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Introduction

We are sisters on a journey, Shining in the sun.
Shining through the darkest night. The healing has begun, begun.
The healing has begun.

We are sisters on a journey, Singing now as one.
Remembering the Ancient ones, The women and the wisdom.
The women and the wisdom.

We are sisters on a journey, Shining in the sun.
Shining through the darkest night. The midwife's time has come, has come.
The midwife's time has come.

This is a book of where we have been. It is a book of where we now are. It is a book of where we are going. The past, present and future are all intricately linked. As our skills as midwives are passed hand to hand, so are our views of midwifery itself.

This is also the story of the evolution of a women's organization. As such, it is a document revealing the search for alternatives to patriarchal structures. It is a chronicle of women and their attempt to move beyond the scope of a "professional organization," of their striving to include a diverse group of women with a common calling. It is of their visions that stretch to women's status in our society, women's value as healers, and the valuing of women's ways of knowing, teaching and sharing.

I have learned an incredible amount in writing this book. Sharing the outlook of so many different midwives has caused me to carefully evaluate and re-evaluate my own beliefs about midwifery, and about the role that MANA, the Midwives' Alliance of North America, should play in shaping the midwifery community. By learning about the evolution of the organization, I have come to a greater understanding of where we are today and the choices that lay before us. I can only hope that my readers share in this awareness, and that it can be translated with deliberation to our future decision-making.

I originally set out to write a "definitive" history of MANA. Shortly into the process, I realized that the women I was interviewing were wonderfully eloquent, and that I could not improve on what they were saying or how they were saying it. Thus I shifted the direction of my work. I chose to let them tell their story. I have inserted my opinion infrequently; my voice, which appears in italic print, generally serves as a transition between the narratives and articles. Rather than follow a time line, I have organized the book by topic, to help the reader see the evolution of thought within the various aspects of midwifery.

There are also many women who played a part in MANA along the way whose names do not appear. I was not able to find some past participants due to address and/or name changes, while others chose not to answer my inquiries. As you read, please keep in mind that I have interviewed approximately thirty women, but hundreds have been members during the past decade, and many of that number have contributed in some way to MANA's evolution.

There was also no natural end-point to this history; even as I finished my manuscript, new challenges and decisions were emerging. This document is simply the first step in the on-going process of recording the rebirth and growth of North American midwifery.

A few of the women I talked with have changed their name in the course of the past decade. MANA's first president Teddy Charvet is now known as Therese Stallings, Valerie Appleton is also referred to as Valerie Hobbs, Susan Leibel has hyphenated her last name to Leibel-Finkle, and Pat Kelly has become Mari Patkelly. I have used their current names in labeling their interviews, but did not change references in older documents.

In this book I have chosen to use the term "direct entry" to describe those midwives who come to midwifery without being certified nurse-midwives. Some of these women have been trained in formal settings while others have not; some are nurses, some come with different backgrounds. I do not claim to use "direct entry" in keeping with any international definitions or regulatory usage. If you have a term which you prefer, or do not like qualifiers to the word midwife, feel free to edit your copy accordingly.

And now, enjoy your visit with the engaging and intelligent midwives whose voices lay within.

Hilary Schlinger
LaFayette, NY
August, 1992

I went to the first MANA conference as a person who was really against organizations. I thought certification was buying into the system and all this kind of stuff. I was so impressed with the process that I saw there. The things that came out of that meeting were really very exciting. We'd sit down with something that might have been modeled after any pretty patriarchal kind of document, and then we'd change it. It might even be just a word; for instance instead of 'Standards and Practice for Midwifery' it became Standards and Practice and we'd include the word 'Art.' And that was exciting.

I became involved with the idea of trusting the process that would go on. No matter what the issues were, I felt that people were dedicated to a good ideal. And as I kept going to conventions, I kept being more and more impressed with it. Instead of anybody selling me out to anywhere, I felt like people were really voicing, not necessarily my opinion, but a correct opinion. I thought people were reaching to get something that was ethical and true.

And then as I went to more and more meetings I realized that when I wanted to go home as a midwife, I went to MANA. There wasn't any other place. I came from a state where midwifery was a felony, and there wasn't any local organization at the time. I didn't have a very good relationship with other midwives in my area and no one had a good relationship with the medical community.

It was great to go home somewhere.

Valerie Appleton

What a wonderful idea: MANA, home for all midwives. And, like most family homes, the Midwives' Alliance of North America has been full of colorful personalities, internal struggles and changes over time. This is the story of MANA. It is not the "true" history, told from an objective standpoint. Instead, this is the story as seen through the eyes of the women involved in MANA through the years, as each remembers events, as the story unfolds in their own words.

Before the Fact

There have been midwives in North America down through the generations. First were the Native midwives, then the European and African midwives who came over on ships. And subsequently, midwifery skills were handed down in communities all over the continent.

Just as women come to midwifery from so many different routes, the roots of MANA drew from many different places. In the years before MANA, some midwives in North America had contact with each other, often informally, sometimes through organizations. There were the American College of Nurse Midwives (ACNM), the International Confederation of Midwives (ICM), the National Association of Parents and Professionals for Safe Alternatives in Childbirth (NAPSAC), the Association for Childbirth at Home International (ACHI), the American College of Home Obstetrics (ACHO), Home Oriented Maternity Experience (HOME) and the National Midwives Association (NMA). Some would even place La Leche League in that list...

La Leche League was just a breastfeeding organization, but it took on so much more meaning. Not only breastfeeding your baby, but a whole philosophy of family, of who women were and what we were, and how powerful we were. The whole homebirth movement started out of La Leche League.

That's what I believe. A lot of us young mothers who got involved with La Leche League, where did we hear about home births? Where did we hear about challenging the whole birth system? Through the founding La Leche League mothers, these ladies with their white gloves and their little pillbox hats. They were the ones who were having homebirths.

We started learning about nutrition through La Leche League. Natural childbirth, through La Leche League. Look at Lester Hazell, Doris Haire, they're all La Leche League people. Gregory White, Robert Mendelsohn, Marion Thompson, all of the founding mothers. In all the old La Leche

League newsletters they were talking about their homebirths. Where do you think we heard about it?

I once said to Marion Thompson, "You know, your La Leche League was one of the most important women's groups in this country. It was a feminist group." I don't know that she wanted to hear that, but yes it was. It was in those La Leche League meetings that we had our consciousness raised, that we found a group to talk to. This is where our network was. I used to bemoan the fact that when I started out as a new mother I didn't have an extended family. So we created our own extended families in La Leche League. That became our extended family. So if you want to really look back to the roots of MANA, start it back then.

Fran Ventre

The paths into midwifery are varied, and so are the paths into organization. Here are some stories of the work of MANA's 'founding mothers' prior to MANA's existence, their work as midwives and their work as organizers. Fran goes on to tell of her involvement...

I started off about 20 years ago in the Washington DC area as a childbirth educator. I then got involved with the homebirth movement because a lot of my friends were having homebirths and I, as a teacher trainee, somehow got involved with being at them. I really got very affected by it. There were some other childbirth teachers there at the time who were involved in home births, and when my best friend had her baby, the doctor who did homebirths in the area didn't make it, so two of us ended up assisting at the birth.

We started attending homebirths and helping other people who were having homebirths. We then decided, about '72 or '73, that we needed to have a support group. We started the organization called HOME - Home Oriented Maternity Experience - to establish this support group. The HOME organization put out newsletters and wrote a book, a manual on homebirths based on our four classes or orientations for people who were having homebirths.

I got licensed as a lay midwife in Maryland in '75, and wrote an article about how I got licensed. The article got picked up by Madelyn Shearer, the editor of then "Birth and the Family Journal", who published it. Then one

of the lawyers that I worked with did a research of laws in the whole country and found out in which states women could get licensed as lay midwives, and we published that chart in our next newsletter. So a lot of people started to question their legal systems to get licensed.

In the meantime I was going back to school. I became a nurse, eventually went to Georgetown University to become a nurse-midwife and then moved to Massachusetts. I found out it was illegal to do homebirths in Massachusetts as a nurse-midwife, so then I started working to change that law, which now has been changed. I also started the first birth center in Massachusetts.

It was at the NAPSAC convention in Washington DC in 1976 that I first met up with other people. I met Shari Daniels and Nancy Mills, and we got together and somehow we started talking about the need for a separate conference just for midwives. We decided that the three of us would try to do this together. And that became the El Paso conference that Shari Daniels sponsored. I have to be honest; Shari Daniels did most of the work.

It was an unbelievable conference. It was like we had been hungry for so long, and a banquet was served up. I think for all of us it was the first time we came together and met all of the people we had read about. And it was unbelievable, the first time this had occurred. It was wonderful, just wonderful. Suzanne Arms was there, Nancy Mills, Ina May. That's where I met Carol Leonard; she was just a baby then. I don't mean that in a negative way. We were all babies. It was the most exciting conference I can ever remember because it was the first one. We all came together and felt like, "God, there are other nuts just like us. We're not crazy, we're not crazy".

I almost didn't go to nurse-midwifery school because of that conference, because of Stephen and Ina May [Gaskin]. They tried to say, "You're selling out." And Dorothea [Lang] was saying, "No, apply to midwifery school." One of her proteges was the director of the Georgetown University program. I was going to drop out of nursing school; I had one semester left to go and I was going to drop out. That's how profound it was. It was a great conference. I don't remember the content, but those of us that came got to meet the people that we'd read about for years and years. Raven Lang was there... to me, big, big names. That's like seeing Elvis.

That was in 1977. It was a good four years from then until the first MANA meeting. This was just like the continental congress and all the little rumblings that go on. This is where people met for the first time. It is

part of the history of MANA, all of these isolated events that brought us together.

One of the things that happened with Shari Daniel's group, the National Midwives Association, was that it became associated with one personality. The same thing with the group with Tonya Brooks, ACHI. These organizations developed more the identity of a single person rather than a democratic organization that was to represent midwives. I'm not putting down the other people. They served a very important role. I think Shari Daniels has been forgotten, and I think she made an important contribution to midwifery. And I think the El Paso conference was significant as part of MANA. That's where everybody met. It should be in the history.

Fran Ventre

Meanwhile, midwives from other parts of the country were working hard to change the status of midwifery in their states. Some formed local midwifery organizations as the need arose, and challenged the status quo. Here's another midwife's tale:

My first involvement with midwifery started in 1971 in Colorado, where I met a physician who provided home delivery in a rural, economically depressed area of Colorado. I moved to Taos, New Mexico in 1973. People knew that I had gone to births in Colorado, and I started attending homebirths. I went to work for Holy Cross Hospital in Taos in 1975, initially as a nurse's aide and then as an obstetrical technician. They knew that I was also a practicing midwife.

In 1977 I went to a conference where I met Dorothea Lang, and was first introduced to the International Definition of a Midwife. At the time in New Mexico it was impossible to get a license to practice midwifery, but the midwifery law had never been taken off the books. In other words, there was a decision via memorandum that they wouldn't be distributing licenses anymore, but they had never changed the law. For 16 years there had been no new licenses issued. There was also a move to separate Health and Environment from Social Services in New Mexico, and there was a legislative act which separated this large department out into two separate departments. And when the attorneys for the state started looking at who handled what, they came across a problem. They had a midwifery law on the books and they had a department that wasn't following it and issuing

licenses. All they were doing was regulating the practice. So the initial thought was that they were going to ask for the legislature to rescind the law.

On a really short notice, I was advised of this problem. It was interesting because a physician had told me I could force the state to license me, and I was trying to figure out what was going on when all of this happened. At that point the choice I had was between taking the state to court and forcing them to issue a license to me, and pushing to get them to start re-issuing licenses. So I opted for the second. I called together a group, and we formed a midwives' association in Taos. We called a meeting together really fast, and I wrote a pilot project for the State of New Mexico asking for a year to do a feasibility study. By utilizing the midwives' association, the physicians in Taos County and consumers to approach the re-issuing of licencing and regulations from a joint perspective, we were successful. The state did give us a year to put that together. And in the meantime the state hired a certified nurse-midwife to start drafting some proposed regulations.

Also, as it turned out, the secretary for the state medical society happened to be this old doctor, Dr. Pond. At the hearings, he refused to give the position of the state medical society, which was to oppose licensing us, and instead opted to speak on our behalf. So we got it through. There were 5 people that sat for the first midwifery exam. Essentially, our regulation recognized apprenticeship educational routes. I sat on the first advisory board for midwives.

Tish Demmin

Others approached midwifery from a different perspective.

I was a nurse. Then I went to midwifery school and I became a certified nurse midwife in 1972. I moved to California right around that time, and found that there was no legal basis for me to practice. At that time I got to know a lot of people who were involved in the home birth scene, a lot of lay midwives. Suzanne Arms is out here, and she was gathering information to write a book to be called Immaculate Deception. Santa Cruz was alive and well. Kate Bowland, Raven Lang -- these were people I became familiar with and got to know, and I began to really respect what they were doing. Initially I was sort of a conservative East Coast person and didn't think this was appropriate, but I really put on a more objective, critical head and said, "Yes, they're meeting a need."

I've always had an interest in public health issues, and I think I began to see this as a feminist and a public health issue. I certainly have no attachment to nursing, so from that standpoint I could see midwifery as discrete. Also, what set into this very neatly was that in the mid-seventies I became a member of the Board of Directors of the ACNM. I was on the board for two years and Dorothea Lang was president for one year and Helen Burst was president for the other year. Dorothea and I used to chat; she's European and grew up in Japan and was very into the Dutch model of midwifery. I thought it made a lot more sense than what we were doing. So I became a supporter of direct entry midwifery.

I was starting to work on legislation in California. They had an old law on the books to license midwives - it didn't say nurse-midwives - but they stopped doing it in 1948. There were efforts being made to work with legislation and create legal basis for nurse-midwifery practice. I heard it was the last actual bill that Ronald Reagan signed into law as outgoing governor of California. So we got legislation passed that would allow us to practice under nursing, under the Board of Registered Nursing. I wasn't really working actively to promote any legal basis for direct entry midwifery at the time, but certainly I was against the criminal invasion of it.

Susan Leibel-Finkle

Not all focus was on legislation. Some women were meeting with the grand midwives and finding out about the wealth of midwifery knowledge the world over.

The first networking I had done was at Tuskeegee. I was invited there by a public health nurse named Selma Walker. She was the person who kept an eye on how the grand midwives were doing. She was worried that the state was going to be unlicensing them, and she felt that they were needed in the community, so she did things like organize continuing education for them so that they had up-to-date information. This was in the late seventies, about 1976. I was invited to come down there and be part of that. They were so excited to know about young midwives that I just felt taken in. It was like getting a really good hug by somebody really loving. I was just surrounded by them, and they were so gratified to see young people taking up midwifery. From then on we exchanged addresses and later they got

"The Practicing Midwife", which began about a year after that.

I was very impressed with them. I had met a couple of nurse-midwives before, newly graduated, but I could feel the confidence these women had. I had had my kids just a year or two earlier, and I related to them as midwives. My feeling was that I really trusted them.

My next contact was when I went to Guatemala. I met a Jamaican-trained woman there who had been midwifing in the highlands of Guatemala for quite a while. She had trained according to the British system as it existed in Jamaica, but she had learned from these indigenous midwives. She's the one that taught me how to deal with shoulder dystocia; she had learned it from the indigenous women. Again, I was very impressed with her; she knew a lot. She had to deal with birth without much medical backup at all, without an ambulance or anything like that.

I had gone to Guatemala through Plenty, our village, rural development and relief organization which we started out of The Farm in 1976. There was a great earthquake in Guatemala, and it wasn't too long after sending some carpenters down there that we had their families go down. They started having babies down there, so we sent midwives down. People were bringing us dying babies. We taught people how to raise soybeans and how to make soybeans into available protein. And so we did deliveries down there too.

"The Practicing Midwife" was started shortly after that. I think it was in January 1977 that that first international conference for practicing midwives was organized by Shari Daniels in El Paso. I went down there, and two of the midwives that I met in Guatemala came to that as well. There was an attempt to organize a midwives' organization at the time, but I wasn't comfortable with the way it was coming down. It appeared to me that it was going to be some kind of a hierarchical deal, and I didn't feel I wanted to be much of a part of that. I was a little worried about the prematurity of it and the way it was happening. But out of that we did agree that we would have a newsletter, which we volunteered to do out of The Farm. That became "The Practicing Midwife".

That was a kickoff time. It was out of the conference that the discussion came of the need for midwives to open lines of communication. I believe the NMA came out of that meeting as well.

Ina May Gaskin

One common thread through many of these stories is the coming together at Shari Daniels' El Paso conference in 1977. Another story involving that period of time is told by Dorothea Lang, who had been working with midwives in two other organizations, the ACNM and the International Confederation of Midwives (ICM).

In the latter part of the '70's there was an obvious need for someone to represent or to be an umbrella for all the midwives that were not called nurse-midwives, or maybe I should say all birthing personnel that were not called nurse-midwives, and whom ACNM would absolutely not consider part of their fold. For nurse-midwives, being active in NAPSAC or participating in anything that was outside the ACNM seemed like you were leaving the flock, so to speak. I went to one of the first midwives' meetings that Shari Daniels had under the National Midwives Association. That was something almost parallel to NAPSAC; NAPSAC took care of the parents, the Association took care of all birthing personnel. And since it was called 'midwife', I was very interested. I remember going incognito, hoping nobody would see me because I was afraid they would stop me from being ACNM president. I was president-elect or president on the board, and had been on the board of ACNM for 12 years before that. I felt I was always representing them, and to be attending another organization's meeting seemed tricky.

I always said that ACNM should have a broader scope. Philosophically I thought it should be the American College of Midwives, and reach out to some of the people who were either foreign trained... essentially reach out to what I would now consider the International Section of MANA. It would just be a philosophical change. They could have done it by the stroke of a pen by saying, "Look, we're going to now be an association of American College of Midwives, like the Royal College of Midwives." The Royal College of Midwives, which we were really looking up to as being the mother of organized midwifery, had an association that included all people who called themselves professional midwives by training, and the two routes of education were the direct entry route and the post-nurse route; they always had both routes.

A lot of us said that we must open our hearts and minds to a different type of entre into professional midwifery. There was always the movement within the college [ACNM] to say that we're not extended nurses, which I fought tooth and nail to preserve. We're professional midwifery that

happened to be nurses, but we are not a sub-group of nursing. With that in mind I became a president, and two or three members of my board fought tooth and nail that I was not allowed to use the word 'midwife' when I represented the ACNM; I always had to use 'nurse-midwife', or else I would be impeached. So you can tell that the backlash was tremendous, because they knew my philosophy. They were afraid that I would walk away with the dynamic core of nurse-midwives who helped establish nurse-midwifery in reality. I would say they did it under the title nurse-midwife only because that was the only way to do it. Truthfully speaking, we were the ones who cracked the hospital and created employment for midwives in the hospital system.

I remember having meetings with Ina May Gaskin during my presidency, and with some of the dynamic leaders from ACHI. I always spoke on behalf of ICM international. I couldn't speak for ACNM, so I always pushed the International Definition wherever I went. That gave me the power to speak on the professional midwife. I was on the ICM board, and was functioning in some way with ICM ever since 1972, when I was a fund raiser for ICM Congress. I was English Recording Secretary once, I became Regional Representative, and after a rule change became Regional Rep for MANA. So I have many, many years of ICM involvement. But that gave me the legitimacy to be able to function and touch bases with both nurse-midwives and other birthing personnel, some of whom were midwives.

I kept saying, "There must be another organization". Since I had been saying that for so long, ACNM was afraid that I might turn the ACNM into something that they didn't want it to be. I remember talking to Helen Burst, who was ACNM president after me, and saying, "Helen, you're now the new president. You've got to reach out to these people." And she didn't know if it was premature, yes she would, no she wouldn't. She served two terms, which was four years. Now, in my era I tried to change the definition of the nurse-midwife, and they would not let me pass it to my board of directors. But when she went in, she was ready to publish her book, and she wanted a new definition in the book before it got published. So she got it through the board during her first year. The definition was key in that it said that a certified nurse-midwife is a professional educated in two disciplines, nursing and midwifery. That changed the concept, that a nurse-midwife was not necessarily an extended nurse. She was a person who was educated in two professions. It acknowledged midwifery as a profession, a key factor ACNM was refusing to acknowledge for many years.

Now, that is only preliminary to the agony of knowing that there's got to be somebody else who's legitimately a midwife who's not a nurse. That's all the molding and the thoughts that were coming around. In California by that time they had something like two thousand women who called themselves midwives who were doing births in the area of San Francisco. In the earlier days, the ACNM was trying to distinguish itself as being different from the granny midwives in the South. Now for the first time, really not so much in my era but in Helen Burst's era and onward, it was becoming that this group needed to be recognized and dealt with.

Midwifery rumblings were being felt from all over the country. The call was coming for a new organization to form, one which represented all midwives. A meeting was called by Sister Angela Murdaugh, one which set a ball in motion. Out of that meeting came MANA -- The Midwives' Alliance of North America.

When Sister Angela took over as ACNM president, she said, "Enough of this." There had been some discussion in the ACNM open forum about needing to reach out, and she just said to herself that she was going to do something, and went on and did it. She almost got impeached at the next convention for meeting with these people and setting up a new organization. She said, "Who needs to be president? Impeach me." Of course there were a lot of us who supported her, and she was not impeached. Some of us felt it was absolutely right on target that she did this, and we were very pleased.

So now we've come to the point of why it was started, the political issues. Shari Daniels became ill. And so automatically there were two or three years where she was not meeting, even though at one time I thought she would be the organization that eventually turned into MANA. But Shari Daniel's group really became more Shari Daniel's baby, but not a leadership that was national. Then she did not do so well physically, it was a recess, so to speak. There were two or three years of nothing.

When MANA began, it really took hold. It was desperately needed, and that's why it flew so well.

Dorothea Lang

MANA Beginnings

The Midwives' Alliance of North America was founded in April 1982, to build cooperation among midwives and to promote midwifery as a means of improving health care for women and their families. The impetus for the formation of the organization came from a group of midwives with diverse educational backgrounds who believed that the time was ripe for unity.

When MANA was founded, there were many organizations which midwives had been instrumental in organizing or that provided a means of communication among midwives. However, none of these had a broad enough membership base or internal support system, or the credibility and political strength necessary to promote midwifery as an accepted part of the maternal-child health care system in North America.

The American College of Nurse-Midwives was the only professional organization of midwives that promoted inter-professional relations, provided guidelines for midwifery education and practice, and that had developed a reliable communication network. But ACNM membership was limited to certified nurse-midwives.

Many nurse-midwives were eager to open communication with midwives outside of the ACNM but were thwarted by the lack of an equivalent organization with which to establish formal liaison. Many midwives recognized the vacuum that needed to be filled. Certain ones had the vision, leadership and organizational skills necessary to instigate the formation of such an organization. One such midwife was Sister Angela Murdaugh, President of the ACNM from 1981 to 1983.

Excerpted from MANA News supplement, July 1985

I was elected president of the American College of Nurse-Midwives at the ACNM convention in 1981. Every year they have what they call an open forum. At the open forum that year there was a discussion about whether midwifery should be nurse-midwifery or midwifery. Since I was taking my new position as the president very seriously, I figured I'd better

sit down and really listen to what people were saying, and so I did. I would say the people who came to the microphone to talk in that open forum were split about 50-50 about whether it should be one entry form or the other. But something that kept coming up over and over and over again is, people kept saying, "We need to be in dialogue with lay midwives. We need to be in dialogue with them." And at that point there really wasn't a formal dialogue of any kind going on, or any way to even enter into a formal dialogue with anyone. I guess that was in my mind, and continued to nestle there.

I had in my day certainly met up with a fair amount of people, so I set about to sending out some invitations to a meeting. My invitations were mainly towards nurse-midwives who had been non-nurse midwives before they became nurse-midwives or who worked with them in some kind of way, and then, of course, the few lay midwives I had met. At that time I had met most of them through NAPSAC. Ina May was there, and Teddy [Charvet] was there, Carol Hurzeler, who was a nurse-midwife out in Lakadosha, Texas, Susan Leibel in California, Genna Withrow from Georgia, Helen Jolly, and the other person was a nurse-midwife who had been a lay midwife for a long time up in Massachusetts, Fran Ventre. Anyway, that group came together at the ACNM at our invitation, and I was able to get NAPSAC to pay for several people to come, so that they were sponsored in. We spent a day together; I don't remember the exact day, but it was a day in October of 1981. I expressed my opinion, especially about the principles of practice and my feelings that there needed to be some kind of dialogue between lay midwives and nurse-midwives, and that I wanted to set the stage for that to begin. And that's it. I tell you, I'm always telling Ina May, I'm given far more credit than I deserve.

They took the ball and ran with it. Ina May says, "You're always being so modest," but I always feel exactly like in this telling. It wasn't that big a deal. I made some of my own members unhappy and I made some of them very happy, but I knew that was going to happen, because there was such a division already. The division as the years have gone on has become very minimal, really.

MANA has been an up, up, up process. I think there's a tremendous amount of maturing that happens every year. I see more and more of that. I see more of it as the MANA conventions occur. I think that it's just good, it's just plain good.

Sister Angela Murdaugh

In 1981 Sister Angela called that meeting. They invited the Seattle Midwifery School to send a representative, and I was chosen. If there's anybody that had that inspiration, that person that just infused us with a mission, it was Sister Angela. There was a mixture of CNMs and direct entry midwives around the table, and she said, "There's all this problem because ACOG and everybody wants to communicate with direct entry midwives, but there's no cohesive organization that's representing them." And then she just looked at each one of us. I don't know if everybody had the feeling I did, but I just felt like she zapped me with this mission, to be a part of creating this organization. I was just infused with it. I was fresh out of school, so it wasn't like I was a midwife grounded in much experience or anything, but I just knew that this was what I should do.

In the course of my two years in school, I'd seen that there were foreign-trained midwives, there were the domestically trained, at Seattle Midwifery School, then there were the nurse-midwives, and we were all floating in our separate spheres. There was some animosity and mostly not communication. So for me, there was that whole sense of needing to get midwives together, to quit working against each other. Ina May clearly felt that too, because ten years later she's still at it. Ina May, Fran Ventre and I really picked it up and started running with it. That was Halloween, 1981. It seems like only yesterday.

Then there was that first meeting in Kentucky, where we tried to go out to a larger group of people. We tried to publicize it to see if people would come. It was actually a fairly big meeting; I think there were over a hundred people there. For the next meeting, which was in Boulder, Colorado in the fall of '82, we sent out flyers to everybody that had responded so far and said, "We're going to try to have a working meeting." Twenty-three women came, and that was where we really hammered out a lot of the structure. Then the next spring we met in Los Angeles with the ACNM conference, and that's when we actually did write by-laws and hammer through them.

We had a lot of CNMs helping us set up the organization's structure, and we just used their whole trip as our model. Our vision, at that time, was that MANA would eventually take in the ACNM and be the umbrella organization for midwives in this country. We modeled our by-laws on them, we modeled our whole structure on them. We didn't just take the ACNM stuff and use it lock, stock and barrel; we combed all through it and hashed and rehashed. We said that we wanted to make this as close as

possible because at some point maybe there will come a leap and we'll all come together.

Therese Stallings

MANA was born out of an idea that Sister Angela Murdaugh had. She was concerned about midwives having low status, putting in an awful lot of hard work, taking an awful lot of hassle and still not being recognized. Well, what she did was she invited about 8 midwives to this meeting we had at the ACNM offices, and Susan Leibel came out of that being the interim chair. We agreed that we would get some word around to midwives throughout the country, and have a meeting at the end of the ACNM convention that was going to happen in six months. I was at both of those.

[Would you say the organization was officially born at the Lexington meeting?]

I guess that was more like conception.

[And the meeting with the 8 of you was the preconception counselling?]

I think so, that's right. And there was Sister Angela, who had the gleam in her eye.

When she gave the state of the ACNM address at the ACNM convention in Lexington as the outgoing president, some of the remarks she made indicated her concerns. She saw that midwives take an awful lot of hassle, that a tremendous amount of work goes into getting an education and then recognition does not necessarily follow. If the midwife, even working in the hospital, wants to carry out her philosophy of care, she can never leave the woman's side. If she leaves for a minute, then there's an IV line in by the time she gets back, or whatever. She was concerned about these things, and with the fatigue that came with that. So she hoped to see a strengthening.

I also saw a tremendous need for midwives to get together, because I just knew that if midwives were working at cross purposes it would be very easy to keep us down. I've always been interested in women getting power, ever since I figured out that I was female and that power wasn't just there. Then, with becoming a midwife, you feel that's what your work in life is to do, and then you find out how difficult it is to carry that out in most situations.

Goals of MANA April, 1982

Short-range Goals:

- To set up a professional organization that would include all American midwives.
- To expand communication between all types of American midwives.
- To host a national conference in the near future whereby more organization details could be worked out.
- To establish a membership list and begin building a financial base.

Long-range Goals:

- To set educational guidelines and the development of innovative educational opportunities for midwives.
- To achieve membership in the International Congress of Midwives.
- To develop a certification process for lay midwives who desire it.
- To pool statistics of midwifery practice and other pertinent areas.
- To educate the American consumer regarding midwifery care.
- To develop unity among all midwives in America.
- To promote better cooperation between midwives and other health professionals and non-professionals.
- To establish an acknowledged and respected national organization representing the professional midwife in North America.

Philosophy of MANA July 1983

We believe that cooperation and stength among midwives will assure the future of midwifery as an established profession, thereby improving the quality of health care for women and their families. Midwives provide comprehensive care and education for women and their families encompassing their physical and emotional needs and fostering their self-determination.

At The Farm we went through the process of putting together a community, getting a big chunk of land and then having hundreds of babies in buses and tents. We were too big a chunk to be assimilated, and by the time that MANA got around to being organized in '81 and '82, we had had 1300 babies and we didn't have the state pressing on us.

I mean, here I was having figured out a great big hole in the wall, not having consciously gone after it in that sense, and I wanted that for every midwife in the world, really, because it's so obviously the right way to do it. Why shouldn't everybody enjoy that freedom of practice, that commonsense, practical way of achieving good results? Not only good results so far as infant mortality goes, but the whole spread on relations between men and women, in the way that you don't have a war between the sexes, in the way that you don't have spouse abuse, in the way that you don't have child abuse. I saw it as a way to solve a considerable chunk of problems of modern life. You know I've always been convinced, from the time that I got into this work, that as a society we're doing it all wrong, and that we need to utterly change it.

So this looked like, at last, a chance to get together with a bunch of educated, intelligent, fiesty women... well, quite thrilling.

Ina May Gaskin

When Sister Angela became president of the American College of Nurse-Midwives, she got the idea that it was time to get nurse-midwives and lay midwives together. When I say 'lay midwives,' it's just to differentiate non-nurse midwives; we don't know what to call ourselves anymore. She said that she felt it was time for the two groups to get together and try to work something out; that we all had the same aims. She was going to sponsor this meeting as the president of ACNM in Washington DC. Could I suggest some lay midwives? Of course I did. Everybody assumed Ina May would be invited. I did mention Nancy Mills, but at that time she was not involved any more. Genna Withrow who was down in Georgia, Therese and Helen Jolly were there. Susan Leibel was there; I'm trying to think who the other ACNM people were. Elinor [Buchbinder] was there and Carol Hurzeler from Texas. I was a CNM by then, and I guess I was included because at the time I was one of the early people who had been a known lay midwife and involved in homebirths who then went the straight route.

We felt that it would be a good thing to start an organization that would bring both groups together, that would not depend on the personality of one person, that would not be linked to one person's ego. I think up until then, every organization that had sprouted up to represent midwives was one person's organization. The disadvantage of that was both the dictatorship, and that if anything happens to that person, the organization goes defunct. The next nurse-midwives convention was going to be in Lexington, KY. We decided that we would meet at the convention and form a new organization of midwives.

We all shared a room and tried to come up with the name of an organization. Ina May came up with the American Midwives Association so that we'd be called the AMA. At first it was going to be the National American Midwives Association, NAMA. Then we were throwing names around, and I said, "How about the Midwives Association..." and then Ina May said, "We want to include Canada and Mexico," so she decided it should be 'North America'...the North American Midwives Association, NAMA. Then somehow the word 'mana' got into my head, and I said, "How about the Midwives Association of North America, and we could be MANA, as in mana from heaven?" We played around with that and it became the Midwives Alliance, which we liked better than 'association'. So that was where the name came about. Sitting around... that's how things get done.

Fran Ventre

I was in Park City, Utah skiing with my husband, who was an obstetrician/gynecologist. They go skiing and then they have meetings for a half hour in the morning and then a cocktail meeting when the slopes close, and that's how they write it off on their taxes. So he came and said there was this woman who was speaking at one of their lectures who was a nurse midwife, and that she was really far out and I just had to meet her. I guess he told her that I was also a midwife, a lay midwife, and she got really excited. So, anyway, we met in this obstetrician's conference -- and it was Susan Leibel. We immediately hit it off. She said, "Have you heard about the meeting in Lexington, Kentucky?" And I hadn't. And she said, "Well, I think Fran Ventre is going down to it." So that's actually how I first heard about what was happening. She was really insistent that I go. She thought my input would be great. So I hooked up with Fran and we flew down, and I think that was the first time I met Fran. The rest is history.

Ina May was there, and Therese, and I remember I brought a couple of films. We called ourselves the AMA - the American Midwives Association - or something like that. And we were doing all these guerilla tactics. We were running around putting up these signs that I made about this meeting in our room, to umbrella all kinds of midwives. It was really exciting because we had this regular room, and the place was packed, I mean really packed; it was kind of overwhelming. This was at the ACNM convention. I think we even had a business meeting, and that's when I was made treasurer. Don't ask me how I got that job because I never even balance my checkbook, but it was a good project for me. I also got the membership, which I did for - it seems like forever - a couple of years, until Mari [Patkelly] took over. Anyway, I came home from this meeting with all these little pieces of paper from people who paid money, for what we didn't know. Then the names just started coming in, and it was really, really exciting. I still remember a lot of the names, because I was so high about meeting all these other midwives. It was just neat meeting all these people that I'd heard about. I had met some people when Shari had the first midwives conference in El Paso. But this was really exciting, really heady.

The next meeting was in Boulder in the fall. That was really great. I just remember there were all these really neat women. It was in this rented antique historical building. Dorothea was there, Tish and Elizabeth [Gilmore]. That's where we got really got kind of formed as far as what we were all about. But, more importantly, it's when we all fell in love. I mean, really fell in love. I just remember staying up all night, sitting in a doorway talking about, "What do you do if you have this hemorrhage?" It was just the way midwives did, but it was really exchanging knowledge, finally, with peers, and we were just falling in love. We were working really well together, and it was just a huge love affair. There was a lot of respect and a lot of excitement. And I remember the Colorado midwives had a white candle on the mantle that they burned the entire time, that was sort of symbolic of what we were all hearing.

In L.A. we were really starting to brainstorm the goals. People were really articulating words, and I remember thinking, "Wow, these people are really into this." I was always more into the wooing, schmoozing, the seducer. I mean, I just loved being around all these midwives. I just had so much fun. Of course, there was the earthquake and I realized that I just hated earthquakes. We were sitting on the couch and all of a sudden this plant on the mantle started going down the mantle, and I thought, "Wow I'm really hung over," because the plant was just sliding down. I've never

MANA

Nearly all languages had a cognate of this word, the basic meaning of which was maternal power, moon-spirit, magic, supernatural force, and a title of the Goddess. *Mana* came back into English via anthropological studies in the South Pacific.

Mana is the stuff through which magic works...proceeding immediately from the nature of the sacred person or things, or mediately [sic] because a ghost or spirit has put it into the person or thing...The cult of the relics of saints springs from the belief that their bodies, whether living or dead, possessed Mana.

Mana also ruled the underworld, which the Finns called Manala. The Romans knew her as a very ancient Goddess Mana or Mania, governing the underground land of the long dead: the ancestral spirits called *manes*, her children. They dwelt in a pit under the *lapis manalis* in the Forum, emerging to receive their offerings on the annual feast day of the Maniae. On this occasion, the Goddess Mania appeared in a fright mask, like the terrifying Crone-face of Medusa or Destroying Kali.

Mania was not solely a spirit of death or madness, however, in classical times. Her "moon-madness" or "lunacy" was viewed as a revelation of the divine, to be received with gratitude. Socrates said, "The greatest of our blessings come to us through *mania*...Madness coming from [the deity] is superior to sanity of human origin." In other words, Mana-Mania was the Muse. Gnostics said Mana is "the divine spirit in man"; and the Great Mana, of Mana of Glory, is "the highest godhead."

Mana may be compared to hindu *Maya*, the Virgin Goddess whose name was 'power,' and Arabic *Manat*, the Virgin Goddess whose name was 'fate' and who represented the Triple Moon. In archaic Europe, Mana was the Moon-mother who gave birth to the race of man--that is, of woman, which is what *man* originally meant.

Mana or Mania became a common name for the Great Goddess as Creatress and Queen of Heaven (moon), because it was intimately connected with the mysterious powers of women, like the moon itself. Scandinavians called the Goddess's skyrealm Manavegr, "the Moon's Way." Celts called it E-Mania or Hy Many, the land ruled by the Triple Goddess. Sometimes it was Emain Macha, the moon-land of Mother Macha.

from the Women's Encyclopedia of Myths and Secrets by Barbara Walker

been in an earthquake, so I didn't know. Here we were on the eleventh floor of the Biltmore, and this plant's sliding down the mantle. And then I realized what it was and felt a shift in the universe. I didn't like that feeling at all. So they made us get up and stand under the archway of the door, and I wanted to go home right then. That's when I met Kate Bowland, who was hilarious. Ina May and I slept on the floor of the suite. Kitty Ernst said that MANA was born out of the bosom of the ACNM, and I said "Well I guess we're just gonna have to nurse for a while longer." But we were still clicking along pretty slick. MANA was getting known. There was some little divisive stuff going on, but basically we were working really well.

Carol Leonard

MANA (Hawaiian):

An underlying vital energy that infuses, creates and sustains the physical body.

Some of the pressing issues at MANA's inception would prove to be topics of recurring debate. Initial purposes for the group's formation included the setting of educational guidelines, establishing standards for basic competency of midwifery practice, creating a MANA-certified midwife, and forming a professional organization.

I'd like to briefly review some of the objectives we set out in the meeting in Washington. The first was, who shall join? Right now we realize that there's very little uniformity among us midwives, and therefore it would be impossible to have a category of membership. What we would like to do is have this organization be available to anyone who supports its activities at this point. So we're starting out with a preliminary membership that's open to all interested parties. In the future we'll be looking into different categories of membership that address the uniqueness of each interested group, but for now it's open to all who wish to join.

One basic activity of the College of Nurse-Midwives that I think needs to be looked at in terms of any professional midwifery organization is that of education -- pathways to education, models for learning that are creative, that look at both tradition and innovation.

Another aspect that I think is most valuable is accreditation. This is looking at programs that allow and promote the learning and education of midwives. I know that this organization will have to address the issue of how one assesses knowledge and skills, and who shall call themselves a midwife? I'm sure it will be a long and careful process, and I don't know if we'll ever get total agreement on it!

Susan Leibel-Finkle
Excerpted from "The Practicing Midwife," Vol.1 No.16 Summer 1982

Midwives seem to have mixed feelings about the degree of professionalism we want for ourselves. Everyone wants respectability, but there are interesting arguments supporting the philosophies of those who don't. It is hoped by many that MANA will solve this problem for us once and for all. Ideas on what MANA should achieve range from a medical-type of "credentialing/ standards of care" structure in contrast to a more open-ended "informed choice only" system. Some see a happy blending of both possible.

I propose that MANA serve as a national network for news about midwifery and legislation from all the states. From this central perspective, I feel it will become apparant that a model will emerge that can serve as a framework within which midwifery can become a reputable profession.

Janet Kingsepp
Excerpted from MANA News, Vol.1 No.2, Sept 1983

Many visions of what MANA should become were being expressed as the organization began its early meetings. By-laws were being written and committees were being formed.

The Boulder meeting in 1982 was very intense. There were about 26 midwives there, and also Linda Irenegreene [attorney at law]. I took the minutes for the two days. It's truly interesting to look back on this stuff. That was when a lot of the bylaws and what-not were being set up. It was an attempt to put some structure on the organization. People from different states came and reported on what was going on, on a state-by-state basis. And there was old business about membership, and the articles of incorporation were reviewed and approved -- that was a big deal. Then

Attendees at the Boulder, Colorado work meeting
Fall 1982

there was conference planning for the Fall '83 conference, which was taking place in Milwaukee. Then, under new business there was, "What are we going to call people -- lay, certified, blah-blah." It's a very hard issue. Then committees were formed and officers were formed. An incredible amount of work got done -- organizational committee reports, communications committee report, education committee report, the purpose of the education committee, the tasks to be accomplished, the practices committee report, and the credentialling committee report.

Susan Leibel-Finkle

Then, in the Fall of 1983, MANA's first convention was held.

MANA's first convention and annual meeting was a grand success and a positive experience for the more that one hundred attendants. The biggest problem was the lack of time for all the exciting information and ideas everyone had to share and the great amount of committee work that needed to be done.

The first workshop of the convention was entitled "Building an Organization." Participants were helped to non-judgmentally identify the diverse backgrounds and experiences that midwives emerge from and practice in. They discussed conflict resolution and how to work together in a group to reach compromises and solidarity, avoiding sabotage. They set the stage for mutual respect and listening among all convention attendants. This workshop set a constructive tone for the rest of the weekend.

The board was introduced and the President's address given. Barbara Katz Rothman, sociologist and author, then gave the keynote address. She stimulated her audience to consider how midwives might regain control of midwifery and supported the need for an organization such as MANA.

Saturday afternoon was spent in an Open Forum, during which time the membership was encouraged to ask questions of the board about any actions or decisions that had been made up to that point. There were questions about board positions, and it was requested that board meetings be publicized to the membership and be open.

Clearly one of the most difficult issues for some members was the notion of "standards of practice," and fears and concerns were expressed. Tish Demmin, chair of the Practice Committee, clarified some of the issues and invited those concerned to join the committee, where their input would be welcome.

Another question that was asked concerned the educational criteria that might be necessary for MANA certification. It was clarified that no criteria of any sort had been seriously discussed yet. The Education and Credentials Committees at this time are only collecting materials about what exists now.

Ina May Gaskin spoke Saturday night, urging MANA members to make efforts to include midwives of other races and ethnic groups in MANA's membership and conventions. She advised all midwives to record their birth experiences in order to build up the body of information about midwifery and to put midwives more in the public eye.

After Ina May's talk, there was more discussion. One of the most important issues that came up was eligibility for membership in the International Confederation of Midwives. Dorothea Lang explained the importance of membership in the ICM.

Excerpted from MANA News, Vol. I No.3, Nov 1983

The stage is set. With committees in place, issues were being worked on, from legislation to certification to standards to affirmative action to international midwifery. One of the first issues to be brought back to the general membership was that of standards of practice, worked on from the fall of '83 until it was voted on at the conference in Toronto in fall 1984.

Standards and Practice

I really do think that at the Milwaukee meeting, in the open forum, we began to focus on standards. We began to focus on whether it was possible to develop any kind of statement of practice standards that would not be exclusive. I think a lot of women came to that meeting curious, but pretty much with their minds made up that this was not possible, and that it was nice to come to a national midwifery meeting, but perhaps there wasn't really a whole lot more than that. In other words, there were a lot of women there that were highly resistant to what they perceived at the time as organized disempowerment. Myself included, because I was coming from a background of oppression. Divide and conquer has been the tactic used against midwives in my state, and it leads to a certain kind of mentality.

Elizabeth Davis

Here we are at the first conference in Milwaukee. First of all, we're all midwives. None of us are really particularly skilled in group dynamics or running an organization. We're all just women coming together because we had this vision, the same goals. At that conference there was an open mike, an open forum. These women - these are the women from West Virginia - started attacking. They were mad, they were jumping mad and screaming mad, and screaming at us, "Who are you to tell us what to do?" Jill Breen did the same thing to me in Toronto in an elevator, "Who are you to tell us what to do?" And I'm saying, "Hold it, we're you. We're just midwives doing the same thing. If you have something to say, then get involved." And most of those people who were reacting like that are still on the board today. It's pretty funny; they did get involved. It makes a difference. You know, it wasn't like we were some selected people. We weren't any different than they were. It was funny though. Standards are a touchy subject, because people practicing have different things available to them. I think the fear was that the standards being designed would be so elitist or exclusionary that they would be left out. And of course that was the antithesis of what we intended, but people don't know that until they hang

out at a business meeting or listen to what's going on. I'd be the same way if I heard some midwife making rules for me.

Carol Leonard

The Standards and Practice Committee had submitted their report to Susan Leibel, who was the acting secretary, before the first conference had started. I think a lot of midwives at that conference really didn't understand the concept of what standards and practice meant. The big fear was of the laundry list, "Thou shalt, thou shalt not." At one of the early meetings of the MANA Education Committee, the Seattle School of Midwifery expressed interest in having MANA perhaps accredit them or their school. I had pointed out that that would be totally impossible without a Standards and Practice statement. It's the skeleton. On that basis, there was more interest in getting an S&P statement passed, with the idea that it really wasn't something that could be put off indefinitely. It was a major thing that we needed to do.

It was also imperative to get the concept across that midwives could define themselves, whether they were in a legal, quasi-legal or illegal practice. It was our responsibility to define ourselves and we didn't have to let someone else do it for us.

I certainly recognized very early on, and I think most people did, that it was going to require getting a high level of information to midwives so that they could understand what this was. At the time, there were two very opposing schools of thought. There were midwives that didn't want any form of legalization, and then there were midwives who did. So how can you take these two and put them together and come up with something that they can feel comfortable with? We started by providing the first written draft. The committee report was given to the people that were at the conference. Then the first report was published in the MANA News, with the idea that in 1984 at the Toronto conference we would vote on it.

Right before the conference, there were people who were very concerned. Valerie Hobbs [Appleton] was one of them, and there also were some women from West Virginia who wrote a letter to the MANA News. The biggest difficulty I had was that a committee had been working for a long period of time on this, and I felt it was really important to at least recognize that the committee had worked and were presenting something, and not to just go totally off on another track.

In Toronto, one of the things that was important was whether the board of MANA was going to support the resolution. In the meetings that occurred, I took a strong position that the board had to come to some kind of decision as to whether or not they were going to support it. I felt that some of the input and concerns that were raised were valid. I particularly recall Fran Ventre really helping out at a sticky point right before the vote was taken, emphasizing that we include midwifery as an art as well as a science. I felt that was a very important part. Also, there's a section acknowledging the intuitive art. I felt that was extremely important. I was able to get across that this wasn't a laundry list. The point was that midwives are responsible for developing their standards. This kind of written statement was really trying to make people understand the International Definition of a Midwife, that it was so open, that what it didn't say was as important as what it did say.

Tish Demmin

Evolution of thought occurred on both a personal and organizational basis. Trusting the process often meant seeing a radical change of opinion in a short period of time. This can be clearly seen in the thoughts of one woman, through letters in the MANA News which appeared less than one year apart.

I'll never forget the open forum at that first convention. One of the women who really sticks in my mind is Val Hobbs Appleton, because she was just so young and so sharp in her scrutiny of any proposal...very independent in her thinking. By the time the conference had ended, I remember Tish saying to me, "Now, if we can get that woman on board, we can do anything."

Elizabeth Davis

I wish to express some concern about an undercurrent of opinion I'm seeing in the MANA newsletter before you meet for the board meeting in May. I began to see a trend develop with the publication of the Standards Committee report. Well-researched and presented, the report puts forth a solid foundation for MANA to adopt a medical model in setting up its structuring for its organization. It allows for a practice of midwifery,

perhaps a new innovation in some areas, but it does it in such a way as to give implicit control to the thought processes that were created and generated by established medical organizations.

At our first conference, our very first keynote address was to call for the separate generation of knowledge by midwives. We need to maintain our own art, and the Standards proposal is the antithesis of this because it follows so closely the medical model.

Valerie Hobbs
Exerpted from MANA News, Vol.I No.6, May 1984

And from the same woman, less than one year later:

My perceptions of the direction MANA has been taking in the standards/certification issue had been giving me a lot of concern. I perceived a willingness to adopt a "medical model" approach in the develoment of standards. It was to my delight to become enlightened once again to the fact that any one person's or group's perception is not always what is actually happening.

I was concerned enough by the Standards and Practice Committee report to begin asking questions. Replies to like questions in recent issues of MANA News created in my mind two opposing camps. One was made up of those who supported the adoption of modes of legitimizing midwifery as a profession. The other camp was made up of those who perceived those modes as the acceptance of models promoted by those who restrict us.

There were many times throughout the Toronto conference when someone would point out that their association with a group of midwives not only gave them a sense of solidarity, but provided the vehicle by which they developed themselves. We are truly capable of growth when we come together to share, to listen, to learn. I learned that my perceptions clouded my thoughts with my own projected fears until I could not see clearly the statements before me.

Let's see if this sounds familiar. The adoption of standards means that I will not be able to assess each client on the merit of her individuality and it will ultimately mean that my practice will be restricted. It means I will never be able to step outside of "accepted practice." It means more transports, less autonomy and the erosion of consumers' rights.

With all that attached to my thoughts on standards, no wonder I was concerned. Even so, I took to heart the idea that from diversity comes innovation. When I came to Toronto, I brought with me the faith that all concerns would forge a remarkable and workable solution.

It was through my contact with the Standards and Practice Committee and with others who had concerns about the nature of standards themselves that I began to see a merging of ideas. There was a true openness to diverging concerns. This led to a desire to figure out some way to take initially opposing viewpoints and discover the areas of agreement. The end result would be fueled by innovation and built on unity.

I began to see standards not as a way to restrict practice, but rather as a way to free ourselves from outside domination. It does not mean that we list what we cannot do. It does mean that we ourselves state who we are in such a way that we cannot be dismissed.

At the same time that we try to recognize and deal with our preconceived notions, we must also realize how important our questioning is. We could find ourselves taking a path that ends up forcing us to defend positions that we do not wish to support. It is the healthy questioning of our motivation that will keep us heading in a clear direction.

Process is all-important. How we came up with the final standards is even more important than the standards themselves. All points of view were considered. Where deep conviction led to criticism, a new idea was sparked that enhanced the standards beyond the capability of any one point of view. The excitement in seeing the process itself unfold assured that innovation would be our framework and intuition our tool.

It is my hope that some of this excitement can communicate itself on paper and that when you read the adopted standards, you will gain a sense of the process that went into its creation. It is also my greatest hope that we always continue to question, explore and speak out clearly so that we never run out of the fuel for our innovations. In so doing, we create the unity that we so richly deserve.

Valerie Hobbs
Excerpted from MANA News, Vol.II No.5, March 1985

Standards and Qualifications for the Art and Practice of Midwifery
(Revised June 1991)

The midwife recognizes that childbearing is a woman's experience and encourages the active involvement of family members in care.

1. Skills

Necessary skills of a practicing midwife include the ability to:

- provide continuity of care to the woman and her family during the maternity cycle, continuing interconceptually throughout the childbearing years;
- assess and provide care for normal antepartal, intrapartal, postpartal and neonatal periods;
- identify and assess deviations from normal;
- maintain proficiency in life-saving measures by regular review and practice; and
- deal with emergency situations appropriately.

It is affirmed that judgment and intuition play a role in competent assessment and response.

2. Appropriate Equipment

Midwives are equipped to assess maternal, fetal, and newborn well-being; to maintain a clean and/or aseptic technique; to treat maternal hemorrhage; and to resuscitate mother or infant.

3. Records

Midwives keep accurate records of care provided for each woman such as are acceptable in current midwifery practice. Records shall be held confidential and provided to the woman on request.

4. Compliance

Midwives will comply with Public Health requirements of the jurisdiction in which the midwifery practice will occur.

5. Medical Consultation and Referral

All midwives recognize that there are certain conditions when medical consultations are advisable. The midwife shall make a reasonable attempt to assure that her client has access to consultation and/or referral to a medical care system when indicated.

6. Screening

Midwives respect the woman's right to self-determination within the boundaries of safe care. Midwives assess each woman for initial and continuing eligibility for midwifery services. Women will be informed of the assessment. It is the right and responsibility of the midwife to refuse or discontinue services, and to make appropriate referrals when indicated, for the protection of the mother, baby, or midwife.

7. Informed Choice

Each midwife will present accurate information about herself and her service, including but not limited to:

- her education in midwifery
- her experience level in midwifery
- her protocols and standards
- her financial charges for services
- the services she provides
- the responsibilities of the pregnant woman and her family.

8. Continuing Education

Midwives will update their knowledge and skills.

9. Peer Review

Midwifery practice includes an on-going process of review with peers.

10.Protocols

Each midwife will develop protocols for her services that are in agreement with the basic philosophy of MANA and in keeping with her level of understanding.

The practice committee came up with a statement of qualifications, standards, and functions. They adopted the International Definition of Midwifery, which was a very controversial issue, and then wrote guidelines for evaluation of midwifery procedures. I think what they were trying to do was parallel what the ACNM has developed. Under the functions, standards, and qualifications of ACNM there was an appendix that referred to how you evaluate a procedure. In other words, how do you decide you're going to do something or not? Say Dr. Jones asked you to start doing

forceps deliveries. How do you decide whether or not you should? So they developed guidelines as an appendix. It's not guidelines for specific procedures. The issue is (1)whether the procedure assists the midwife in managing the care of a normal woman and infant, (2)whether it is within accepted OB practice in that particular community, (3)whether it's been objectively evaluated, (4)whether it shows a demonstrated need, (5)whether it's legal, and (6)whether there should be guidelines within these guidelines that plan for evaluation of how it went. It's just a general framework for helping a midwife evaluate any procedure that she's going to do.

Susan Leibel-Finkle

By the time the Standards and Practice statement was introduced, a lot of education had gone on. There are certain things that we have forgotten. This came to my attention at the 1991 El Paso convention. I didn't get my packet of materials in advance of the convention, so I wasn't aware of the proposed definition of a midwife coming out of the Carnegie Foundation meetings [from the Interorganizational Work Group on Midwifery Education]. One one of the things that stood out to me was that line in the Carnegie definition of a midwife, as opposed to the scope of practice, saying that the midwife will arrange for consultation. That's actually directly opposed to our Standards and Practice statement, because in our Standards and Practice - and this is something that Tish carefully crafted and argued strenuously for - it was not the obligation of the midwife to have or arrange for consultation, it was the privilege of the parent. There was a certain principle involved; if you charge the midwife with the task of setting up backup, then that does two things. It obviously increases physician liability, and it also may funnel clients into the care of a provider that is not their choice.

Hearing we were supposed to vote on the Carnegie definition just took me back to that time, to how carefully that Standards and Practice statement was crafted, and with what foresight. During the process of creating that document, it felt like everything about MANA in those days felt: number one, like sky was the limit, and number two, like we were breaking ground and establishing midwifery as an independent practice. We were not only looking to incorporate ourselves into an existing system, but we were also creating new institutions to meet the definition of the midwife that we were evolving. And that was just the most exciting and thrilling and wonderful thing.

Elizabeth Davis

International Midwifery and the ICM

Then MANA got involved internationally. What I found so exciting about that was that for the first time, when some midwife from West Virginia would get up and say, "You know, I'm really uncomfortable with certification process," whatever she would say, I felt like she had a voice in the international community. I felt that she was being listened to. I felt that way about all the stuff MANA was doing was to protect and honor the traditions of midwifery. And even though I'd never been to an international meeting, I had the sense that the international community, having gone down this road towards professionalism to a big point, was also looking to MANA to bring back the traditions. So all of a sudden I felt like whatever we were doing would have worldwide and lifelong impact on midwives everywhere.

Valerie Appleton

It was during the Open Forum that I personally was helped through a quantum leap from a somewhat elusive desire for a credential to a clear idea of what I might benefit in strength and support from national credibility. Dorothea Lang, the North American Representative to the International Confederation of Midwives spoke, "I am here very actively hoping that this organization of midwives can become members of the International Confederation of Midwives which has tremendous status. To be a member of the ICM instantly gives you credibility. It has been proposed that MANA members accept the International Definition of Midwifery, which is important in that members can say, 'I am a member of MANA, which has the same definition of midwifery as the ICM headquarters in London. This same definition has been accepted and endorsed by the International Federation of Obstetrician-Gynecologists.' So you know that the body of OB's in the United States, which is a member of the body of OB's in the world, has already endorsed the definition that you are living by. It's a beautiful friendship circle."

This made sense to me and I also noted that right then and there I was willing to drop some of the petty issues which I had brought to this meeting, so that we as midwives would not compromise the possibility of gaining such a valuable tool. More than anything else, as a midwife, I wanted to see the end of this insult that we are incompetent, or in some states even criminal, for providing skillful, loving care to families in childbearing.

Mary Edson
from MANA News, Vol.I No.6, May 1984

ACNM had the corner on the ICM, as representing all the [North American] midwives, and since they were only representing nurse-midwives, only the nurse-midwives were recognized. Since I knew ICM's history and I knew ICM's by-laws, I knew there were loopholes that could someday be used for another organization in the United States. So when MANA became halfway standing on its own feet, I remember saying to Tish Demmin, "Look, the biggest visionary thing would be if we could see if MANA could get ICM membership."

That was when MANA was only one year old. Sister Angela's meeting was '81, the Lexington meeting was Spring '82, and then at the meeting in Boulder Colorado in October '82 we slept on floors in sleeping bags and formulated the first board. I went to all of those.

I've always talked ICM. I was crazy about ICM, I really was. I felt that that was the future to salvage midwifery in the world. In '83 when Tish was executive secretary, MANA first put something together sort of loosely and applied, just plainly applied. They were rejected. In September of '84 was when the ICM meeting was in Australia, and that was the time when MANA got accepted for membership. So it was really three years from the meeting with Sister Angela to ICM membership.

ACNM thought they would never be recognized. But I knew that there was a clause in the new by-laws in ICM that organizations that were not exactly true to ICM demands, for instance, a nursing association that had a midwifery branch or a medical association that had a midwifery branch, if in fact a branch would be available that would meet the standards of ICM, that branch could be acceptable. Since MANA recognized all birthing professionals, so to speak, some of them would not be recognized by the International Definition of Midwife. We said, "We will gather together all

The International Definition of Midwifery

A Midwife is a person who, having been regularly admitted to a midwifery education program fully recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.

The midwife must be able to give the necessary supervision, care and advice to women during pregnancy, labor and postpartum periods; to conduct deliveries on her own responsibility; and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance, and the execution of emergency measures in the absence of medical help.

The midwife has an important task in counseling and education -- not only for patients/clients, but within the family and community. The work should involve antenatal education and prepration for parenthood and extends to certain areas of gynecology, family planning and child care.

The midwife may practice in hospitals, clinics, health units, domiciliary conditions, or any other service.

ICM, 1972

the foreign trained midwives that were located in America who were members of MANA and call it the International Section." And when they were rejected the first time around, the second time around they came with a complete picture of the membership for the International Section. And so they were recognized. This was a tremendous success and identifying factor for MANA, which now had a voice in ICM equal to ACNM.

All that helped MANA become stronger and stronger, more internationally visible. Now we could say in the United States that there were two associations representing the title 'Midwife,' MANA and ACNM. So it essentially gave it unique identity. So that is how I see the evolution. And I would say that I give 90% credit to Tish Demmin for the writing of the second document for MANA's recognition to ICM. That was a masterpiece write-up. It took hours of telephone discussion back and forth, and she had

the stamina to somehow put it together in words that would be acceptable. And I do think that people did not recognize that that lady probably gave much of her personal health to the cause. She was a business woman in every way, and she gave her heart and soul to this organization.

Dorothea Lang

One of the things that we did very early on was to start the paperwork to get into the International Confederation of Midwives. That decision was made in '83 at the conference. Initially there were people on the board that wondered "Why even bother?" They weren't sure whether it was something important to do. I felt very strongly that it was extremely important. I was looking at it from the point of view that we had perspectives to offer. The ICM works with the World Health Organization in developing international maternal/infant health care policy, and I felt it was extremely important that we become members.

I was in charge of doing the first application. The strategy of our application was that we were asking for membership in the ICM with special consideration, because the United States was a developing country in the area of midwifery education and public access or consumer access to midwives. By the spring board meeting we had gotten back a letter that the ICM board of management had rejected our application, and that our next step, if we wished to continue pursuing this, would be to resubmit and take it to the floor to vote in Australia. The issues they were concerned about were apprenticeship education and the position of our organization that all midwives could be MANA members regardless of educational background or legal status.

We had to make a decision what to do, and we decided to form a separate section of MANA called the International Section. That created a lot of debate because of the concern for elitism or creating categories. Our bottom line when we made this application was that we were standing in support of apprenticeship as well as direct-entry schools.

One of the interesting aspects we worked through in discussing these things was getting the concept across that you don't have to wait for the state to define you. You can form an association, you can determine your standards, you can develop a test; we can do it ourselves. That was, I think, a big eye-opener to some people; that in other words by going for this we would set in motion a vehicle that would make it possible for midwives in

an illegal situation to be members of the International Section of MANA. It didn't mean that they wouldn't have to do some work, but it didn't cut them out. On that basis, we opted to resubmit. The one thing we decided we absolutely would not budge on was that we were committed as an organization to our position of membership open to all midwives.

So I did that application and it was sent to Therese [Stallings]. One of the things that happened was she made a change without notifying me. In the International Definition it says that midwives are duly licensed and/or registered, and that can be by government or by professional organizations. In arguing for apprenticeship education, I made some rather extensive reference to New Mexico's process because it was legally recognized, and while it had a proscribed course of study it was open as to how that could be met. On certain things on the form I had simply said "yes" and not gone into detail. Therese got into expanding, and specifically it was with the Oregon Midwife Council. Then the application was voted on and it was passed. The only person who voted against MANA was Judith Rooks of the ACNM, while Angela Murdaugh voted for it. After Judith Rooks got back to the US she wrote a report to ACNM in which she explained the negative vote that she cast at ICM. She also started raising a fuss about the Oregon Midwife Council, and some dialogue started opening up in the MANA News between Therese and Judith Rooks.

At that time Judith was president of ACNM. The ACNM was having a conference in Houston, and we were having our spring board meeting at the same time. One of the things that happened was that Margaret Brain, who was the treasurer of ICM, happened to be at that ACNM conference. At some point after our board meeting, Carol Leonard and Therese Stallings were supposed to meet with Judith Rook and Margaret Brain. Carol didn't go. It ended up in a situation where Therese was by herself with Judith Rooks and Margaret Brain. The upshot of this was that there was support of Judith Rooks' concerns about formal education. And Margaret Brain, who was on the ICM board of management, was present.

The next thing that happened was Carol Leonard got a telephone call from Frances Cowper Smith, who was the executive secretary for ICM. Carol was advised over the telephone that there was a move on, which grew out of this meeting, to possibly rescind MANA's membership.

In the first place, this whole thing was totally preposterous. According to the way ICM was set up, member associations could put forth resolutions. The ultimate thing any resolution that goes before ICM has to do is to meet

or support improved maternal-infant health. If a resolution goes forward with that objective, then educational recommendations can be made in order to support such an objective. But education varies from country to country. The ICM is not an accrediting body. This was totally off the wall.

But Frances Cowper Smith tipped us off that we were in serious trouble over this. So Carol asked me to respond, and I did. I wrote them a letter, making it very, very clear that we were supportive of the concept of resolution and debate and vote, but that we felt that this did not fall into that kind of category. I also pointed out that it was up to MANA to determine who was a member of the International Section of MANA. Certainly the ACNM could not make that decision, nor could ICM. It got us off the hook. Basically, what I found out later was that the letter was shown to an attorney over there and the ICM was advised that because they're chartered out of England, they couldn't do something that went against their own charter or their charitable status.

It was all a definite part of a learning process. At one board meeting we ultimately had to discuss the ramifications of this. The ultimate thing we really understood was that you don't send one person in such a situation; you send two. This problem occurred because of pressure, of Therese being the only one out there, and of not having a clear directive from the group when negotiating. Again, these are learning processes.

Tish Demmin

Dear Tish and Carol,

We were saddened, at ICM headquarters to know about the pressure which you and your colleagues in MANA have been under, to justify your status as midwives, and as members of the International Confederation. Many thanks for sending your detailed letter, dated June 25, 1985 restating your position.

I would like to take the opportunity to make clear the constitutional position of ICM on qualification for membership. Paragraph 6(i) of the constitution states that an association applying to become a member of the confederation shall "consist of midwives recognised by their government or professional organisation as competent to practise midwifery." Thus, assuming that the other requirements (5i & ii, 6ii & iii) are fulfilled, the midwives belonging to an association are either recognised by statute or, in its absence, by the applying association, as competent to practise midwifery.

In other words, if MANA states that the midwives in the International Section are competent to practise, the ICM must accept their eligibility. Neither ICM as a body, nor its individual members, have any power of veto on this matter. In addition, of course, the member association should have aims in harmony with the aim of the confederation, the major component of which is the advancement of education in midwifery. MANA gave ample evidence, in its submission last year, that the purpose of its existence was exactly that - the advancement of midwifery education.

The confederation agreed with WHO and FIGO regarding the definition of a midwife, more than ten years ago. New member associations would be expected to agree with this definition (although it is not a membership requirement), and to work towards its components, if they are not already in existence. In affirming this definition, ICM recognises that there is no way in which any member association could be coerced to conform to educational programmes, modes of entry, standards of practise, which are laid down by another association. Individual member associations develop midwifery according to the needs and conditions prevailing, as they see them, and as they respond to them. All over the world, midwives are prepared in different ways but, as long as they fulfill the requirement of ICM's constitution, neither the confederation, nor its individual members, are at liberty to argue that a particular programme, practised by another member association, prepares people who are less worthy of the name "midwife." "Different" is not necessarily "worse" (or better).

I would also like to clarify that ICM is a federation, and not a private club. We are registered as a charitable institution in the UK, under "the advancement of education" grouping. Members cannot be voted in or out, but are accepted or rejected solely on the criteria set out in the constitution.

I hope very much that the comments here will ease your mind, to some extent. Please be assured that the confederation values your membership, admires your work, and wholeheartedly supports your commitment to improve midwifery education and provision in North America.

Yours Sincerely,

Frances Cowper Smith
Executive Secretary, ICM

from MANA News, Vol .III No.2, Sept 1985

The experience of the individual midwives attending the ICM Congress in Australia was quite different than what was going on organizationally.

The whole ICM meeting was a blast. It was great. There were midwives from all over the world, and most of the old hippie midwives were crashing in our room, so we had to step over about 20 bodies. But it was really great to have midwives from everywhere with us. We brought a typewriter and were just typing madly. There was all this scuttlebutt that we were going to be really controversial because we had members that weren't nurses. Therese typed up this speech and we just addressed that. We basically said, "That's true, but they're recognized acccording to the International Definition. They're recognized appropriately." We said that we, North America, did not have a long history of midwifery like the European nations did, that we were a developing nation as far as midwifery was concerned, and that we needed their support, not just for nurse midwives but for the other, direct entry midwives. So it was fine. There was only one vote against us, and that was Judith Rooks of ACNM. But it actually was fine. It wasn't as controversial or hot stuff as we thought it would be -- not on the floor anyway.

Carol Leonard

And what of the acceptance process into the International Section?

The process that we had in place to accept organizations into the International Section was really basic. We had a checklist that more or less evolved from a standardized model of state licensure/certification. We took the basic component elements of your typical licensure/certification process, for example peer review, educational requirement, experience requirement, just basic areas without specific numbers, and then came to more or less an average of numbers. We took an overview, and then came down to averages. When we would receive a packet from a state or an organization within a state that was applying, we would compare it to these averages and make recommendations. No states were turned down, but I know that when California submitted its process, both Tish and Carol Leonard submitted detailed lists of recommendations that got fairly specific

International Section Criteria

Below are the criteria used in evaluating the certification of applicants to the International Section of MANA.

1. Required to follow state or MANA standards
2. Informed choice agreement required
3. MANA membership required
4. Required to follow protocols
5. Periodic peer review required
6. Required experience in all aspects of midwifery
7. Coursework or other comparable education required
8. Examination required
9. Verification of skills required
10. Required continuing education
11. Recommendation from supervisor required
12. Procedures to discipline
13. a. State Licensure
    b. State Certification
    c. State Registration

Excerpted from MANA News, Vol.III No.6, May 1986

regarding some of our protocols and regarding our peer review process and the like. The standard to which we had to improve was not clearly defined, either. They were just recommendations, but for the most part the recommendations were so good, with a rationale given for each, that we adopted most of what was recommended. It helped us to have someone that had taken an overview and could say, "Here's the mean, and here's where you guys are, and this mean reflects such and such a standard of care and maybe you ought to look at this, and maybe it would be to your political advantage to adopt this."

Elizabeth Davis

Opinions on the formation and maintenance of the International Section are still strong and often divergent. In 1991, the MANA board was faced with taking another look at International Section status, since the original documentation for states included was lost. Not everyone agreed that the same process should be repeated.

The International Section thing, the whole making members of the International Section versus not, sets up a power situation. I wasn't involved in the structuring of that, but now I'm going to be, and I have some ideas about how to decrease that. I've been very uncomfortable, and when everything was lost, I came up in the bathtub with, "Oh, that's just perfect," because now we have to redo it and I am going to propose that we redo it by just having states file with us what they do, and they get to declare whether they're part of the International Section. No member of MANA or group of members of MANA would make any determination, but they would just declare they are. We'll have to decide first if that's acceptable to us, but then we'll also have to interact with the ICM to defend our position. If we don't, we don't, and then we're not members. I feel strongly enough about not being a regulatory body that I would be in favor of getting rid of our ICM status if we had to, if they want us to be regulators.

There's no advantage to being a member organization of ICM for our kind of midwife, only networking. Networking, getting inspired, learning different peoples' point of view, supporting worldwide midwifery. It's us supporting them, as far as I'm concerned, as well as them supporting us, in a networking way. I don't think they have that much political power, anyway. And plus, it mixes everything up. It's a power situation. I think that's the kind of power they would like to have. I think it's the kind of power the ACNM has some of, and wants more of. But I don't think we should go in that direction.

Mari Patkelly

What is our role internationally? And how does MANA impact on midwives in other countries? Is our continuted participation in the ICM important or not? What follows are a few experiences of MANA members with the international midwifery community.

The kind of midwifery that I did, those all-homebirth practices where we do that continuity of care and personal service, that's been lost almost all over the world. I'll never forget, at the ICM conference in Australia this one woman came up and gave me this big hug and said, "I've been wanting to give you this hug for five years." It wasn't me. It was the idea of that grassroots midwifery that the women in this country do. That grassroots is keeping that kind of midwifery alive, that sort of pure form that isn't really very practical in today's day and age; it's not economical, it's not time efficient, it burns us out, but it's such a wonderful model, and we're keeping that alive for midwives all over the world because even in Europe and Australia and New Zealand, where midwives have gotten to be a big part of the system, they've lost their soul. They look at the MANA midwives as the soul of midwifery. That was a real eye-opener for me, because I thought they were the ones that all had it together and we were the ones struggling.

Therese Stallings

I'm sure that both MANA and the international midwifery community have something to offer each other. I think what we can get from them is a sense of what it's like to have, from our perspective, a lot of midwives; to not have to explain what that means to people at quite such a detailed level, and to see how midwifery can be integrated in a health care system. But I have to say that most of what I see in industrialized Europe is not that encouraging. It's the alternative movements that give me heart there, because what you can see is that you can have a national health plan and have midwives lose a lot of their more traditional status. To me, that's to the detriment of their ability to care for and respond to the real needs of women. What we have to offer from the United States is that some of us really are independently working, able to work as midwives in a way that isn't really possible in other parts of the industrialized world. We're doing very important research into how women's bodies work. We're really able to work according to a whole different model of birth, with totally different assumptions about birth. This is very exciting and very needed, because this behavior can be endangered. There are certain kinds of behavior that you can't see if all the rules are made in such a way that it isn't possible for it to happen.

Ina May Gaskin

I received a brochure in the mail about a congress going on in Brussels. I laughingly said, "God, I'd love to do that," and it all fell into place. So the midwife who trained me and I went to Europe in May of 1991 to the International Congress of European Midwives. In some ways the Congress was a real disappointment, as far as that the topics discussed were very technological. The midwives there were mainly working in hospitals. There were a handful of midwives that they called 'radical midwives' who were doing homebirths. Our communication and bonding with them was instant. They were so like us, and their values for women having babies at home were so similar. But they were the tiny fragment of Europe.

When they asked us, "Are you radical midwives?" I thought, "Any midwife in the United States is radical." I'm not sure that applies the same way in Europe. But what it did make me want to do is come back, get more involved in MANA, get more involved in the Association of Texas Midwives, and see midwifery survive, because it just seemed like the type of midwifery that I would like to see women get is dying all over the planet. I always thought Europe was the stronghold and America was just kind of building. Now I see that America is more of a stronghold. Number of midwives-wise, more of us are doing the kind of midwifery that is holistic. There are more midwives in the home delivering babies now. I came back very committed to seeing other women join and become midwives, and being more interested in the work that MANA's doing.

Melanie Van Aiken

I see ICM as potentially a pretty good political force. I think it's served a very good purpose in a lot of ways. I think there are things that I'd like to see happen in ICM to encourage more strength in midwifery in countries that aren't already up and functioning and moving along. I also think there are some really relevant midwifery issues that are impacting and affecting midwives around the world that don't necessarily get dealt with or looked at or discussed in the ICM. Things like the invasion of technology and its impact on midwifery practice. You know, it's more political than anything else. Where has midwives' power been affected and how? And I think it's pretty universal. Meeting midwives from around the world was pretty exciting because what you heard was similar sorts of problems. For instance, how there has been a chipping away of the midwife's autonomy, and how her role in childbirth has been eaten away gradually as more and more technology gets introduced, and then it becomes more medically

based, with institutional and physician influence. That kind of stuff is occurring all around the world. But there isn't much of a focus in ICM on that. Or, it seems to me, that if there is an awareness of it, it's not being dealt with, and I see that as very necessary. I certainly think abstracts should be submitted around these issues so that the whole Congress can get into discussing it and make sure that other midwives are aware of it. There were quite a few of us who were disappointed that none of the relevant midwifery issues were being addressed [at the ICM Congress in Kobe, Japan]. The radical midwives in England and the New Zealand midwives and others who were there were thinking along the same lines. Kind of an awareness that there was more to do than the rubberstamping of changes to words in by-laws, which happened at the business meeting. It just doesn't seem to be right that all this money was being spent to bring all these people together, and then we didn't really find out that in Jamaica the president of the midwives association has just had a death threat because the midwives in Jamaica are applying for an increase in wage to be comparable to nurses. There's some important stuff happening out there that nobody talks about other than in their own private conversations.

I did make some suggestions, and I know Mari [Patkelly] did too, to the ICM board and to the next conference planners in Vancouver as to how to restructure things to have more of the open forum idea. So I see that maybe MANA has some things to offer ICM. I wouldn't want to be presumptuous enough to say that everything has to change, because I don't think it does, but I think there could be some things that would be modified or included that might help the awareness around the world of what's happening to midwifery. What's happening and what is the impact, and how can we maybe work on diminishing those changes and not have midwives' roles be depleted like this? Where do we need to focus politically? ICM could have a lot of power politically if it used it. The way I see it, the focus for ICM right now is more the Third World and developing nations. It's like, "We're established, we're set up, we're okay. Now we've got to help these other nations with their terrifically high maternal mortality rates to achieve a better status." Well, that's fine too, but what about what's happening in the developed countries, where it's so-called so good? Maybe there aren't as many women and babies dying, but what about midwifery, what about some of the practices we see as being not particularly healthy? Let's not just focus on developing nations as having the only problems.

Sandra Botting

When I went to Jamaica I went down to the nursing council in Kingston, and when I mentioned that I was a midwife from the United States, there were several women there that were aware of MANA. You are getting beyond borders. They did have interest, and I think they had several people who had participated in conferences. I pretty much feel that it's a connectedness, a web that keeps us all together, even when we're really stretched.

Annie Robinson

The MANA Board: The Challenge of Process

I think that the board process has been a tremendously educational thing for everybody that's been involved with it. It's a skill of a high order for women, for anyone but since we're talking about women I'll narrow it down to that, to really see things from each other's perspective. I think what we're learning, and we've been doing this from day one of the organization, is what a difficult and yet what a rewarding thing it is to really come to see things from each other's perspectives, and then try to out of that build a common vision about what to be. I'd say that we're getting a lot better at it, and we're growing in those skills. They're difficult to attain. It doesn't just happen for the wanting to. It's constant practice, it's patience, it's forgiveness. There are all sorts of human qualities that we have to develop and learn and regrasp.

Being Americans, we are from all sorts of backgrounds; some of our ancestors came here as slaves, some were slave holders, some were the indigenous people who were pushed off of their land or who were restricted into a tiny bit of what once their people roamed on, some are people whose ancestors fled from oppression in Europe and Asia. We're everybody here, and of different religions, religions that have had wars with each other, and here we are, trying to get along.

Well, I've always felt like the men don't have a prayer of getting along if the women don't get along. And I don't think women have an easy thing of getting along if the midwives don't get along. So I've always held that in my mind, as I've been with us trying to go through our changes and come to listen to each other and build a language even to discuss this stuff.

Ina May Gaskin

The nuts and bolts of running an organization often come down to the workings of its board. The MANA board meets twice each year, in the spring and at the time of the fall conference. The board is composed of an executive council of five (the president, two vice-presidents, treasurer and

secretary) and the regional representatives. New board members come on in the fall; the old board meets before the conference, and the new board meets the day following the conference.

The MANA board got a reputation right from the start as being a fiery meetingplace of opinionated women. The stories of those first boards and the evolving process follow, again through the eyes of the participants.

I think that most of the women that were on the board at the beginning had an appetite for innovation. I don't think that, taken as a whole, we were particularly detail-oriented, or sometimes even very task oriented. I think that we were the ground-breakers. The process of board evolution exists independently from the personalities involved. And some personalities, like Ina May, have stayed involved through all those phases. Partly it was the women that were attracted to the process, but it was also the process itself. I think in the inception of an organization there will be a lot of visionary activity, a lot of fantasy, and a lot of dialogue that is not necessarily aimed at producing anything in the immediate. We operated that way up until the San Francisco convention.

Suddenly after the '85 convention we had nine or ten thousand dollars that we made as profit, and this was a new thing for us; we had never made money before. We sat around trying to figure out what to do, and Gail Allison, one of the conference coordinators, said, "You know, you need a budget. There's something called a budget." And I think that was the first time we had ever set up a budget. That tells you something about the way in which we operated up to that point. If we had some money, we allocated it for whatever seemed to be at the top of the heap, but committee work was not really established and directed and funded until that point in time. A whole lot of what was going on was generating ideas, generating projects, generating outreach to specific individuals and to some degree to other organizations.

One of the facts of the first MANA board is that we didn't trust one another enough then, we didn't have the experience to share our half-baked truths and evolve understanding together. In the beginning, people were fixated on their ideas and their positions. They held to their positions way longer than they needed to.

The meeting in Philadelphia was like the board meeting from hell. It was one of our "learn how to have a board meeting" meetings where we just

MANA Meetings and Conferences

Fall 1981 Washington, D.C.; 1st meeting at ACNM headquarters

Spring 1982 Lexington, KY
Fall '82 Boulder, CO; work meeting

Spring 1983 Los Angeles, CA
Fall '83 Milwaukee, WI; "Birth of an Organization"

Spring 1984 Philadelphia, PA
Fall '84 Toronto, Ont; "Creating Unity"

Spring 1985 Houston, TX
Fall '85 San Francisco, CA; "Roots and Renewal"

Spring 1986 Vancouver, BC
Fall '86 Wheeling, WV; "Midwifery in Transition"

Spring 1987 Orlando, FL
Fall '87 Denver, CO; "Giving Birth to Tomorrow"

Spring 1988 Detroit, MI
Fall '88 New Orleans, LA; "Celebrating the Joy of Midwifery"

Spring 1989 Concord, NH
Fall '89 Boston, MA; "Midwifery in the Community"

Spring 1990 Monett, MO
Fall '90 Kansas City, MO;"Strengthening the Family Through Midwifery"

Spring 1991 El Paso, TX
Fall '91 El Paso, TX; "Sisters on a Journey"

Spring 1992 Douglas City, CA
Fall '92 New York, NY; "Creating Unity, Supporting Diversity"

marathoned it, not even drinking enough water, barely knowing how to stay functional. We had to vote at that meeting on whether or not MANA would become a member of the ICM and there was a lot of confusion and miscommunication, I think, around the real issues of membership. I was led to believe that the only way that you could be a member was if you were legally licensed. So I thought, "Well, that leaves out all my constituency. Oregon doesn't have legal licensure, California doesn't, Alaska doesn't (didn't at the time), Hawaii doesn't. The only state that does is

Washington, so I guess I have to vote against this." When it came time for the vote, I wasn't the only negative vote; there were a number of them. And I remember that Carol Leonard looked at me and said, "What's the matter, Liz? Don't you trust us?" I just banged my fist down on the table and all the coffee cups went flying up into the air, and I said, "It's not a matter of trust. I'm just trying to do my job. I'm a regional representative." The point of this is that there was a point in time where there was not clear communication, where people on the board did not know what their jobs were, and where the organization was still struggling. We did not feel powerful. Luckily we got past that point. I'll just never forget that, when the coffee cups went flying, and everybody laughed.

Elizabeth Davis

In West Virginia I attended a number of board meetings before the conference. It was frustrating, but it was very interesting. At that time I had the feeling that the women were trying to get things accomplished and relate to each other without any prior accepted models of how to run an organization, because of a strong sense of feminism and not wanting to use male models; that everyone was trying to be true to a woman-centered kind of processing, but it was something that wasn't defined. So it tended to be really emotional. I think the board had a hard time getting through its business every day because efficiency was lowest on the list of priorities.

I know that the board process deteriorated a lot more after that, but I wasn't a witness to it. I certainly didn't know whether the organization was going to keep going, because it certainly seemed as if there was enough fire that it could all just burn down. But I personally had a lot of faith in Mari Patkelly and a number of the other people. For me, that really was a way that I didn't get too discouraged. In terms of the specifics, as to how business meetings were conducted and so forth, I just held back. I think I've always been somebody who has efficiency higher up on the list than the organization as a whole.

I was the president of the Massachusetts Midwives Association, and I didn't let meetings go by where the agenda wasn't completed. So I did find observing MANA to be kind of frustrating, but I also learned a tremendous amount about letting go of stuff. I think I'm not going to be able to say in my own mind whether all of it is necessary till we see whether we get where we're going or not.

Peggy Spindel

MANA Executive Councils

1983 President: Therese Stallings
1st VP: Ina May Gaskin
2nd VP: Rene Porteus
Secretary: Susan Leibel-Finkle
Treasurer: Carol Leonard

1985 President: Therese Stallings
1st VP: Ina May Gaskin
2nd VP: Carol Leonard
Secretary: Tish Demmin
Treasurer: Lea Rizack

1986 President: Carol Leonard
1st VP: Tish Demmin
2nd VP: Debbie Farnsworth
Secretary: Valerie Appleton
Treasurer: Lea Rizack

1987 President: Tish Demmin
1st VP: Sandra Botting
2nd VP: Debbie Farnsworth
Secretary: Valerie Appleton
Treasurer: Lea Rizack

1988 President: Sandra Botting
1st VP: Sondra Abdullah Zaimah
2nd VP: Lisa Hulette
Secretary: Karen Moran
Treasurer: Mari Patkelly

1990 President: Diane Barnes
1st VP: Sondra Abdullah Zaimah
2nd VP: Candace Whitridge/Jill Breen
Secretary: Karen Moran
Treasurer: Mari Patkelly

1992 President: Diane Barnes
1st VP: Anne Frye
2nd VP: Diane Holzer
Secretary: Signe Rogers
Treasurer: Rahima Baldwin

Regional Representatives (in order):

New England: Fran Ventre, Dev Kirn Khalsa, Jill Breen, Penfield Chester, Judy Luce

North Atlantic: Lea Rizack, Karen Moran, Laurie Ardison, Alice Sammon, Hilary Schlinger

South: Genna Withrow, Marilyn Green-Dickey, Ruth Walsh, Ina May Gaskin

South Central: Ruth Cobb, Kathy Acree

Midwest: Karen Lupa, Jill White, Diane Barnes, Mary Cooper

West: Elizabeth Gilmore, Pat Pedigo, Carol Shane, Diane Holzer

Pacific: Elizabeth Davis, Kate Davidson, Maria Iorillo

Canada: Ava Vosu, Lee Saxell, Sandra Botting, Vicki Van Wagner, Holiday Tyson, Simone Varey, Eileen Hutton, Elana Johnson, Evonne Smulders

Mexico: Alison de Parra, Laura Cao Romero, Guadalupe Trueba

Woman of Color: Jeanne Shenandoah, Makeda Kamora

There were a lot of struggles. MANA's still full of really strong women who are very opinionated, but in the early days we had the women on the forefront of the forefront. I think as women we are all very wounded. And to learn how to work together with our wounds and not tear each other's hair and eyes out was something that we didn't know how to do in those early years. There were some very intense meetings. There was one meeting where I vomited all night because of the power struggles. I was in the position of president, and even though I always feel like I don't set myself up as an omnipotent person and I never did as MANA president, because I was in that position, people would put me there and they'd push against me. That was very intense. The woundedness in us as women almost destroyed the organization years ago, and that energy came to its peak. There was that critical point that we got to in 1988 where the organization almost went financially belly up and personally belly up because of the nature of the woundedness of the people that were dealing with power at that point.

Therese Stallings

The subject of the crisis point in 1988, revolving around the central office, comes up again and again as board members speak about the evolution of process. The central office was originally established to handle membership and correspondance, as a clearinghouse for organizational tasks. Soon the newsletter was coming out of the central office, and many treasury tasks were moved there. The idea for hiring an office person for MANA had its roots in the membership work.

I came into MANA in 1984. I got involved through Carol Leonard. Carol was the treasurer and I apprenticed with Carol. That's how I got the membership; she was keeping track of membership as well as doing all the treasury stuff early on. So when I was apprenticing, all the mail was coming to her and she was keeping all the lists of the members. There was no membership person. I had just gotten a new computer and I had a mail list program, and I had another friend who was the founder of a national organization, Concerned United Birthparents. She knew how to do membership stuff from experience. So I set up the whole program to do the first membership stuff, keeping track of expiration dates and all that.

Because I was very involved in the membership, I started to go to board meetings. The first board meeting I went to was in San Francisco in '85. I

was really the first central office person, because they tried to hire me to do the membership. I got hired to do it for five dollars an hour, which of course was peanuts. The idea was to pay me to do the membership and some secretarial things for the board. I thought, "Oh, that will be easy." I don't think I got paid more than one month, and it dawned on me that this was going to be a dumping situation. So I immediately said, "I'm not doing it as a paid job because everybody's dumping everything on me, so I'll do it volunteer and I'll do what I want to do and only what I want to do."

I became the chair of the membership committee, and we did membership drives, and there were people that helped me work on it. Betty Clark was great; she helped me do a lot of the mailings and I had a committee of people that would help with membership. I was doing all this membership stuff, and the mail was being handled by one board member, and we were getting more and more members. So I was actually the person who organized the hiring of the central office person. I put the ad in the newsletter calling for the applicant, set up a whole application process, and I copied all the applications and sent them around to members of the board. That's how we came up with the two final applicants that went to Florida. I also ended up going to the Florida board meeting for Carol because that's when Ken died. Carol was supposed to be president, but I went in her place. So I was at the board meeting where Julie [Buckles] was hired. So not only was I really the first central office person in the sense that they hired me at five dollars an hour which I rejected after I found out it was a dumping place, but I initiated the whole central office hiring thing.

Mari Patkelly

As with many organizational decisions, there is an often unspoken but important financial impact. As Elizabeth Davis related earlier, MANA was just learning about budgeting and finances. This created long-term stresses within the organization.

This is what I would like to say about the central office. The initial decision to have a central office was the first problem that we ran into. MANA had been operating on volunteerism, and [Mari] Pat Kelly was doing membership work. She advised the board she just couldn't do it; we needed to have a central office.

MANA's first officers (clockwise from top right): Ina May Gaskin, Susan Leibel, Teddy Charvet, and Carol Leonard. May 1983.

Initially, Lea Rizack, who was the treasurer of MANA, was not very good about giving MANA financial reports in a timely fashion. There were a number of board meetings prior to making the decision to have a central office in which there was not a financial report available. So when the board first voted to look for someone to run a central office, I voted against it. But the first decision was, "We're going to do this, and we're going to at least issue a call for people to apply for this." Then different people

applied for the job, and the field of applicants was narrowed down to two people who came down to Florida for an interview with the board. At that board meeting we didn't have a financial report from the treasurer, and information that she gave us verbally was that we had money in the bank which we didn't have. There were two applicants; there was Julie, who got the job, and Mary, who withdrew her application. Mary was sitting in on part of these MANA board meetings and she decided that she did not want the job. Julie was hired.

Mary talked to me much later when this uproar came down, and one of the things she asked me about again was the financial report. She had been concerned because she saw certain areas in which MANA had been a little bit lax. We had been wavy and lax over voting on things without really considering the financial impact, and this was a problem.

The next year, Julie asked me if I was interested in going into practice with her up in Wyoming. I made a decision to go up there. I felt like it would be good because I'd be available in the central office, and I had already informed the board in Denver that I was not going to run again for a board position. So I didn't feel like there was any kind of conflict of interest in me being involved, working as a midwife in Wyoming and also being available in the central office.

We did a lot of work with that central office; there were a lot of interviews and press opportunities, so it functioned as a clearing house for information. One of the positive things about it was that the organization was able to respond relatively fast to things that would come up, to put people in touch with others from the organization who would be responsive. With a central office, a lot of paperwork also got done. MANA was getting so much correspondence that it was very difficult to make sure it all was answered. You're getting letters from people who want midwives, people who want information on education, and it goes on and on. We developed certain form letters to send out. The organization was really growing very, very fast, and my feeling was that I saw no way that we could handle that growth without having a national central office and some paid staff member.

There were some weird things that came down, and not in a very positive manner. Right from the beginning, Julie kept telling the board that the organization was in financial difficulty. It almost seemed like it was reaching a point of, 'kill the messenger that's giving you bad news.' She did insist that they start using a form of bookkeeping that could identify

MANA Officers in West Virginia, 1986 (from left): Carol Leonard, Tish Demmin, Lea Rizack, and Valerie Hobbs

money owed. Then at one point, Julie gave herself an advance on a salary, and something happened. We were getting ready to go to the board meeting, and were putting together all of the stuff we were taking. We were sitting there with the financial report for the closing of that month and were looking at it, and Julie said, "There's something wrong here." She said, "This is too much for salary. My God, I double paid myself." And so I said to her that she should call the executive council of MANA.

So what MANA ended up doing was hiring a CPA who came in and did a financial review. They didn't do a full audit because the council determined they couldn't afford it, so they opted for this in depth financial review, which was quite extensive. They pick certain months at random; you don't know what month they're going to pick, and they go through everything: every single receipt, every single deposit. MANA was in financial difficulty.

Tish Demmin

Central office, to me, was the climax. It definitely was the make or break situation. The conflicts escalated over the years, and became more pronounced. There were more vicious sort of attacks happening at the board meetings. Every board meeting and every time we got together it became more and more tense, and we were getting more and more crippled, and not dealing with business as much because most of our energy and time seemed to be focused on other arguments. The Detroit meeting was the one that really did us in.

The Colorado conference hadn't made money. MANA tried to pull out of that one, but we were really hard hit financially. That was the beginning of some really tough times. We put out an appeal. We decided to do a mail-out campaign using Val Hobb's list; I helped coordinate that first mail-out, wrote the letter, and we sent out thousands of these appeal letters. We made a total of about seven thousand, and then with expenses deducted I think it brought in, clear, about five thousand. That helped a little, but certainly it wasn't the solution.

We were basically spending all of our money on the central office at this point. While it seemed as if a lot was happening at the central office, tons of paper, tons of stuff happening, phone calls, whatever, we weren't really functioning very well. Projects weren't getting done because we didn't have the money. The newsletter wasn't getting done the way it was supposed to be done and we'd been paying for. It was just terribly inefficient and we were going down the tubes really quickly.

So then the Detroit meeting was really the clincher. That was the one that really broke it, that said to me for sure that this has to change, we just can't do this anymore. Detroit was such a fiasco; it was the worst of the worst. The terrible physical conditions, six of us all crammed into one room, and no good food. There were three people with new babies there nursing, and we were meeting until three o'clock in the morning, that kind of stuff. Tish resigned at that meeting, and then somehow or other, the board said, "No, we can't let her," and so we carried on. There were walk-outs, all kinds of personal stuff going on, people in tears...

Dealing with the debt of the organization and the central office was left to the very last part of the board meeting. We were up until four o'clock in the morning and people didn't even sleep before they went home. It just seemed like everything that was brought up in that board meeting brought out our emotions. It was so clouded, it was so confusing, that nobody really knew what the heck was going on. We were all exhausted, of course, and

when you're working under tense conditions, very poor physical conditions, that just escalates the whole situation.

The day, in fact an hour before I was to leave to catch my plane, Julie came up to me and told me that she had overpaid herself. She said Tish and Val Hobbs [Appleton] knew about it, and they had worked out a plan where she would just pay it back. I said, "I think the rest of the board needs to know this. You don't need to feel that you have to hide this, but certainly we need to know about it." It was the finishing touch to this horrible situation.

So when I got home, I talked to a lot of people, talked to Linda [Irenegreene, MANA's legal counsel], talked to Lea [Rizack] because she was treasurer. We were trying to figure out, "Okay, we're in a mess. Now what do we do?" It felt like a wrestling match, in a sense, trying to wrestle back the control of the organization. I wasn't president yet; I was running for president and noone else was on the ballot, so I knew that probably I would be president. We had this huge mess on our hands; could we try and figure out something before the next board meeting? We had to, to try and get ourselves functioning, look at our financial situation in reality, because I don't think any of us really knew exactly what we were doing.

So I wrote a letter to the board and informed them, and made a suggestion that we needed to assess our situation. Basically I suggested we have a vote on sending the treasury back to Lea and trying to manage the situation and find out exactly where we were at financially and as an organization. When I went to that board meeting in New Orleans where I became president, I was prepared to either carry on as president if it felt like we were going to be able to close central office and manage the organization, or, if the decision was that we were going to keep on with central office, then I could not do that because we were dead in the water as far as I could tell.

Sandra Botting

I was starting to do some work in New York legislatively and meeting with the Midwifery Task Force and Laurie [Ardisan, North Atlantic regional representative] knew about that. Laurie and I had had a bit of contact. She called me and asked me if I'd take her place at the board meeting. Basically she needed someone who was willing to go. There weren't a lot of people who wanted to go. The board had quite a reputation

at that point, of board meetings being very stressful. That first one was quite incredible. It was in New Orleans. I had gotten a hint of some problems before, although Lea [Rizack] and Linda Irenegreene were very good. I had a lot of contact with them at that point and they really didn't give me much information at all. I went in being able to evaluate the situation without being biased by their biases. That was a very, very wise thing for them to do, I thought, because they had very, very strong opinions, and I didn't go colored with their opinions. I had been getting calls from Julie about the central office before I went to the board meeting. At that point I felt that there was a need for a central office. I had the no idea of the magnitude of the financial difficulties or the interpersonal relationship difficulties.

There was a facilitator at the meeting. The whole first day, everyone was talking around the issue. It took some of the new people to actually break it open. The board meeting before that had been much more difficult. The facilitator was positive and broke through the negative stuff, got to the issues, and moved on. MANA was not in a state of good health.

Alice Sammon

I became treasurer at the board meeting where the central office was closed. New Orleans was a very emotional meeting; making the decision to close the central office was very emotional. There were people that still didn't think it should be done even though we were $15,000 in debt, which was absolutely outlandish.

Sandra Botting and I, as president and treasurer, really felt that MANA was going to disintegrate. See, I took on the treasury when we were in all that debt from the closing of the central office. I'm the person who had to unravel all the financial mess. And then Julie sued us. So Sandra and I handled all the litigation stuff. I had to write to all the people we owed money to, many, many, many people, and tell the situation and start a payment plan. We wrote to the members saying, "Are we going to live or are we going to die?" There was a big fundraising drive that year, and people like Carol [Leonard] came up with the funding. Other years there was always money to fund the conference, but that year we were minus $15,000.

Mari Patkelly

Carol Leonard had a tremendous amount of faith that this organization was going to pull through. It was through her putting up the seed money for the Boston conference and the Boston ladies who were really willing to put their necks out on the line with very little guidance and just going ahead, and the success of that conference that we made it. Fran Ventre and Carol Leonard opened up their homes for board meetings. We were at Carol Leonard's that first board meeting after the central office was closed. It was a very nurturing, healing space and it was a very calming environment. It was someone's home, and it was much more the way midwives work, out of people's homes. People were more at ease, even dealing with difficult issues.

Alice Sammon

When I had been off the board for maybe two or three years, and had not gone to a few meetings, I came back and I talked to Alice Sammon, trying to get the lowdown. "What is the board doing now, what's the process like?" This was after the whole central office blow, which I think was really the end of that era, the end of personality manipulation on the board. She more or less said, "We work by group process and we work by consensus and we respect one another," and I was just thrilled. I believe this was a natural evolution. I think that just like there are stages in labor or stages in child development or stages in a love relationship, there are stages in the evolution of a board. I think you go through the rosy phase, "Everything's great; we can do anything," and then the discovery that you can't without a lot of hard work, and then struggling with your own investments in your beliefs and learning how to translate those beliefs into cooperative interaction. And that is sometimes the hardest thing.

Elizabeth Davis

Most of the problems that I saw happening at the closure of the central office had to do with process. We could easily get back there. I don't think we should ever feel like we won't ever be there. At the 1991 El Paso convention, this lady got up and said, "Wow, I'm feeling really confused and I don't know if I want to risk what we're deciding." I could really identify with her as the person who was me ten years ago. I suddenly realized that there's always going to be that viewpoint. In a way that freshness is really a good thing. But there's always this tendency among the

people who maybe once held that viewpoint, when they hear it come up, to roll their eyes or think, "Do we have to go through this argument again? Wasn't this finished?" And it's not that the argument isn't finished. It's that the process continues. So no, it's never going to be done, and it's a good thing. It shouldn't ever be done, because I think the process is where the strength is. It's not the diversity, it's this process of incorporating the diversity that is where the strength is. And you have to make an organization built on a process that has that fluidity to it.

That's the challenge. You have to put your faith in the process. You have to be able to make it safe for people to be able to express very diverse lifestyles and opinions and personalities. You have to make that very safe. Then, when it feels really anxious and hysterical, you have to go back to having trust in the process. You can't really have a trust in the view point or allowing the viewpoint unless you have to have trust in the process.

Valerie Appleton

We've gotten old and wise enough now that we can have these loaded, heated discussions without any kind of malice or ugliness or sending that poisonous energy out that just makes people sick. Now, I see one of the women on the board not treating herself well; people are concerned about her health, that she works too hard and she's going to burn herself out. But what I hear when people talk is, "We want to nurture her," not "We're sitting around tearing her down; isn't she neurotic; she's not dealing with her issues; blah, blah, blah." It's this wonderful loving thing, "We really care about her. What can we do to support her? What can we do to help her nurture herself better?" That's really different.

I think that we have clearly come the whole gamut, and it bodes well for the future. That we could endure through that difficult time, come to the other side of it and pick ourselves up and keep going is really a wonderful testimony. It's what we all have to do personally, as women; come through our wounds without self-destructing. I have been transformed by the work in MANA, I really have. Not only the group skills, but the consciousness-raising, the empowerment of women issue that happened at levels I can't even articulate.

Therese Stallings

All of North America

Whereas most professions have national organizations, a decision was made at MANA's inception to include all of North America. This has had continued impact on MANA, as the relationship between the United States, Canada, and Mexico, has evolved.

I attended the first conference that MANA had, in Milwaukee. I really enjoyed it, but I saw the need for better representation as far as Canadians go, because at that particular meeting none of the Canadian reps were present. I was there from Western Canada and there were some other folks from Eastern Canada. I made the suggestion at that point that there should be an alternate rep to make sure that some kind of representation was there at the board meetings and at the business meeting. That became a resolution, and became policy within a year. The Western Canadian rep really didn't have the energy and time to put into MANA. I was volunteered to take on the job, and then went to my first board meeting in Philadelphia. We used to meet alongside the ACNM annual convention, so that happened in the spring.

Then the second conference was in Canada, in Toronto. The Canadian conference was done differently than the Milwaukee one in that there were two other groups involved besides MANA, the Midwifery Task Force of Ontario and the Association of Ontario Midwives. It was a three-way effort, and that was the first time that that had been tried, because MANA was just new.

The convention was great; it was a wonderful convention which pulled a lot of people together, with interesting things happening alongside of it, such as the visit to the legislature and whatnot. They did a great job, and made some money.

The woman that had really done the work in organizing everything and pulling everything together appeared at the first day of our board meeting pre-convention. Rather than her being complimented and encouraged and

supported, she got all these really heavy criticisms. It was pretty devastating. There were some bitter feelings that occurred, and I think some people were bruised quite severely from those interactions. We never quite recovered. In a way, it created tensions between Canadian reality and MANA, which resulted in most Canadian midwives and midwifery organizations seeing MANA as being more US.

In Canada, we're dealing with a different sort of political situation. We're dealing with very small numbers of midwives. And we're also dealing with a different health care system, which in a lot of ways we have to our advantage. We estimate there are around 100 midwives practicing in the entire country right now. That includes nurse and non-nurse midwives. At one point back in the '70s there were more. In most of Canada there have never been any midwives, nurse or otherwise, who have been legally legislated to practice. So we haven't had as much division between midwives, which is good.

I think Mexico's different, too, but with similarities. We really have to look at what is MANA's role. I think that MANA has been helpful in giving some skills to Canadian midwives. Certainly the conferences, the conventions, are something that Canadians have never had. In a way, it's been more like a nurturing role, offering the opportunity for midwives from Canada and Mexico to get together and share some ideas and learn from each other, and probably assist somewhat in organization. Particularly I'm thinking of Mexico, assisting them to get up their own organization and become strong enough to do that. And then there may be a need to separate in a certain sense.

That's what happened with Canada at the Boston conference. I think there was the recognition that we just couldn't afford to put all this energy into the MANA organization any more because the demands were such in our own provinces and in our own country that we just had to pull back. We tried to come up with a formula that would still allow for a relationship but not be too draining. So we made a change and made the recommendation, in fact the resolution and policy, that both Canada and Mexico would have the money from memberships in those countries to fund a regional representative, and one regional rep would come to the annual convention and board meeting, but not the spring board meeting. It reduced the number of days and amount of energy being put in, and also recognized the fact that Canadian regions, the Western and the Eastern, were not large enough population-wise to ever consider a conference or the kind of involvement that I see happening in the regions in the US. I think

it's more important politically for US regions; MANA has really done a lot of good things there. I think the change is okay, it's healthy.

Sandra Botting

Canada is following a distinctly different evolution of recognized midwifery than exists in the United States. In Canada, the first provincial Government to initiate steps toward legal recognition of midwifery has recommended that midwifery be defined as a separate profession with its own scope of practice, its own regulating body, and with a direct entry educational program. In all probability the other provinces will be influenced by this model. In other words, Canada is unlikely to have two midwifery factions. The National or Federal midwifery association to which all existing provincial midwifery associations send representation is called the Canadian Confederation of Midwives (CCM). The CCM represents all practicing midwives in Canada who choose to be members of their provincial organizations, regardless of route of entry to the profession.

There is currently a single Canadian representative to MANA who is on the current CCM board, and who is appointed by that Board for the usual two-year MANA term of office. CCM is responsible for funding of the MANA representative, which spreads the funding nationally and allows a representative from anywhere in the country access to the MANA position. Because the rep is also on the CCM board, there is better communication of Canadian Issues to MANA and likewise provides a forum for reporting back MANA business to midwives from across Canada.

Excerpted from MANA News, Vol.VII No.3, Sept. 1989

In Canada I have found a hesitation, a reluctance to get involved with American midwives. Granted, there were some fairly colonial attitudes on the American midwife horizon, exemplified by symptoms which were first laughed at, such as one of the Canadian midwives receiving in her board packet American stamps to mail something to the States from Canada. It was also frustrating to constantly remind Americans to add "provinces" each time they would draw up a MANA resolution involving "all of the states." However, I feel that the criticism of MANA by Canadians became somewhat excessive, or at least impolite (to use the strongest word that a Canadian can muster). It seemed to become all-inclusive and stereotypical. The "American way" became described to Canadian midwives, by some of

Canadian representatives Lee Saxell of British Columbia (left) and Ava Vosu of Ontario. May 1983.

the Canadian delegates returning from MANA meetings, as one that was too unruly, too interested in spiritual midwifery (a phrase not to be uttered among politically astute Canadian midwives) and not one capable or interested in presenting enough of a "professional image." Some of the midwives went so far as to say that American midwives were so interested in touting the rights and beliefs of their own individual midwifery that they were deprived of the good sense of community that Canadians have. It's

pretty easy to cry "colonial attitude" at Americans and forget that it is ripe at home.

Highpoints of Canada's relationship with MANA have been the learning and exchange of ideas at all the wonderfully colorful conferences that have occurred over the years. The ability to get together with Mexican midwives and keep each other up to date on what issues are at stake has been particularly useful. However, I did see the need for restructuring of our relationship with MANA because of the large distances in Canada and the lack of resources to maintain two reps. I had already been attending board meetings by the time that I became co-rep for Eastern Canada and things were coming to a head, and could see no alternative other than to reduce our relationship to one rep.

Although I realize that we need to put more energy into the Canadian Confederation of Midwives (CCM), I have misgivings about the implications of stepping aside too much from MANA. I'm concerned that now we need MANA more than ever to maintain our broader perspective. The official CCM delegates for the most part are those whose main agenda is to legalize midwifery in their provinces. Broader issues such as de-regulation, apprenticeship, the ethics of midwives, and the definition of a midwife are seen largely as distractions. On several occasions in midwifery political circles in Canada the easiest thing to do with those of us who have had any strong beliefs in promoting the apprenticeship approach or traditional midwifery has been to brand us as "American" or those with "American" ideas. There has been a fear, not necessarily unfounded, that heralding an image like this in Canada will harm the impression that midwives are really very good girls, of the studious, upright, conservative sort: i.e. the type of midwives that the government professionals and medical establishment here might actually consider. Working well with the nursing and medical professions and government administrators has become the gauge of importance in assessing one's worth as a midwife.

In retrospect, I feel that I did not defend MANA strongly enough in Canada during the shaky years; I have learned that those who remain silent when criticisms are being laid are condoning what is being said whether they intend to or not. At a time when I was feeling that MANA was actually a very visionary organization, unique in that it has always allowed itself to dream and articulate ideals without concerns about censorship or looking silly, I was watching an incredible destruction of its credibility in Canada. This was also at a time when I realized that most Canadian midwives that I talked to, who were more involved in the carrying on of

their practices and community ties than in provincial or national politics, actually had similar concerns to ones often being discussed more freely at MANA than in their own provincial associations. I think that Canadians have gotten behind in discussing broader midwifery issues not just because there's an illusion that they're not our issues, but also because they just look too unwieldy.

Suffice it to say that I think that Americans and Canadians and Mexicans have a lot to learn from each other. While Canadians and Mexicans need to step aside periodically from the States in order to form their own approach to midwifery, we need to maintain a good relationship with our American friends in MANA. Many of our issues are the same: the saving of a women-centered, informed choice approach to midwifery care, the saving of traditional midwifery apprenticeship approaches, the re-definition of "midwife," the use of research to promote better care with less technology, and the biggy, maintaining unity in diversity. There are too many things we need to present at ICM together to allow relationships to slip. Sometimes we need general larger forums of midwives for these discussions to take the heat off of bringing it up too close to home.

Betty-Anne Daviss-Putt

Mexico has a very different political reality than either the United States or Canada. Midwifery is legal, but there is a very different population of midwives; issues of poverty, nutrition and basics of care are at the forefront. Mexican MANA members must also face a language barrier when working with their northern sisters.

In Mexico, midwives are tolerated. 50% of the births in Mexico are attended by traditional birth attendants, midwives. There are not enough doctors in the rural areas to take care of birth, so the government tries to train midwives and to back them, and they have to tolerate them. It's absolutely needed in our country at this moment.

We have several different midwives here in Mexico. The majority, either traditional birth attendants or trained by the government, are very poor. They are not so educated as to be able to speak English. Most are midwives from rural communities. I wouldn't consider them to be isolated, because they are very well known in their communities, but they are isolated according to the government or to associations like ours. So it is difficult

for me to get them interested in an association like MANA that they don't really understand, with a different culture and different language. They wouldn't even be able to read the MANA News, and many have never been in an association.

Some of the other midwives are ones like me, who have been trained either in the States or by books as direct entry midwives. Some have been getting practical training in El Paso, at Casa de Nacimiento or Maternidad La Luz or places like those. As far as I know there are just a few of us, maybe twenty or so. These are the ones whom I've been getting interested in MANA.

The third group of midwives are the university ones. Those are the nurse-midwives who are trained as obstetrical nurses. They usually have no opportunity to work in hospitals, because most hospitals won't let them do the births or do the prenatal care. Those are also the people who might get interested in MANA, but they usually don't speak English. They don't think they need to belong to a society that doesn't give them anything in Spanish. And they don't go to conventions, because they wouldn't have many options like simultaneous translation for some of the lectures. So our big problem, usually, is language.

There was definitely some change in the perception of MANA with the El Paso conference [in 1991], and many people expressed interest in going. But then we didn't get attention on translation again for New York. If MANA really put some attention on language and translation for programs and the newsletter and such, then we would be able to get a lot more people involved.

Ticime is our Mexican organization which has been taking care of midwives. We formed this group when we started our own training program three years ago, and now we also have a newspaper. We try to get together as many traditional midwives as possible and help them out. It's not part of MANA, but we are trying to get some of the people involved in Ticime involved with MANA. We had a wonderful International Day of the Midwife on May the fifth this year [1992]. We got together about 100 midwives; we have plans to make another longer workshop for next year. The response of these midwives has been wonderful.

We took money from MANA in order to gather these people together for that day. They paid nothing for training, and we even fed them. MANA helped a lot economically, but how could we talk about the MANA association to these people? They can't even read, not in English,

sometimes not even in Spanish. Of the people we took to El Paso in 1991, three or four didn't know how to read or write. They're just midwives.

I do believe that we have to keep on working with MANA. The midwives who are a little bit more educated and can get in touch with the organization can learn a lot on how to get a society running and how to get some facilities for working in a group. I think we should be a chapter in MANA, one which midwives can come and be part of, perhaps not with MANA directly but with a chapter that depends on the needs of the communities. That's really what we have been doing here in Mexico.

People in MANA need to know our reality, the labor conditions, the nutritional conditions, and all the problems that we have. The 50% of midwives that attend births in Mexico will receive a chicken or eggs or beans as payment. They won't charge money; they do it by their heart.

Guadalupe Trueba

Affirmative Action and Women of Color

What does Affirmative Action mean? How does it relate to an all-women's organization? And why have an Affirmative Action Committee? These question are answered here by the committee chair:

What is the Affirmative Action Committee?

I have recently received inquiries concerning the work of the Affirmative Action Committee. In applying for membership to MANA, some people have stated they don't know what 'affirmative action' is. Others have asked, "What is the focus of the Affirmative Action Committee?" These questions are necessary for the continued existence of the committee, because whenever issues of definition arise, a certain amount of consciousness-raising is indicated and the potential of the A.A. Committee to continue its work is realized.

The (purpose and) progress of the committee can be seen in the dramatic increase within MANA of women of color. The growth of the Women of Color Caucus, the ethnic diversity of the speakers at every conference, workshops and panels geared to the issues of under-represented midwives, the Lesbian Midwives Caucus, as well as guidelines for achieving affirmative action on a regional level are the direct result of the work of the Affirmative Action Committee. We realized there were midwives who felt MANA was not an organization which could (or cared to) focus on the concerns of their practices and who viewed the organization with a certain amount of skepticism in terms of its ability to accept the different needs of under-represented communities. Due to the committee's effort, these midwives are actively involved with MANA and are helping to expand and enrich the organization. Many midwives live in areas where pursuing affirmative action policies for membership in regional organizations could make them feel as though they were "hunting" Black, Hispanic, Lesbian, or Native American midwives. What affirmative action means in these instances is, if at all possible, actively seek these women and affirm the organization's need to have them form an active part of the regional

program. To neglect any segment of the midwifery population, in addition to being uninformed, severely limits the power of the alliance... Through the process of communicating and sharing information, one's ability to actively affirm the contribution of others is greatly enhanced...

It is a known fact that a sort of "identity skin" exists between particular groups of people. Us and them. This attitude is pervasive and separates us from people who differ in ethnicity, have different political beliefs, speak a different language, express their sexuality in different ways, dress differently, and the list can go on and on.

We of the Affirmative Action Committee feel it is our duty to be that nagging little voice at the back of the organization that continually questions the practices of MANA (in terms of its "organizational complexion"). Instead of differences which fragment us, our differences can enrich us. We wish to affirm these differences and have MANA become an open organization which allows the life-giving breath of change to keep it free of entropy. The idea of creating this reality takes more than one person or a single committee; hopefully it will find its way into the hearts and minds of all members and remain an ongoing effort.

Sharon Ransom in MANA News, Vol.7 No.3, Sept. 1989

I could see the heart of the people that were involved with MANA, and I saw that they had the heart, but they didn't have the experiences with other peoples. What I could see was that midwifery would become a middle class white woman profession, and that it would exclude so many people that needed it as a means of survival. There were going to be decisions made and policies set that would impact on the future of midwifery. I felt that my original purpose in becoming involved with MANA was to make sure that there was a whole level of folks with another reality involved, and that they wouldn't get forgotten when all these decisions got made.

And from there, I came to understand that this wasn't a job for one person. I could think of all these wonderful power women, intelligent women, some educated, some uneducated, but with the motherwit and the experiential knowledge that MANA needed to be balanced and to be clear and to really represent midwifery in this country, and not just white middle class women. CPAD (Childbirth Providers of African Descent) had formed that same year as MANA, and we were a national organization. So there were all these folks that were functioning all over this country that MANA

didn't know anything about, and wasn't likely to know anything about unless the groups were introduced.

It's not a black agenda. It's an agenda for all the people that are different. It's not just for us, so that we then become the ones who have to speak for all the quote unquote minorities. I can't speak for a Native American woman; she's got to speak for herself. I'll never think of all the things she has to say; even though we have so many things that are the same, we have a lot of things that are different. It wouldn't be the same for a Vietnamese woman in her community, and it wouldn't be the same for the Mexican women or for the Native American women that are out in the desert as opposed to in upstate New York on a reservation. It's different, and so you've got to think in terms of making sure that the definitions, decisions, directions take everybody's reality into consideration.

So what I am is the trailblazer, the one who breaks the ground and sees, "Well, Gladys could build her house on this spot, she'd like this kind of spot on top of a mountain," and somebody else might like it down by the ocean.

Sondra Abdullah Zaimah

There were changes in the Affirmative Action Committee while I was president. It really expanded and became more of a reality. There was a pressure which grew from the membership and the Affirmative Action Committee, and that was very good. I think that's one of the most exciting things that I've seen, just to see that more and more women of color are there, and there are more pertinent topics. I don't see that in Canada, and I think that the diversity is probably my favorite aspect to MANA; it's wonderful.

Sandra Botting

At the Annual Business Meeting of MANA in Kansas City, Missouri on November 3, 1990, a new region of MANA was created to be called the Woman of Color Region. This proposal was brought to the membership for approval after being approved by the board of Directors. The Board has had a Woman of Color seat since Fall 1988, however, the position has been filled by a different person at each board meeting and sometimes not filled at all. Funding was from the Affirmative Action Committee (AAC) which

represents the interests of many minority midwives other than women of color. A regional representative from the Woman of Color Region elected to a three-year term will allow more continuity and improve the effectiveness of the seat and the board. We also feel that more women of color will join MANA to become members of this new region. Funding will come from the AAC, the Regional Fund which helps support the other regions, regional fundraising activities of the new region, and can be supplemented when necessary by the MANA Treasury to insure board meeting attendance expenses. Membership dues from the members of the region will help make this possible.

Jill Breen and Sondra Abdullah Zaimah
Excerpted from MANA News, Vol.IX No.1, January 1991

Sage Femme

My first networking was with grand midwives, and I couldn't ever forget them. When I met them they were practicing, and they were just in the process of being shut out by Medicaid. Once Medicaid became available, you had the only time there had been any incentive for the doctors in central and southern Alabama, and other states as well, to look after poor women's maternity care. They did it just long enough to get the midwives out of the picture, and then Medicaid requirements got tougher. So we then had people who weren't allowed to have midwives but couldn't afford to have care at the going rate, and in effect were prevented by the law from having any care. And that's a situation that's gone on in some places for at least ten years.

I brought those grand midwives to the attention of MANA. I kept saying that, despite the lack of formal education, they had things that they could be teaching us, important stuff, the heart and soul of midwifery, the difficult stuff to learn.

I'm gratified that we've done what we've done for the grand midwives, and I want to give us credit for that, but I also want to see us do it in a bigger way. Speakers, celebrations, treasuring these women that may not be with us that many more years. Finding them, identifying them, honoring them and then trying to create ways in which they can teach us what they know. There's a lot of creative ways we could do that.

Ina May Gaskin

The Grand Midwife

The Grand Midwife is any midwife in the United States who practiced under local regulation prior to 1965.

Whereas there is an acute shortage of midwives in the United States and a growing number of communities within which there exist competent midwives with many years of experience who have been excluded from

practice in these same communities that continue to desire their services, the Interorganizational Work-Group on Midwifery Education recommends that these Grand Midwives be reinstated to practice in those jurisdictions where they have previously been legal if they are able.

We recommend that these Grand Midwives work under arrangements that involve them with other care providers to enhance their knowledge, skills, currency of practice, and their ability to work as part of the health care system.

We further recommend that all midwifery training programs utilize the expertise and knowledge of these Grand Midwives.

Accepted by the Interorganizational Work Group on Midwifery Education 9/29/91

And then MANA started honoring the grand midwives. And there's no other organization I have ever been involved with, anywhere, that has ever done that.

You know, ten or fifteen years from now, the Sage Femmes will all be gone. There's no new generation of grand midwives. It's not like when we're 65 we're going to become the grand midwives, because our background is so totally different, and the way we came to midwifery is so totally different.

I see it as our greatest honoring. It's interesting that while we struggle within all our meetings to create this 'professional midwife,' our greatest honoring goes to someone who would never fit that definition. It's such a contradiction. But the reality is, in another 15 years there won't be that kind of midwife to honor anymore. There will be the idea of that midwife, but this generation of midwives is just totally different from that. There has to be a way in the creation of our ideals to embrace the honor of that tradition.

Valerie Appleton

A Grand Midwife is honored by MANA at each Annual Convention, where she is presented with the Sage Femme award. The Sage Femme is chosen by the region in which the convention is held, and is a resident of that region whenever possible. The Grand Midwife is a midwife who has practiced the art of midwifery over many years, and serves as an

inspiration through her dedication to midwifery. Descriptions of a few of these women follow.

Della Keats San Francisco, 1985

For nearly 60 of her 74 years, Della Keats (who prefers her Inupiaq name, Puyuk) has been meeting her people's needs. She travels throughout northwest arctic Alaska to treat patients living in remote and isolated villages.

Besides a few traditional herbal remedies, Della's only tools are her hands, heart and mind. Della's hands have been the first to receive a number of the area's newborn children. Her style is very personal and reflects her people's traditional values.

Born in April, 1907 in Noatak, Alaska and one of seven children, Della began spending time with her community's traditional healers at the age of 14. By the age of 16 she had become a practicing midwife.

Della began acquiring her skills at a critical junction in history. The advent of Euro-American arrivals to the region brought new diseases against which only western medicine proved effective. Inupiaq people were losing faith in traditional cures. Della kept her faith alive and took advantage of the new knowledge. She supplemented her traditional skills with a physiology text in the village school. She read books left in the village by visiting public health nurses and tried to practice the first aid techniques she had from them. Della's growing knowledge was nourished by both the traditional past and the arriving new culture.

She'd like to retire, but says, "I won't. People keep coming in and asking for help."

Margaret Smith Wheeling, 1986

Margaret Charles Smith is an 80-year-old midwife of Greene County, Alabama who has delivered more than 3,000 babies during her career. A mother of three, she became interested in midwifery after she sat with her husband's cousin, a mother of 14, while she was in labor waiting for the midwife to arrive. "Sometimes by the time she got there, the baby would already be here, and I would be done bathed her," she said.

Della Keats (left) being introduced by Elizabeth Davis, 1985

She received her training in midwifery by working with Ella Anderson. "I just watched her," she said. "If you think you're interested to learn something, why, you just put your mind to it." She accompanied "Miss Ella" around Greene County for two years before embarking on her solo career as a midwife when she was around 40 years old.

Mrs. Smith began her practice charging $5 to deliver a baby, but often she would go unpaid. She says with pride that she never lost a baby or a mother during the 35 years she served as a midwife in Greene County. If the women were experiencing a difficult labor, Mrs. Smith used a simple but effective technique. "I just had to console them the best way I could," she said, often telling them, "These things need to be. The pains are gonna get close, harder, and it's gonna hurt, but it'll soon be over, after the baby is here."

Mrs. Smith was one of the last midwives practicing in the state before she was issued her last permit on March 24, 1981. She says she misses midwifery "a good bit" and thinks the trade should be continued. When honored a few years ago by the Eutaw City Council and given the keys to the city, she responded by saying that she didn't want them; she only wanted to be able to practice midwifery again.

excerpted from MANA News, Vol.IV No. 3, Nov. 1986

Jesusita Aragon Denver, 1987

On our way to Mexico we met with Jesusita Aragon, one of the few remaining licensed lay midwives in New Mexico. A sparkling, energetic woman of seventy, she told us she had delivered 11,926 babies (as of June 1978) and that she's delivering 10 to 12 a month. In the past she used to deliver 20-24 babies a month, and one time she delivered nine babies in one night.

Now she is the only one left, but there used to be 65 midwives in Las Vegas, the little town about an hour from Santa Fe where Jesusita was born and has spent most of her life. She has delivered the same number of babies as the population of Las Vegas.

She said she had had an elementary school education, learning English by reading when she became an adult. She first started going to births when she was 14 -- her grandmother was also a midwife. "I went to school in 1940," she states. "They used to give us some meetings every month. I have my license, my diploma, my pin."

In all her births, she has never had a mother die, although there have been some stillbirths. She has delivered 11 sets of twins, 1 set of triplets, and numerous breeches. "Breech is a little hard," she says. "I don't want to scare the patient, so I don't tell them if it is a breech, because if they get scared, the baby won't come out."

Her patients receive prenatal care at the Centro Campesino in Las Vegas. Mostly she delivers Chicana women, usually in her own home. Perhaps 10% of the deliveries she does are home births with the parents taking classes, the husband present, etc. These people come from all over to be with her -- New York, Mississippi, Puerto Rico.

from an article by Rahima Baldwin

Onnie Lee Logan Boston, 1989

Onnie Lee Logan came into the world at the hands of a midwife in Sweet Water, Alabama around 80 years ago. Logan's mother was a midwife, and also her mother's mother. At the time, half of all births in the U.S. were attended by these unlicensed specialists in home delivery. In 1947, the year Onnie applied to become a midwife herself, she was required by the state Board of Health to pass a nine-month training course.

Onnie Lee Logan, who was divorced, widowed and married a third time, had only one child, a son. She made her primary living as a maid for a wealthy white family in Mobile, while on the side she delivered black babies in the poor sections of the city and white babies in the hinterland of Mobile County.

The grand midwives were outlawed in 1976, but Logan was allowed to continue practicing until 1984. She was the last lay midwife in Mobile.

Beula Clay Kansas City, 1990

I was born in a little town called Smithfield, Missouri that is not on the map anymore, There were nine children, all born at home, in my family growing up. I married in 1925 and I had three sons and a daughter, all born at home. The first one was delivered with the assistance of a doctor, and the rest were with midwives. But we didn't call them midwives then; we just called them neighbors.

I began attending births with my mother and sister when I was 17 years old. Mother retired and my sister opened a restaurant, leaving neighboring mothers to call on "Beula" to help them. I did the best that I could. I have no idea how many babies I have delivered.

Two grand midwives were honored in 1992, on the occasion of MANA's tenth anniversary.

Elizabeth Smoke New York, 1992

Elizabeth is 78 years old, mother of five, with many grandchildren and great grandchildren. She is a traditional Spiritual Faithkeeper for the Wolf Clan at the Cayuga Long House.

Elizabeth has been a midwife to many people on her reservation in the past. Although she has not practiced for a number of years, she is still a consultant to the doctors and hospitals in her area. She still gets calls from the area hospital if they are having a difficult time, and many times she has solutions that can prevent technical interventions.

Elizabeth is also a very, very well known herbalist. People come great distances for the remedies she dispenses. All of her medicines are gathered in the traditional way of thanksgiving and respect for the plants. Elizabeth also works within the traditional way of not charging for her services; she accepts only what people offer her.

Elizabeth has very happily given many years of her life to this work. She has also been a great inspiration to myself and many other women. To be able to raise her family and to do so much for others is truly a thing to be honored for. I am glad that MANA has chosen to honor her here in New York, which we consider to be part of the same territory as Elizabeth's home. She is a great example for many to follow, and I am honored each time I am in her presence.

Jeanne Shenandoah

Gladys Milton New York, 1992

Gladys Milton is an inspiration as a midwife, mother, community leader and educator. Mrs. Milton is 68 years old and has been a community midwife for 33 years. She has delivered over 3000 babies with excellent statistics. Most of the adults and children within a 25-mile radius she claims as "her babies." She has been a staunch supporter of direct entry midwifery education for Florida, and was appointed by the Department of Health and Rehabilitative Services to the first Midwifery Advisory Council in Florida.

How did Mrs. Milton become interested in midwifery? The story goes that one day when her twins were little girls, they ran home to tell her that all the mothers were meeting at the school. When Gladys got to the meeting and looked around, she realized that all the rest of the women there were

pregnant. She tried to leave, saying that she must be in the wrong place, but the health department nurse asked her to stay anyway, and looked right at Mrs. Milton while she asked if anyone in the room was interested in training as a midwife. Later that day, as Gladys was discussing it with her son, Henry, he said, "What have you got more important to do than that?" Her inner voice kept haunting her by repeating this phrase. She started training with the local health department, and was first licensed in 1959. She went for further training with two local doctors, and later attended nursing school and worked as a labor and delivery nurse in a nearby hospital. Meanwhile she was doing home deliveries in conjunction with the local health departments. In 1989 Mrs. Milton continued her education by becoming licensed as an Emergency Medical Technician. The State of Florida has changed its midwifery law at least five times while Mrs. Milton has been a practicing midwife.

Her spirit and faith are undaunted even when the state authorities have twice tried to take her license away and close down her birth center. Her motto of strength has become, "Why not me?" instead of "Why me?" She has been steadfast in showing younger midwives that the government can't push midwives around, and that midwifery isn't going to vanish. She believes that every family has the right to midwifery care. Mrs. Milton continues to deliver babies in the Florida panhandle, passing on to midwives the true essence of midwifery.

The Grand Midwives have a wealth of midwifery knowledge. May their skills and wisdom be passed on to the new generation of midwives. And may MANA keep honoring these women as long as they are alive to be honored.

Ethics

To me the ethics statement[1] is one of the most phenomenal milestones in MANAs history, because it is the document to which all other documents will refer.

Elizabeth Davis

The International Congress of Midwives was trying to formulate an ethics statement. In order for any member organizations to be involved in that, they had to be working on their own ethics statement. So I believe it was in 1984 or 1986 that Star Cross was appointed as the first chair of the ethics committee specifically to draw up an ethics statement that would give us a foot in the door on having input into the ICM situation. And that was the sole purpose of putting together an ethics committee.

She set to work on that, doing an extensive review of every bit of ethics information she could find which other similar organizations had come up with. She gathered ethics statements on an international level, writing different nursing boards and so forth. It seemed at the time that many of those organizations were also in the process of trying to formulate something in relationship to an ethical code. In her best effort to get something together, a statement was brought together that was rather long, tedious and pretty involved. Unfortunately it was, in my view, a real disaster of a document. This was because the values in most ethics statements are the values of the patriarchy, which are based on power and authority. She was trying, within the kind of ethical code framework that predominates in patriarchal organizations, to slip in certain ethics that were based on totally different values. As such, it just became this hodgepodge, and was a totally unworkable document.

In New Orleans, I was told that Star Cross no longer felt like she could be the chair of the committee, that she had a document that she felt was in an almost final form, and that they wanted somebody else to take over the

[1] See Appendix A

chair. I accepted the position, and the first thing I did was enter the document as she had written it into the computer. I found that it was fraught with difficulties. As a result, I wrote a letter and presented the idea that we needed to rewrite it or reword it; something needed to change.

We worked on it as a committee. At first it was a larger one, but when I didn't get feedback from people, they were dropped from the committee. I wound up with a small group; Laurie Foster, Jill Breen, and Mari Patkelly were three of my main people in formulating this. And Valerie Appleton has looked over it and given me some feedback on later editions of it.

We knew we needed to have something that was based on our own values rather than trying to write an ethics statement in which the values were implicit and assumed and the values of the patriarchy. The thing is, values are usually assumed. Values are almost never addressed in ethics statements as they stand. The AMA ethics statement doesn't have a list of values that say 'We value being an authority figure,' or 'We value our parent/child relationship with our clients.' They don't have that in there, but it's obvious that the ethics they have set forth very much rely on those values.

Because women's work and women's values are so devalued in this culture and so invalidated, I felt it was important to start out from the point of values. We have different values, therefore we will behave differently in many situations. The MANA ethics statement as it stands is a statement of values and ethics that very clearly, and some people feel too specifically, delineates a whole laundry list of values, and then goes on to discuss how one applies one's values in acting. Ethics is actually the process of acting out values. When you act in a way that meets the needs of the status quo, which is often antithetical to your values, that in essence is not ethical because you're not in line with your values.

Certainly the point of the ethics committee is not to make any sort of final judgment as to midwives' values. Our purpose, as it has evolved, is to try to probe into people's understanding of what they're doing, to try to help them clarify just what their values are, and then help them understand how their actions may or may not line up with those values. Basically, I think that the statement speaks for itself.

Interestingly, the feedback I've gotten from people that have some ethical theory behind them is that it is absolutely revolutionary. Of course there are some people that don't like it. The main complaint that I have gotten is that the values are too specific; and some people disagree with the values. For

example, Barbara Katz-Rothman told me that if she were a midwife, there were a lot of those values that she wouldn't agree with, and does that mean that she can't be a midwife? This is a very good question. However, the feedback that I have gotten about it that has been positive has been absolutely glowing. Now, there was a really vehement letter that we got from somebody who felt like it was too wishy-washy. And one could say that it is very wishy-washy. For somebody that comes from a background with an extremely patriarchally-oriented "you act this way" kind of attitude, it leaves far too much to individual discretion. It just doesn't jive with that kind of attitude. But then, it's the antithesis of that.

It's very important that the statement remain a fluid document, so that it evolves as the membership does. I think it's a tool that you can use to examine how you are functioning as a midwife, something to help you think about what you're doing and how you're relating to the women you work with.

Anne Frye

On the Interorganizational Work Group I tried to do some kind of ethics. There are certain ethical standards to which midwives need to be held, for me, as a non-midwife, to be ready to see the state empower midwives. There aren't many of them and I think they aren't that hard to get midwives to agree to.

The MANA statement, and the principle of saying there can be no standards is very distressing to me. For instance, and I think this is a real concern here, a midwife refuses to treat a woman because of some characteristic of hers not related to her ability to give birth. Her religion, her race, or her sexual orientation is probably a very good example. The midwife says, "I don't like 'blanks,' so I can't work with you well, so I won't." It's not acceptable to me to leave the woman without care. The argument that, "Oh well, she'll never really give the optimum care because she doesn't like Jews or lesbians or blacks or born-again Christians, or whoever it is she doesn't like," that may be true, and it may even be appropriate for her to tell the woman, "In spite of the fact that you're a lesbian and I totally think you're morally repugnant and going straight to hell with your baby, I'll still do the best I can for you, if you want to work with me under those circumstances." But there is an ethical obligation to provide services.

A few of those kind of ethics - disclosure of information, willingness to work across whatever barriers - a midwife does have to be held to in order to be a state-empowered profession. I well understand the feminist philosophy and theory, but that doesn't obviate the need for an ethics statement. I think the MANA ethics statement is not an ethics statement; it's a statement of many, many shared values. I know that I could not be a midwife because I do not share all of those values. I think it's far too detailed, and assumes that anybody should share the nitty-gritty of three hundred different values in order to practice midwifery.

A basic thing that worked with the civil rights movement is, "I don't really care what your values are, at some level. That's your business. There are certain things you have to do. You don't have to value whatever, but you still can't make people go to the back of the bus." And so whether or not midwives can or cannot come up with a statement of shared values is interesting and a nice project to work on if you want to, but it's not ethics, and I wouldn't insist that a midwife share my values to become a midwife. I was very distressed at the thought of midwives saying, "You're not a midwife if you don't have certain values." But I do think it's appropriate to say, "There are certain things you have to do if you're a midwife' and some of those fall into the realm of what we call ethics. So I think that there needs to be an ethics statement; and the values thing is nice to work on, but I think potentially more divisive than anything else.

What's the point of an ethics statement? To establish yourself as worthy of state recognition. It's not another process.

Barbara Katz-Rothman

Working on the ethics statement was one of the most exciting things I've done with MANA. In the beginning, we brainstormed with the board. It was refined a little bit, and we got it together. Those were the basic tenets we started out with which we presented at the ICM meeting in Kobe, Japan. Now it's gone on and on.

I had a client who taught ethics at Harvard. I did a presentation at her class, and she thought it was brilliant. She was saying how that is not the way an ethics statement gets done, getting everyone together, putting it out in a newsletter, having comments from members and all that. It's been a process, and I think that's why the ethics thing is so exciting.

Mari Patkelly

Statistics

Right from the beginning, statistics and media were the two areas that I couldn't say no to. And so right from the beginning, while we were opening lines of communication amongst ourselves, we also were very much alive to the need to correct the image of the midwife. This obviously had been based on an idea that was very wrong and very damaging, yet was so ingrained in the public and leading people into all kinds of error. It's still the case, but we're getting closer to where we're going to have great change. You don't just have a depression and have a situation where one-fifth of the population has no right to health care without having the conditions for change be created. So we are coming into the times that really are going to call that question. Pressure's building for a national health care system. I don't know that we'll get midwifery, in the sense that we understand it, to be part of that from day one, but you're not going to wipe out midwifery; it will be there.

With the statistics, women can look at all these scientific studies that finally demonstrate that yes, it is good when women take care of women in childbirth. So we could have told you that, if you would listen. But the fact is it's not so easy to convince the powers that be, the way it's been arranged and the way we've inherited it after so many centuries and generations. We don't just turn that around only on anecdotal evidence. You've got to be able to build a statistical case to back you up.

Statistics alone won't do it either; you can have all the statistics in the world, and they can be kept out of public view, unless you're going to push them forward. So I've always thought we had to do both, and both are giant tasks. A lot of inertia is pushing against our doing them, but it remains very important.

You know, these are long-term goals. I've never had the idea that this was going to be a short haul.

Ina May Gaskin

For those of us who began doing homebirths unaided by a degree or by knowledge that there could actually be external sanction from statistics, there was still always confidence that the form of care we were providing was needed, sanctioned, justifiable. But there came a time when we tired of the horrified looks of in-laws, the allegations of physicians, and the insinuations of hospital staffs that homebirth and physiologically-managed births were somehow an inferior form of care or provided worse outcomes than hospital births. We now know that this criticism is unfounded by research. Although we also know that much of medical practice is not founded on science, it doesn't mean that we, too, have to go on theory and our own experience as our only guide. We find ourselves in need of talking the scientific language to be able to relate to people who require that approach to be persuaded.

Some of us have felt the need to collect homebirth data more keenly than others. Ina May felt it early because she had compiled an amazing number of births at the Farm. For me, it became crucial when my own peers were putting me up against a wall because I was doing VBACs (vaginal births after cesarean) at home. I remember that was the first time that I felt a strong need to talk with Carolyn Steiger and the Oregon midwives who had done the herculean feat of collecting their stats. I spoke with her about the possibilities of tapping all of the midwives' practices in the States and Canada who were doing VBACs at home, but it seemed at the time like an insurmountable feat to get everybody's cooperation let alone not make errors in the format of the collection or the interpretation. Recently that first dream, of tapping already pooled resources, came true when we needed to collect stats on long second stages for an inquest. Carolyn came through, as did Ina May and others who had already compiled or were willing to compile their data quickly. It showed us what resources we have at our fingertips. And shortly after, it came full circle, with a situation in Quebec in which we realized again that we still need to pursue the statistics on VBACs at home.

To be prepared each time a midwife gets into trouble, it would be wise to have a pool of data that shows that other midwives do similar procedures with good outcomes. We need to be able to challenge those who may say that what she has done is "unacceptable" or not done anywhere by any reasonable practitioner. Each time a province or state legislature attempts to legislate out of practice those doing homebirths, we need to be able to produce the evidence that such a move is inappropriate.

In the land of epidemiology of pregnancy and childbirth, there has recently been a focus on evidence resulting primarily from randomized control trials of specific procedures. However, the randomized control trial cannot tackle the issue of homebirth. With the possible exception of Holland, how would those of us in most countries ever have clients agree to a study in which they were obligated to have home or hospital births at random allocation? Furthermore, randomized control trials have not been used to compare the whole package of active versus physiological practice, which is really a central issue of homebirth versus hospital birth.

We are in the position where we can do this research, compile all our data on the births that we've done already as well as those in process and in the future, i.e. retrospectively and prospectively. North America is one of the few places in the world that has had ongoing relatively unrestricted midwifery practices using physiological management coupled with a knowledge of technology. Our procedures have not been scrutinized and belaboured by artificial parameters as much as elsewhere. If we can do research effectively and efficiently, we will have not only data to evaluate the efficacy of homebirth, but also to study the merits of some of our forms of care such as no routine use of oxytocics or allowing women to go for a few days when her membranes are ruptured.

There have been several challenges to the collections of our statistics. The first and foremost, which has been the holdup from the beginning, is the difficulty in establishing a form that both contains enough data (enough "fields" of information) to make necessary comparisons but one that is short enough to secure compliance from midwives to fill it out. Holliday Tyson had begun collecting some forms when she was head of the Statistics and Research Committee. When Abby Kinne took over from her in 1987, she continued the compilation and brought it to fruition by drawing up a form that was a composite. Her solution to the compliance issue was to combine a data collection form with the prenatal form so that midwives wouldn't have to fill out information more than once. Unfortunately, the amount of information that we collect prenatally is too much to really warrant statistical analysis, and it made the form too unwieldy and difficult to collect from each midwife.

In 1989 I began working on a form for Ontario with Ken Johnson, an epidemiologist at Health and Welfare Canada, incorporating the MANA form proposed by Abby with data forms from around the world. We had the benefit of having analyzed the homebirth/hospital birth statistics for Ontario midwives from 1983-5 and saw several flaws in the collection style which

we have eliminated with the new form. We are now, in 1992, at a point where we are testing the resulting form in parts of the States and Canada. The only changes that have been made on it in the last year of use have been minor, and we see now that changes will always be made as new issues come up, but they should be minor as well. In taking over the Statistics and Research Committee jointly, Ina May and I have decided to go with this form and encourage the states and provinces to do likewise. Abby is back in the picture again, helping us with Epi 5, a data analysis program that Ina May has discovered.

Each state and province will have to assess how they want their statistics collected. Some already have the compilation done, and we are happy to analyze it for them, with them, and get them on the road to do it themselves. There are certainly questions that came up for consideration with some of the states and provinces when we were collecting the second stage stats: do you want your regulatory body of midwives to be collecting the statistics, or will that color the stats because the midwives will be afraid to admit the types of procedures they have done if their disciplinary body is receiving the information? Who will publish the stats? Who will present them?

It has taken us ten years to come up with a data form. Now we have to fill these forms out! Midwives have been telling us that some of their files from ten years ago are on little cards saying "Baby good. Mother no problems." We're going to have to fill out what we can. I've been collecting my stats since 1989; the form has changed, but not enough that I have to redo the ones I've already done. It was not easy to get me to do this. I had made a decision when I became a midwife not to be so note-oriented, and did not keep records for many years for fear that if I was caught, my records would be used against me as evidence that I was practicing. It took an epidemiologist to get me to do it, my apprentices to help me out. It may require an inquest to help others.

Betty-Anne Daviss-Putt

Credentialling: Legislation & Certification

In the course of the first few months I was ACNM president, I received a couple of complaints about nurse midwives that were supposed to have brought some cases into emergency rooms that didn't seem appropriate, and upon investigation found out that they were indeed not nurse midwives at all but were lay midwives. As a consequence, I felt really strapped that there was no one to go talk to, no one to say, "There's one of your own out there, and I'd like you to look into it," like someone could do for me, which is exactly what folks could do. They could call the college and say, "X, y and z is happening here by such and such who is a member of your organization. We believe you should take a look at it."

One of the things that also was brewing in my mind and which I have never yet changed my position on and one of the reasons I drew people together as well, was I always thought that if you are really according to Hoyle, in other words, if you are authentic and really sincere about what you are doing, then you never mind being measured against an objective set of standards for practice and education which you yourself were part of developing. You just simply weren't afraid of that if you were doing what you knew was the correct thing to do, you set the standards yourself and you held yourself to that standard. I never have thought that it was right that midwifery on any level be measured against the medical model. It's not what any of us work on. We should be measured against a standard that we ourselves develop, that we adhere to, and that we expect people who say they're going to be part of this to adhere to.

There is a lot of credibility in credentialling. If one takes an examination because they met a certain educational standard, a person can go back and say, "Well, what that means for you to have those letters or have that certificate, is that you have this much education and you were tested against this set of educational principles."

Sister Angela Murdaugh

Certification and accountability were on the minds of some of the founding mothers of MANA. The issue brought an immediate response from the new membership.

I'm writing to you in regard to MANA. I am very excited that MANA has begun. I have felt for quite some time that such an organization is needed for many reasons. The biggest reason we need to do this, in my opinion, is that midwives *need* to certify midwives. We should not ask doctors or hospitals or even medical schools to approve midwifery. (Certainly CNM is a method for training and certifying.) I feel that MANA should set standards and grant certification based on compliance with those standards. All midwives need to unite and make our forces stronger to be more effective for the public at large.

I've been working with home births for eight years now. My experiences have been very positive in that my skills have grown as the need for them is presented -- and back-up consultations have been available on friendly terms when needed. In spite of this my political vulnerability has frightened me at times, causing me to feel a need for self-protection, low profiles and a certain degree of withdrawal that is not personally satisfying. Yet I have not been able to force myself to go to medical school for credentials to obtain benefits of peace of mind, hospital privileges and formal back-up. What I feel I need personally through certification is the guaranteed availability without personal legal repercussions of including more technical medical care when appropriate for my clients and/or their babies who need this extra component for their birth team.

I'm not sure how certification might work. I would think practical and "other" training would be appropriate. Didactic work, number of hours in training workshops (CE [continuing education] credit), apprentice experience might be "other" types of training to document as minimal requirements. Numbers of babies delivered personally and observed deliveries can be a tricky requirement. I would hope there could be in-depth discussions over the actual numbers and methods of documentation. I also think a written exam on midwifery skills and perhaps regional practical/oral "testing" for the initial groups of certification. Grandmothering some midwives right into MANA certification would seem appropriate also. After setting up certification requirements, codes of ethics and code of standards -- then we could begin to set up educational methods for training more midwives.

I would like to see the momentum already begun with MANA continue at its present rate (or faster). The times are becoming increasingly critical that midwives be acknowledged and supported. Once MANA is under way it will be very important for ACOG and hospital administrators, etc., to know that we exist and expect our own certification to be acknowledged and respected as "the" national organization for midwifery (not state-to-state recognition). Too many midwives are dropping out to go to school for certification purposes but *leave* the study of obstetrics/midwifery to do this. I personally feel troubled to see midwives give up for these external reasons and wonder at times if I will be forced to also. Now with MANA's conception I feel there is definitely new hope and possibilities to come. I support MANA full heartedly and wish to see it become strong.

Thank you for you personal dedication and vision for the whole.

Nancy Friedrich, Family Resources
in 'The Practicing Midwife,' Vol.1 No.16 Summer 1982

Others had very different opinions regarding credentialling. Right from the start, this was destined to be one of the "hot" issues facing the organization.

I read with interest the notice of a proposed midwifery guild. My feelings are that such an organization that seeks to unite *all* midwives is certainly a good one. However, I am greatly concerned about what such an organization seeks to do in the way of setting those standards and educational guidelines mentioned as objectives. My concern stems from the fact that "testing," "standards" and "licensing" are tools that have a monopoly in the health care "industry." An example of this is that before "regular" doctors put pressure on state legislatures in the 1800's to outlaw all other forms of medical care, the American consumer was free to choose any type of health care he/she so desired, e.g. herbal treatments, homeopathy, etc. When all practitioners, including the midwife, were outlawed because they did not attend a "regular medical school, graduate and become licensed," the American consumer found himself/herself in the position of having no choice or input into the health care that they received. Today midwives find themselves in the position of not being able to practice in a clearly legal way.

While I do *strongly agree* that basic midwifery skills and training experiences should be made available, I do feel uncomfortable that the regulation of midwifery be left to the state or even a "midwifery organization." I feel that the midwife's ultimate responsibility is to the people of her community, not to a midwifery licensing board. While many may argue that licensing prevents incompetency, it is a weak argument in view of the many incompetent practitioners working today. What licensing really does is create a monopoly. True competition will actually encourage good care.

Another reason why I am concerned about attempts to legalize and license midwifery is that traditionally these "licensed" professions have virtually excluded low-income, minority groups, and those persons lacking "test-taking skills." A good example of this unavoidable discrimination occurred in El Paso, Texas where midwifery is legal but regulated by a city commission. To practice with a license, a midwife must pass a written test. Is it any surprise that all the Spanish speaking midwives failed the test? Yet many of these practitioners have 30 years experience.

Please let me again state, I am not opposed to opportunities for experience and training; in fact I strongly support midwives *having access to learning* basic skills. What I am opposed to is having our granny midwife passed over or condemned as "ignorant" simply because her cultural and educational background is different from our own. Please let us not forget nor seek to exclude our grannies in our attempts to become legitimate and respectable -- they are our history and our heritage.

Carolyn Vogler
Excerpted from 'The Practicing Midwife,' Vol.1 No.16 Summer 1982

In approaching the issue of certification, we must recognize that there are two opposing views of health care which lead to opposing views regarding certification.

What we might call the "traditional" medical model is actually a fairly recent invention, having gained power over herbalism and homeopathy about two centuries ago. This perspective sees birth as an essentially pathological event in which the feelings of the untrained parents must be subordinated to the medical skills of the certified "initiates" who alone believe themselves able to guard against the "host of dangers" which birth entails. Thus the person coming for care is supported to feel helpless and to

rely on this system for well-being, and the system, based on the power and authority of a few, is furthered.

The perspective which we, as midwives, support, however, is based on the recognition that birth is not a medical event but a healthy human process carried out by the woman herself. We affirm the mother's right and responsibility to study the birth process and to make an informed choice regarding the type of birth attendant and environment that feel most suited to her needs. Thus we support each other to feel responsible for and in control of our own lives.

It is obvious that just as the traditional medical perspective includes certification as a necessity for maintaining the separation between professionals and lay persons, the latter approach finds certification fundamentally inconsistent with each individual being *truly* responsible for their own experience.

Because we are so accustomed to thinking within the traditional medical framework, it is easy to fall into the trap of believing that opposing certification is tantamount to opposing quality health care. It is important to make clear that we are not so much negating certification as we are encouraging informed choice.

To certify ourselves, even with the best of intentions, we would run the risk of merely creating a new class of birth professionals, and quickly lose sight of the very things which most require transformation. We would be in danger of becoming part of the system which no longer serves us, leaving it up to future sisters to make this needed change.

As a new generation of lay midwives in America today we stand at a crossroads in our history. The implications of the position in which we have placed ourselves is staggering. We are helping to facilitate putting the power of the birthing process back into the hands of women, which will have a broad impact on every aspect of our lives. Like it or not, it is a radical position. Knowing full well avenues to traditional certification exist, we have chosen to do something different, and we must have the courage and conviction of our age-old sisterhood and stand our ground. Let us continue to strive for a new social form -- one in which our rights as individuals to make choices and practice our craft are upheld.

Anne Frye

Excerted from 'The Practicing Midwife,' Vol.1 No.16 Summer 1982

And this was just the earliest response to the subject! MANA formed two committees, Legislation and Certification, to follow the issue of credentialling of midwives. The Legislation Committee kept abreast of the status of midwifery across the country, while Certification looked at whether MANA would offer a credentialling process internally. Below, Peggy Spindel explains the difference between the two terms, and then delves further into the progression of MANA and certification over the years.

Legislation has to do with the laws that a state makes, and generally, in this country they have to do with licensing a professional, the meaning of which is permission to practice the profession. The implication is that those who do not have state permission to practice this profession are not legal, so the state is granting an exclusive right to do a certain thing to a certain group of people. And that's the way it has been done ever since the turn of the century in this country in terms of all kinds of different professionals. For better or for worse, it's pretty pervasive with some notable exceptions. I think the meaning of it is that the state is acting in the public interest to protect the public from incompetent practitioners. My sense is that nowadays the politicians are getting savvier and realizing, especially because the regulation of medicine has been so horrendous, that licensing doesn't actually serve the purpose of protecting the public.

Credentialling, in my mind, is internal to the profession and is the community of that particular profession saying that a particular individual has accomplished the training requirements for that profession. The way I put it in my mind is that if somebody has a license, the state gives that person permission to practice. What certification means is that the certifying body says that that woman at that point in time had a certain amount of facts in her head and a certain amount of hours, whatever the criterion are, at that point in time to be accepted as one of us. And that's it.

My vision, at least initially, was that credentialling was a really, really important issue that MANA had to address. I took my initial task as being the one to force the issue, like calling the question. From my very earliest experience with MANA, I had such a strong sense that there was such an internal wisdom in the development of the organization that the collective will of the organization would come up with the right solution, and I didn't even have to worry about it. But I felt there was also a terrible sluggishness to the organization because there was so much diversity, and that it will always need prodding. I thought of myself as being a prodder, saying,

"Come on, let's look at this." So that's what I did. Initially, I thought I would put out a bunch of proposals based on the different state processes; this was in San Francisco. But I ended up proposing only one or two things that I put together from all the different state processes I had gathered up for the International Section, and posted it as a possible national certifying process.

What followed was a very, very difficult process which took two full years of very active work. The first thing that I did was to get up a committee and start calling for feedback and letters on people's opinions. Then I started publishing people's opinions in the newsletter. After posting the initial proposal in San Francisco, we worked up a questionnaire that went out to all the membership through the newsletter on their views about certification. The questionnaire had things on it like, "Do you think MANA should certify? Do you think there should be an exam?" There were about twenty different kinds of questions. Then I tabulated all the responses I got, and basically used what the survey said as the basis for making up the final proposal.

Peggy Spindel

The issues we must face in evaluating and revising the proposal include whether or not we want MANA to certify its members at all; whether such certification should be mandatory or voluntary; whether the skills to be tested for should be entry level (minimum) or more advanced; and how certification would relate to the states and provinces and also to the International Section.

The feedback from the San Francisco conference centered on three areas of concern. Some felt that the proposed experience requirements would be too difficult for many midwives. Another area of concern was the discipline of midwives and how that should be handled. Some felt that MANA would be more objective in this role; others felt that the matter should be handled by the states and provinces. The last general area of discussion was how MANA Certification would relate to state or provincial certification.

Two exciting ideas that came up in the Open Forum were:

1. MANA accreditation of state or provincial certifications (rather than MANA certification itself).

2. A MANA "Registry" exam which would facilitate reciprocity and

perhaps give MANA midwives a credential somewhat more advanced than the local certification.

These new ideas are very consistent with each other and with what the International Section is currently doing on an informal basis. Clearly these thoughts point to a possible new direction for MANA credentialling which we will be looking at this year.

Peggy Spindel
Excerpted from MANA News, Vol. III No. 4, January 1986

Then, through a lot of communication, the proposal was refined. It had started out being more like certification, but then at some point between San Francisco and West Virginia our proposal gradually molded into this registry system. We had a lot of help from various people who just gave wonderful feedback and really good ideas, managing to find solutions to various kinds of problems that were posed by what the survey said and what the political and philosophical realities were.

We worked incredibly hard at the West Virginia conference. There was a meeting at the beginning of the conference with a lot of wonderful ideas. Then a lot of people, especially Lisa Hulette, helped me put it into the final draft. All the various drafts had gone to the MANA board, and had been published in the newsletter prior to the conference several times. The board rented me a computer at West Virginia so I could make changes based on the meetings that we had there. It really was a very exciting process; it was exciting to try to mold a document based on a movement. We also got credentialling onto the agenda at a lot of regional meetings, and we got feedback through that route. We didn't have any opinions, we just took all the feedback.

Peggy Spindel

The West Virginia meeting was heavy. The fact that we have a registry board, versus all this other stuff that the ACNM has, has to do with what went on in West Virginia. That was a very, very heavy meeting. Giving a test and administering a test and saying, "You've taken this test and this is it," is not regulatory. It facilitates people doing a thing that they seem to want to do. I personally think it's sad we need this kind of affirmation, but we do, and so it facilitates midwives being able to take a test and fit into

the cultural picture that is there. If it does get to be regulatory, I won't support it. At this point it's just a structure set up so people who don't have a test locally can take that test, and then use it in whatever way they want.

I think national certification would be horrible. But I'm a radical feminist/anarchist. I think the best regulation comes eye to eye, from one person saying, "Don't do that to me," or whatever. It's very close and very local, and it has to with heart to heart talking about what we should do that is ethical and has integrity. I think the whole centralization of power is horrific and that our "rule of law" doesn't work for women and children.

Mari Patkelly

We were actually looking at a national credentialling in 1985. Peggy Spindel submitted an excellent proposal at the San Francisco meeting. We discussed her proposal, broke into work groups and looked at the prospect of setting up national certification. We had some very sticklish problems with that. We had rural midwives in certain areas with minimal numbers of births, and wondered how were we going to make our required experience levels adequate to demonstrate competency, yet be fair to them. At that meeting, I identified for myself that it was more important to encourage states to develop their own processes than it was to come up with a national process at that point in time. (Now, most states that are able and willing have done this.)

Another reason that national credentialling was scrapped at that point was on advice from Linda Irenegreene, our lawyer, who said that the liability to the board would be outrageous, and that we were not in the position to insure ourselves if we expected to really create a bonafide credentialling body, something where we were more or less going to say, "This person is qualified to practice."

The registry exam is a little different. All we're really saying is, "This person has passed a national exam." We're not saying anything about their competency, because we're not testing it. So that's how we got to where we are.

I think that having a national exam is a step in the right direction, and I think eventually we'll have some sort of a national certifying process. Part of the reason I believe this is that it would certainly simplify the reciprocity problems that we have now. In trying to get legislation through in California, we are running into a huge problem with our educational

proposal, which features a mechanism for off-site education and challenge and all of the things that we more or less hold dear so that apprenticeship can be maintained. There can still be some kind of organized didactic or theoretical so that more midwives can be trained, but we're hearing from the legislators, "Well, who's going to accredit your program? Who's your national organization, and where are these standards coming from?" And in a state like California we're hearing, "We don't care what they do in New Mexico." So we have to point to the nurse-midwives and their standards and their minimums for certification. I just think national certification is something that will eventually happen.

Elizabeth Davis

Why do these women think that they have to have permission from daddy in order to do what they know, in their blood and in their heart and in their soul? That's part of where I do this other dance on certification, because I was born a midwife. I knew the first baby that I ever attended that I had done it a thousand times and I knew exactly what to do. And why would I have to ask some guy to give me permission to do what I already have in my blood and my heart?

Carol Leonard

MANA has not chosen to pursue national certification. Instead, other groups have formed which are associated with MANA but at an arm's length; the Registry Board, the National Coalition of Midwifery Educators, the Midwifery Education Accreditation Council, and the Interorganizational Work Group on Midwifery Education sponsored by the Carnegie Foundation. All of these groups dove-tail with MANA, and new ones may be formed in the future to meet future needs. One of these groups may someday offer national certification, but MANA has not assumed any regulatory functions.

The Registry Board

Participants in the 1986 annual meeting voted to establish an Interim Registry Board which would continue work on the proposal for a North American Registry of Midwives. The goal of the Registry System was to provide a simple mechanism to:

1) foster reciprocity between local jurisdictions;

2) create an optimal final common pathway for all independent midwives;

3) offer the states and provinces a national test for entry level competence in independent midwifery practice.

The Fall 1986 proposal included specifics on how such a Registry would be established and implemented.

The purpose: To prepare, administer and evaluate a standardized examination system for those independent midwives who are interested and eligible; and to maintain a Registry of midwives who have passed the examination.

The North American Registry of Midwives shall be administered by the Registry Board, which shall be appointed by the MANA Board of Directors. The Registry Board of six members shall include, but is not limited to, a certified nurse-midwife, a direct-entry midwife from each country represented in MANA, a member of the International Section of MANA and a member nominated by the MANA Affirmative Action Committee. The initial responsibility of the Registry Board shall be to develop tasks, timelines and procedures for implementing the Registry System.

The content of the examination shall be antepartum, intrapartum, newborn, postpartum, professional issues, including both fetus/newborn in

all areas. Eligibility for this exam shall be set by the MANA Credentials Committee.

The Registry Board shall not discriminate among applicants on the basis of age, sex, sexual preference, race, religion, national origin, handicap or marital status and shall include a statement of non-discrimination in its materials.

The Board shall determine the appropriate title for those who successfully complete the exam. It is the policy of MANA to encourage state or provincial certification. Therefore the scope of the Registry shall be limited to the examination of eligible midwives as described above. All requirements for discipline, continuing education, periodic peer review, etc., shall be left to local jurisdiction.

Excerpted from MANA News, Vol.IV No.4, January 1987

In the early days of MANA, people were learning this vocabulary; core competencies, guidelines, standards, protocols, certification, registration, licensure. All of this kind of stuff was not needed in our vocabularies until there was an organization, for the most part. When we began, Susan Leibel said that many of us of are such variety, with such diversity, that we are not going to start out having membership classifications and categories. Some day we were going to have to face that. We're only now doing that, nine and a half years later, in the exam process. Susan had said, "Right now we're going to be all inclusive; we're going to take in folks. We're going to build lines of communication." She talked about how being accredited did not carry power with it, from where she was speaking as a CNM. I think that being all inclusive was very much in our minds at first.

Now, as we've come closer to achieving our goal, or at least a perceived goal, there's been this increase in the need for some sort of way of measuring knowledge base. The registry exam is answering that. I think it's good.

I think it's very important though that we not lose sight of the shortcomings of such exams, and of the fact that there's been safe midwifery in lots of places that was not based in any way on a formalized system of training or a way of measuring that. We've had to always look at, who do you leave out, and what does that do to them? I work with people who would not be part of that, the Amish midwives that live just a few miles away from us whom we've trained from the beginning. We've felt

like every community should have its own midwife; that's just the conviction I have, and so I've always kept that in mind.

Ina May Gaskin

How do you set up an examination for those who want it, while not using it as a tool of exclusion? Balancing those two views can be like walking a tightrope.

I'm not really too keen on the certification exam they've just come up with. I hope that it doesn't isolate the direct entry midwives. I've seen in Jamaica, where I'm living now, that direct entry midwives are the bottom of the totem pole. And once a woman becomes certified or becomes a nurse, there's a definite power. I hope that that power trip does not happen here.

I think that we need to keep the traditional midwives alive or we're going to lose everything that we've achieved so far; everything that MANA has helped achieve here in the United States, and also networking throughout the world. In my culture, if you go anywhere to find a direct entry midwife, her average age will be 72 years old, which is very sad. These women are mostly blind and deaf and sometimes just a little off their rockers. It's because of the power trip that goes on and the fear that they've had to live with all the years trying to practice and do what they do for their sisters on the island. I found that even in coming to El Paso, sometimes the women who want to do births feel kind of fearful because they are not certified. I went into midwifery blind, and without fear, and I will never regret that.

Annie Robinson

Others view the Registry exam as work which needed to be done.

I think that the work MANA's done in getting their core competency literature together and the testing for that is really valuable. What I see in our community is a sense of unsurity about how midwives are trained, what they are about, and what they know. I think the more credibility we can give to our profession without becoming something else, then that's the direction we need to head.

Melanie Van Aiken

Then there was the practical aspect of putting it all together.

I was pretty involved in the whole process. I wrote up the initial forms for gathering questions that people were letting us have, and the application for hiring the person that was going to oversee the writing of the test. I helped gather the names of the people that would review the original pool of questions. I put together the draft for the application for those taking the test, as well as the brochures. And then I reviewed questions.

I was working on the brochures before we really got the ball rolling on getting the questions out to people, but the process itself actually took a really short period of time, about 4 to 6 months once we hired Mary Ellen Sullivan as our testing consultant after the Kansas City conference. She's got some sort of degree in test writing, and was a great person to choose to oversee the production of the test. For one thing, she's not a midwife, and although that does present a certain amount of problem because she doesn't necessarily know the questions as well, it's not so incestuous. With MANA, everything has been everybody's friend and sister, which has been problematic at times. So I feel like choosing her was really good.

That first pool of questions which we gathered up were appalling. They were absolutely embarrassing. Some of them were completely irrelevant, the most obscure stuff; it was just ridiculous. There were even answers that were just plain wrong. I threw out everything that I felt was just vocabulary review. I don't feel like knowing big words is necessary to being a midwife. So I tried to define words in the questions that I wrote. I wrote lots of those questions because absolutely none of the questions we had obtained addressed things that I felt were pretty important. Apparently there are now enough questions so that we can have two tests. I have yet to see them all. I really would like to see them all; I feel they definitely need more revision.

The group that reviewed the original pool of questions were people like me and Ina May and Jeanine Parvati Baker and Elizabeth Davis, Therese Stallings, Sharon Wells, Mari Patkelly, and Carol Leonard. The idea was that the test would be originally reviewed by people that were "respected" experts in the field. And we tried to get as many of those people that were recognized from as wide a variety of backgrounds as possible. I feel like we did a really good job on that.

Now unfortunately, the people that actually got to test the test were people that had passed a test someplace else. I really made a big stink about that at the El Paso conference and said that we should have some people take it that had never been tested, but that were recognized as competent in their community. Delight Davis was one of those. Her feedback was that a lot of it wasn't entry level; that in many areas, for the correct answer it required diagnoses, such as CVA tenderness related to kidney problems. She felt that an entry level midwife should just know that certain things were normal and certain things were not normal and she should know when to refer. And I can hear that. Jill Breen has also taken it -- she'd never taken a test before. There were other people I also suggested take it. I'd also like to see the test written on a third grade level, which is something that Sharon Wells has offered to do.

I think the whole thing of test-taking is pretty irrelevant to midwifery. That's one reason I wanted to be involved in the process; I wanted to have as much say-so as possible about not having some completely ridiculous test. I feel that there's nothing wrong with an entry level midwife wanting to challenge her own knowledge against a base of knowledge that many other midwives from diverse backgrounds have said is important to know. I can see how that can be valuable to an individual. That's the way that I see a test working the best. If she gets some sort of recognition for taking that test and passing it, I don't see anything wrong with that. The thing that I see wrong with it is the inevitable tendency of those that have taken it to misrepresent it as some sort of measure of competency. I know people that could pass that test that don't have any business being midwives. I think that's the problem, and that's why I wrote up that thing in the application about representing oneself honestly.

And then there's the issue of it being used in certification processes. That horrible pool of questions that we drew this from was from certification tests all over the country. It was absolutely a disgrace. At least these questions have been reviewed by a lot people. There's been a lot more input into it. There's been an enormous amount of thought that just can't be gathered from a smaller group of people. As such, I feel that it will evolve into a much fairer test. Having that kind of input into it will help to insure as much as one can that if this is taken up by state legislatures or whatever, there won't be some really off the wall, impossible-to-pass test out there. I felt like that was one of my main agendas in being involved as well, just to try to keep it simple.

I don't feel like the test is finished. I feel like the test needs an enormous amount of work. But given what we started with, it's better than it was. I think as many people as are willing to look over the questions and give us feedback on them, about how is this confusing or ambiguous, or how is this irrelevant, as much feedback as we can get, will help to get that test really solid and really useful to as many midwives as possible, and would be a valuable contribution from the general membership.

Anne Frye

Education: Roots and Routes

How do women become midwives? There are many paths to midwifery. Some choose to learn through apprenticeship, others through schools, whether direct entry or post-nursing, others through a combination of experience and more formal study. MANA's Education Committee began to gather information about the ways members came to be midwives, as well as looking toward the future of midwifery education.

In February 1985 approximately 350 surveys were mailed to those MANA members identified on the mailing list as midwives. The purpose of this survey is twofold:

1) to begin to centralize and disseminate information about all the educational opportunities for midwifery training that currently exist in the US and Canada (a directory to be compiled), and

2) to develop a data base about the variety of educational backgrounds among MANA midwives -- a description of roots and routes. This is an important precursor to developing guidelines/standards/recommendations about desired educational pathways for midwifery practice.

Needless to say, there is an abundance of opinions about what constitutes appropriate educational preparation for today's midwife. However, there is little in the way of objective data that sets aside all the "sacred cows" to take an unbiased, pragmatic, long-term look at the education process and midwifery.

Before drawing conclusions about settings, models, program length, etc., it is necessary to ask questions in order to begin to analyze the relationship of education patterns to practice realities. We need to begin to develop a consensus about the knowledge and skills to be possessed by all midwives within the complex context of our pluralistic society. We need to discuss the pros and cons of "standardized curricula." We need to talk about the impact of state/provincial legislation on educational requirements and vice versa.

I raise these issues to encourage questioning and to discourage any entrenched beliefs about inherently "inferior" or "superior" midwifery training models.

So much is changing in the health care scene today. We need to open our minds with a keen view toward the 21st century.

Susan Leibel
in MANA News, Vol.III No.1, July 1985

Opening our minds...not as easy as it might sound. There was much internal debate over the ideas Susan raised: Was there was one "best" method of training midwives? And what is the endpoint of such training? Who deserves the title "midwife"?

Some of the fire got fueled by comments that followed the ICM meeting in Australia at which MANA was accepted for membership. An article by Judith Rooks, then-president of the ACNM who cast the sole opposing vote to MANA membership, was printed in the MANA News, making a distinction between "lay" midwives who learned through apprenticeship and those midwives trained through more formal educational routes. In her closing paragraph, she stated:

...In the United States the term "lay-midwife" may include some people with a significant amount of formal training as well as those who have had only an informal apprenticeship. I would challenge MANA to look closely at the WHO definition of a midwife and to clarify which of its members are direct-entry midwives and which are lay-midwives (or birth attendants)...We all need to stop using the term "midwife" carelessly, and to know of what we speak.

Judith Rooks
Excerpted from the MANA News, Vol.II No.4, January 1985
Originally from 'Quickening', Nov/Dec 1984

In the same issue, MANA president Teddy Charvet [a.k.a. Therese Stallings] also gave her opinion about both the past and future of how midwives obtain their education.

Firstly, I think it is important that we sort out the short-term realities from our long-term goals and ideals. I think these are very different.

The reality of the current situation regarding midwifery in North America is that there are very few educational programs, especially for direct entry midwives, and there has been a growing demand for midwifery care. Thus, over the past decade or two, the "lay" midwife was called into action. Because of the inaccessibility of formal educational programs, she got her training by hook or by crook, usually a combination of self-study and apprenticeship, though for some, there wasn't even anyone to apprentice with, and they just got going after reading a few books.

Midwives who started in this way say it is a difficult, sometimes frightening, way to learn. But the reality exists: few schools, few homebirth practitioners, and many communities with a need for someone to help women who want to birth at home. A void needed to be filled.

And now, as a result of years of experience, many of the so-called "lay" midwives have a tremendous amount of skill and knowledge -- more, in some cases, than midwives who come out of formal training programs. Many of these midwives want validation for their skills. They want to be legal. They want to be acknowledged as competent. They want to preserve their right to practice.

However, the long-term goal for midwifery education, I think most of us will agree, is a clearly defined educational process. Judith Rooks, in a personal letter to me, describes this as "an organized educational program with admission criteria, opportunity for students to interact with a variety of qualified clinician-educators, a controlled learning environment, access to adequate library resources, clearly specified educational objectives requiring mastery of a base of theoretical knowledge, critical thinking skills and clinical performance, required learning experiences designed to lead the student to achieve the educational objectives, and valid and reliable methods to assess whether each student has mastered the essential knowledge and skills."

Would any of us disagree that most of this description fits our picture of "ideal" midwifery education? Wouldn't we all agree that over the next decade or two, we'd like to see midwifery programs developed that provide this kind of learning experience for midwives in training? Yes, we want midwifery education accessible to women from all walks of life, from all socio-economic brackets, from urban as well as rural communities. But nothing in the above description necessarily precludes any of this. In our

designing of midwifery programs, it is our responsibility to be sensitive to the issue of accessibility, and to create programs that address the needs of different types of women. This is long-term planning, the picture for the future.

Teddy Charvet
Excerpted from MANA News, Vol.II No.4, January 1985

Answering comments quickly came from the general membership.

Teddy Charvet, in her article in the MANA News stresses the need for a "clearly defined educational process," and goes on to describe a program based on the university system of lectures, tests, research, etc. She asks if anyone would disagree that this is the "ideal" midwifery education. (I, for one, disagree.)

"Experience is the best teacher" is a maxim which is true. It doesn't take much thought to decide which midwife you would prefer at your labor: one who has taken 25 units of didactic training each year for ten years, but has never attended a birth; or a midwife who has attended 25 births a year for ten years, but has never read a book!

I do not believe that apprenticeship is an inferior education; in fact, I beleve just the opposite. For many years, apprenticeship was the only way to master most professions, from doctor to nurse to farmer to baker.

And, contrary to what Ms. Charvet seems to imply, midwives who learn by apprenticeship also do a great deal of reading and individual research. Is this to be discounted because it was not done in an academic setting?

One further point about apprenticeship: if a fact is presented at a lecture by a professor, there is only theory to back it. But if a fact is presented at a birth and then the circumstances of the birth prove it true, the effect on the student/apprentice is going to be far greater.

Certainly I am not saying that only apprenticeship should be used to train midwives, but neither should midwives be trained only through academic programs. There are those who learn best by didactic training followed by practical application, but this is not true for all. There are many who learn best by observation through apprenticeship, and I do not want to see these capable, skilled midwives excluded from the profession of midwifery

because they gained their skills and knowledge in an "unacceptable" way. So long as all midwives show a standard level of knowledge and skill, what does it matter how they attained it?

Lani Rosenberger
Excerpted from MANA News, Vol.II No.6, May 1985

I would like to defend apprenticeship as a valid mode of midwifery education. In her article Judith Rooks implied that apprenticeship is not an educational program, but I must insist that apprenticeship is one of the best educational programs there can be. Though not all apprenticehips are organized or complete in their presentation of material, this is the fault of the individuals involved, not of the apprenticeship format. Direct hands-on experience is worth a lot more than hours spent reading the textbooks, or in classroom lectures. And though what is needed may be a balance of both these modes, there is no way that apprenticeship can be seen as less valid than "formal" educational programs.

The issues are complex, but what is at stake is the future of midwifery. I know we can work out creative solutions to our differences of opinions. What is important to me is that midwives come to respect each other, in spite of our different backgrounds and practices. There is room for all of us. For it is only when we acknowledge and respect all aspects of ourselves as midwives that we can work together to create a future for midwifery.

Janneli Vojta
Excerpted from MANA News, Vol.III No. 1, July 1985

The other task of the Education Committee, gathering information on existing education programs, would also prove to be longer and more on-going than most imagined. In 1987, the Education Committee still listed their primary goal as developing a comprehensive list of educational routes for MANA midwives, including schools and apprenticeships. In 1989, the committee chose the following projects: (1) compilation of an "Information Packet" for aspiring midwives, including learning resources such as books, audio-visual learning tools, networking contacts, and school/learning options list; (2) writing an Educational Opportunities list including a description and comparison of all learning opportunities for midwives; and (3) refinement and approval of "Core Competencies" for entry level midwifery practice.

The "Information Packet for Aspiring Midwives" was finally available in mid-1990. Alongside that work, the "Core Competencies," [1] defining the essential components of midwifery education, were being drafted.

My involvement with midwifery education actually came before my involvement with MANA national level. Basically, I couldn't afford to go to conventions because most of my money was going into creating, manifesting, and operating a midwifery school while I myself was in school. Of course I was always very active in my state organization. Then, when I moved to New York I became involved in MANA, where I started working with the Education Committee right away.

New Orleans was my first national MANA confernce. The educators were a very exciting group of people to get to know. I'd never met any of them, although I'd talked to them on the phone, so there was already a bond with people like Therese Stallings and JoAnne Myers-Ciecko. This group was trying to collect a list of the current schools of all the different educational types, including apprenticeship. And almost instantly we also started working on the core competencies. I just jumped into the middle of that.

I think that as people who were involved in education, we all realized that there was a basic core knowledge in midwifery. No matter how you cut the pie, there was still this basic knowledge. And the people who were in this group had already articulated some form of this on paper, because most of us had run schools or were in the process of making schools or trying to put down apprenticeship on paper. We were talking about a basic core of information you need to know to be a safe practitioner. We tried to keep it as broad as possible while still retaining the core knowledge.

The first core competency document was started from the ACNM core competencies. This was before me, with Therese as the Education Committee chairperson. She took from the ACNM, looked at that, revised it. The words are entirely different because we approach it really differently. This had then gone to MANA, and I think the MANA board had actually approved it. But when it got looked at again by the educators and people on the Education Committee, we realized it really wasn't what we wanted to say. A lot of places were too picky, and were not what we wanted. Therese said, "Okay, we're going to take this back and we're going to revise this again." So that's what we did. We really tried to keep in mind multicultural, multiracial, multifeminist points of view for every

[1] See Appendix B

single core competency that we looked at, so that it would be inclusive rather than exclusive.

With each revision it became more and more our own. It is a working document right now -- meaning we're always going to be changing it. That's the way ACNM's is too. When we lined up both groups' core competencies side by side at the Carnegie Work Group meetings, except for the wording - and we liked our wording better and they liked their wording better, but they talk about management and we don't - they're very similar. That's because what they contain is a basic core knowledge of midwifery. It's the core for traditional midwives; it's the core for grand midwives.

I've sat and talked to grand midwives, and they know all the stuff covered by the core competencies. They don't necessarily have the names for it - for example, shoulder dystocia - and they can't necessarily verbalize it. But a lot of it is watching their hands and watching them, how they describe it when they're talking to you. They all know it. I always tried to think about the grand midwives and their knowledge; the grand midwives and other traditional midwives have extensive knowledge, but they don't necessarily have the medical terminology to back it up.

The only part that we really had a lot of questions over was the family planning section. But then when we got down to it, we realized that a midwife doesn't only deal with one group of people, no matter where she is. She's going to have a diversity of people; people will approach her from everywhere. And she needs to know that basic knowledge, because someone might ask for it. Just because she has that knowledge she doesn't have to use it on a daily basis.

Two other questions arise with the core competencies. One is why were they being amassed in the first place. And the second is how they were meant to be used. The Interim Registry Board was formed to look into designing a test, and their input was that we can't have a test until we have a list of a basic core knowledge that we're going to test. So it was only fair that we develop a core knowledge, make it known to everybody, and then be able to test it. That request came to the Education Committee from the MANA board.

I think that the core competencies can also be used as a check and balance for ourselves, as to what our basic midwifery knowledge is. And they can provide a structure for proprietory schools and apprenticeship models who are developing programs. It is not a matter of how you get the information, but what information you need. The document is, basically, a study guide, and I think that is how we are going to use it.

We also may use it in how we define midwives. We, being Carnegie, and we, being MANA. How do we define midwives? Core competency is the midwife. Core competency is the bottom line on what you need to know. It's no frills. And then from there you develop all sorts of things like behavioral objectives and you group it into courses, and that's how it gets interacted into the real world. The core competencies by themselves are just a list of things you ought to know.

Sharon Wells

Not everyone viewed the "Core Competency" document in the same light.

I recently attended the Northeast Regional meeting that took place following the celebration of Maine Midwifery Week with Ina May Gaskin in Portland, Maine. We were fortunate to have drawn a large and wonderful number of regional midwives to Maine to share the festivities and workshops with us, and many stayed on to attend the evening meeting for MANA. Our focus went to the issue of the Core Competencies for Basic Midwifery Pracice, and as we warmed up and then heated up, it became apparant that our collective nerve had been struck.

As we spoke in rising voices, I saw that I was not alone in my concerns. Looking around and watching this escalating debate really made me very aware of the temptation to resort to a document like this. It is not easy to honor our feminine! It is long, tiring and circuitous. It is like trying to reinvent the wheel, because, as women, we have had the knowledge taken from us. We are intimidated, belittled, and isolated in our relationships, our workplaces, and our communities.

Yet who among us as midwives does not know the power that is found in each birth? From the very beginning of our work with a woman and her family, we are rebuilding what we have lost as women. It is evident in the growth of our relationship with her, her mate, and her children. She in turn is part of a community of families. Her individual experience ripples out from her and reaches others. Her personal empowerment becomes a collective strengthening that then becomes visible in her community. It brings about change: in attitudes, in practices. This change comes slowly and surely, and is truly reflective of the community as a whole.

The Core Competencies as passed by the MANA Board have lost sight of the midwifery community as a whole. To begin with, they are not written in my language; they are written in the jargon of the medical system. Words like protocols, etiology, expulsion, and puerperium have little real meaning to me, and probably none to the women I need to converse with about such things. Clinical applications, parameters and methods, and managing or conducting deliveries are all descriptive of the mindset I strive to avoid. My only regular contact with language like this takes place on the pages of medical texts or when a lofty doctor is trying to impress upon me my stupidity. I'm not fooled for a minute!

Secondly, they have no sensitivity or respect for the uniqueness and beautiful strength of my community, or yours, or another person's. We have become accustomed in this patriarchal society to accepting authority from above. We elect a small body of (mostly male) rulers who write the law and dispense it from above through a system of enforcement. Those who don't follow the rules are brought into line through punishment or withholding of privilege or position. In the system, we become REACTors to the forces in our lives. In order to become ACTors, we must move into a position of power in this system, where we in turn elevate ourselves to a higher place. In my opinion, the Core Competencies, as written, come at us from above and inevitably leave us in a position of REACTing to them. This is a fearful place to be; a place where I worry about what I will lose and whether I will have to become covert to preserve my essence.

If you can see, as I do, the amazing and subtle grassroots renaissance of women's knowledge that is happening all over the continent, then look at where it has arisen from. From millions of women, midwives, mothers, healers engaging in basic female relationships of nurturing, nourishing, respecting, and accepting. These women are widely different individuals from many different communities. In a woman's world, there is a place for all children regardless of their flaws, defiance, weaknesses, or confusion. I believe that MANA can translate this to the definition of core competency in our work. We can greatly elevate and honor midwifery in the process. I know we can, because I can feel it in my heart, and I have shared it with every midwife I have ever met. We are especially gifted in this knowledge because the work itself clarifies and magnifies it for us.

The task really is not to sit together in a small group and define our community, but to visit the many communities through the women who help form them, and in that way to define ourselves. Then we will have

core competencies that invite us all to be ACTors together -- acting upon what we have in common in our hearts as women and midwives.

We are very beautiful!

Ellie Daniels
in MANA News Vol.IX No.3, July 1991

The "Core Competencies" remains an evolving document. Can the wording reflect the concerns of all MANA members, while still retaining its usefulness as a guideline for establishing educational programs and outlining core midwifery knowledge? Once again MANA has tried to balance the often-divergent needs of its membership. The wisdom of the group process may again be called upon for the next "Core Competencies" revision.

Meanwhile, midwifery educators were feeling the need to meet outside of MANA. New groups were forming to look at the future of direct entry education.

At the meeting in New Orleans, there came about the idea of a group of educators having their own workshop. At the next MANA meeting, we realized that we were indeed going to have to meet together as educators, because the MANA Education Committee has a broader responsibility than the educators. Educators are the people who are actually running schools, running programs, or are anticipating doing this level of work, whereas the MANA Education Committee doesn't necessarily have only educators on it. So the educators decided to meet together to talk about education and how we visualized education.

In the beginning, we didn't make a decision to do that separately from MANA. We were basically the same people; and it was always a very interesting group. At first we did a lot of defining so that people would understand what we were talking about with terminology, because all of us didn't have the same terminology. We needed to have a common language. All of this was with direct entry midwifery education, and we even approached apprenticeship within the group. It was pressing for us to understand what we were talking about - college based, university affiliated - all of these educational concepts that were being thrown at us were necessary for us to understand.

And then, at the next meeting I went to, we named ourselves and we gave ourselves a purpose. We called ourselves the Educators Coalition. The Educators Coalition met in 1991 simultaneously with the MANA board. And the board, separate unto themselves, and the Educators Coalition, separate unto themselves, decided that for the good of all we needed to become our own separate organization, not under MANA's umbrella. We formed our own separate entity as educators, the National Coalition of Midwifery Educators (NCME).

Then we realized that we had to take a quantum leap -- we had to form a non-profit group that was an accreditation body, because if we were truly to do this, we had to be able to accredit our own schools. The only way to do this was by forming an accrediting body. At that point, ACNM was only able, and will continue to only be able, to certify nurse-midwifery programs. So there was nobody to certify our programs. Well, if you are going to be a recognized educational entity that can receive grants, fellowships, and monies - monies is a big factor with these schools - and even for affiliating with colleges and universities, you want to be accredited within your own field. And that's how that came about, absolutely out of necessity. We could see that ACNM wasn't going to do it for us. We had to take it on ourselves. We formed MEAC, the Midwifery Education Accreditation Council.

An accrediting body only deals with institutions that wish to call themselves schools. There are already apprenticeship models that call themselves schools. If they meet - and here is where core competencies come in again - if they meet the core competencies and all the requirements for an educational institution, requirements which we wrote ourselves, again using ACNM's model, then they can be accredited. We didn't have any reasons to exclude apprenticeship models, even if they have only one student; that has nothing to do with it. It's whether you meet the requirements. We believe there are apprenticeship programs out there that definitely meet the requirements. Realistically, it's going to be late 1993 before we're able to start the accreditation process, which for educators is a long time. For example, the Seattle Midwifery School received accreditation for its nurse track program through the ACNM, but the same program is not yet accredited any place else for direct entry.

As for the future, I see nurse-midwifery educators eventually meeting with this group of midwifery educators. Carnegie is the first step in that direction. But there are other educators that need to be meeting together with these educators so that they can talk and share. See, a lot of it is

sharing. This is where the educators get together and brainstorm about how we're going to be more innovative and reach more students, and how we are going to do things like create tracks that will be more applicable to everybody, that you could do in the your home, etc. We hash out a lot. When we're meeting at the Educators Coalition, we get to do things with programming, devising, and defining. Whereas when we're the MANA Education Committee, we're working on a more global view of education.

Sharon Wells

When asked about the differences and the connection between the MANA Education Committee and the midwifery educator's coalition, Therese Stallings, longtime committee chair, had this to say:

The juicy kind of interchange at MANA, like the stuff that happens in discussions all over the conventions, about feminist politics versus joining the system, and creating an educational process that's woman-centered rather than patriarchal, all that stuff is really important. It's good for all of us to hear, because we've all been conditioned in this culture and can all too easily slip into models that are the same-old same-old. We need that kind of consciousness prick. On the other hand, in the MANA Education Committee, those issues can generate so much discussion that we don't get a bit of work done. We get to the end of the meeting time and no tasks have been assigned and no plan laid out for work, because we get hooked into those whole conversations. And the educators are getting really frustrated. They want to learn from each other, they want to start talking educational language and learning the terms and learning how to communicate with the system. Philosophical discussion stops everything at that level, because it takes so long and it goes on and on and on.

So I think that's why it's useful at some point for the educators to just go; the people that are involved in formal education and think it's a good thing and want to help each other do it right and exchange ideas and brainstorm and help increase the general quality of the whole process need to be able to get away from that whole philosophical discussion to do that. But then they need to also come back and hear the philosophical discussion again. The two are definitely linked.

Therese Stallings

I am a midwifery educator, and I have been since 1982, when I started teaching my own course. Education is the area that is most near and dear to my heart. I think that what's happening is very exciting. I believe that our models for midwifery education need to be revolutionary, as per the standard model in education, and certainly the standard model in health or medical education. Medical education models are some of the most archaic educational models we have today, and need changing. One of the simplest ways I can state this is that I have really come to believe that the job of an educational program is not just to train a technocrat, but to more or less midwife the student into a position of responsibility. And that means educating the entire woman, the entire person. That means working with a woman so she is capable of knowing her shortcomings, of knowing how to get help with those shortcomings, of utilizing her strengths, and of developing her own style and model of practice so that she'll have staying power. That's the bottom line. If we really want to have midwives that stay in this demanding profession and uphold the vision of truly enabling women while we face the challenge of standardizing education, we're going to have to really look at curriculum design, we're going to have to really look at our educational models and we're going to have to look pretty far into the future to come up with something that's good. And to me, this work is happening very fast. That's one of the cutting edges right now.

There's a lot of fear in MANA that we're going to end up with an educational process that puts us in a box. I think that this is due to how quickly we've expanded, and grown. I know that there have been times when I have been really afraid. But it's like anything else we've had to do. When working on a certification process, you more or less take the bull by the horns and say, "Okay, this could be a box or this could be creative. Now what kind of language can we create that will put the loopholes in the places they belong? If we predict an eventuality of five years from now, the most awful, conservative, nightmare board in the world is appointed, what can we put in the language that will not allow that board to undermine the integrity of midwifery?" It's the same in writing legislation; you also do the same thing, I think, in developing curriculum and educational models. I'm not afraid of that process. I feel fortunate that, largely through MANA, I found other women who aren't afraid of it either.

I think that us setting up our own accreditation council, as we have, is a wonderful thing. I can't tell you how neat it was to be there; that was another ground-breaking meeting. We educators came together and we didn't really know what our agenda was. We assumed, at that particular

point in time, that the American College of Nurse-Midwives had the corner on accrediting midwifery programs, until we discovered that they were registered under the nursing division, and therefore only had the corner on accrediting nurse-midwifery programs. I think it was Dorothea Lang that made the discovery, pretty much then and there at that meeting. That's when we said, "We're going to do this, and not only are we going to do it, but we're going to do it today. We're going to sit down, and we're going to take the guidelines that the American College uses for accrediting, and we're going to expand them and adapt them and make them suitable for everything from a program like the Seattle Midwifery School to a one-on-one apprentice situation." So that's the work we did in that one weekend. We've gone through some drafts since then, and nothing is set in stone; it's still very open.

Another thing that was most outstanding about the educator's coalition meeting was that I don't think I've ever been in a group of women that worked more quickly, because they truly understood the meaning of consensus. And it didn't mean anything to anybody if a particular one of us changed her position on an issue four times, as long as it was part of an evolution to a mutual understanding and conclusion. Nobody kept tabs. Nobody held on...and you can't do better than that when it comes to women's ways of knowing.

I'll give you an example of the kind of thing that happens. When Elizabeth Gilmore brought her educational program to the educator's coalition meeting, we looked at the learning areas she had set up. She had something like 35 modules. All of us educators are learning about this whole business of modules, but how to make them work as part of a system is something that we're just beginning to explore. My observation was that if we have 35 modules, then that may lead to the necessity for a student to take 35 exams to challenge out, and we can't do that. We need to come down to the most basic areas so that challenging is simple. And we did. I think we came down to eight areas. That sounds like a lot, but consider that human life science includes all of anatomy, physiology, and microbiology in one section and is weighted equally to intrapartum care, or antepartum, postpartum, newborn or well-woman gynecology, with a smaller section on midwifery laws and regulations. With those, a test in each area is not preposterous.

We decided this in spring of '91, and now those are the areas we've designated in proposed legislation in my home state of California. We

would like to be able to get away with one qualifying exam the way New Mexico has, but we can't; we've already been told that. So we see that the impact of the decisions we're making is great. And Elizabeth sees that. She knows that the National College of Midwifery has to fit with the needs of midwives in a variety of states. Lots of people really should be involved; anyone that has a concern about education can definitely get involved in the educator's group.

Elizabeth Davis

Concurrent to the formation of the Educators Coalition and the Accreditation Council, another group was being drawn together in order to discuss direct entry midwifery education. These meetings were being sponsored by the Carnegie Foundation, and began with a gathering in July 1989. After a few introductory meetings, Carnegie moved on to sponsor an Interorganizational Work Group on Midwifery Education, with representation from MANA, ACNM and consumers. The time for meeting together to examine routes into midwifery had come.

Carnegie Work Group on Midwifery Education

I think being invited to participate in Carnegie was just a good reflection of how strong MANA has become. The ACNM was at least recognizing the fact that MANA existed and that it clearly represented a lot of other midwives that aren't part of the ACNM, midwives that are there, that are practicing, and that may in fact have legal recognition. I think it was really a vote in favor of the political power of MANA.

Sandra Botting

The first Carnegie Foundation Seminar on Midwifery Education was held in July of 1989. Dr. Ernest Boyer called together thirty people, including MANA's president and second vice-president, and two MANA Education Committee members who also represented the Seattle Midwifery School, to discuss the expansion of direct entry midwifery education. Other participants included representatives of the ACNM, the American College of Obstetricians and Gynecologists, public health and higher education officials.

One year later a second seminar was held, reaffirming the need to expand the profession of midwifery and validate multiple routes of entry into the profession. At this meeting, Carnegie offered funds to establish an interorganizational task force on midwifery education so discussions between MANA and the ACNM could continue.

The first Carnegie meeting was devised because of the needs of New York State, where midwifery legislation was pending. The people who were invited from MANA were Therese Stallings and Joanne Ciecko-Myers, who represented direct entry education, and MANA's president, Sandra Botting. I must say I was very upset because I didn't get an invitation, since I am a direct entry educator who lives in New York, and I was very vocal about this at the next MANA meeting. The next year I did get an invitation, and I went.

Statement of the Interorganizational Work Group on Midwifery Education

The primary purpose of the Interorganizational Workgroup on Midwifery Education (Workgroup) is the promotion of midwifery through the development of alternative educational routes to professional midwifery. The Workgroup consists of six representatives each from the American College of Nurse-Midwives (ACNM) and the Midwives Alliance of North America (MANA), and six consumer advocates. At the June 7-9, 1991 meeting, the Workgroup reviewed the MANA and ACNM statements of Scope of Practice, Core Competencies, and Standards. The group affirmed essential agreement of the content of the comparable documents of the two organizations, and accepted the few remaining areas of difference. Based on these areas of agreement, the Workgroup is committed to exploring and defining multiple educational pathways for professional midwives in order to increase access to midwifery care. The groups represented are charged with the responsibility to present this statement to their respective organizations.

Signed by all Workgroup Participants

The meeting was at Princeton, a very posh affair. There was a more equal representation of direct entry and nurse-midwives this time. Mari Patkelly brought up this whole thing about variety and diversity, but they didn't want to talk about apprenticeship, so they tabled that. What they were there for was to talk about education, and that is what they wanted to stay centered on. The purpose was to set up core competencies -- although they had two organizations that already had core competencies. As far as I could tell, Ernest Boyer was defining the goals for the group, with the help of Dorothea [Lang] in setting up agendas. And I had the distinct feeling that they wanted me there more to listen than to talk, and really didn't want me to present my ideas at this group. However, I did anyway.

From the last Carnegie meeting came an Interorganizational Workgroup on Midwifery Education. There were 18 people invited to that: six midwives from ACNM, six midwives from MANA, and six consumers. When that group got together, we realized that midwifery education was not the first step. We had to back up and decide what we were really talking about.

Right now we are working on, "What is the Professional Midwife?" We are defining what we call the profession of midwifery, and we are, within that definition of midwifery, trying to develop educational programs. We also realized that promoting midwifery was a big issue. Just as of last time, we are trying to develop marketing techniques to broaden midwifery use in the United States.

If the IWG is going to develop and define midwifery education, we want to do it as broadly as possible. One of the things we're supposed to do is to identify multiple routes of entry. In doing this evaluation of entry routes, we are being judgemental at some level because we're saying this is a core competency and this is a core competency, and these are both acceptable. And these are standards and these are standards, and these are both acceptable. We're evaluating each other's documentation for midwifery. And coming up with that they're very similar.

By looking at each other's documentation we are upgrading ourselves in MANA. It's forcing us to develop, say, an ethics statement -- which we never had. This defining is upgrading. We've had the philosophy, we've had the ideology; now it's forcing us in MANA to put in down on paper.

I see MANA as including all types and varieties of people who wish to call themselves midwives, which will not necessarily only be women who call themselves professional midwives. There might be a very highly skilled midwife who may never want to call herself that. But what we're defining is this person who calls herself a professional midwife. It's a fine line; but the group has to set up some guidelines for what we are calling a profession. Every profession has guidelines, every profession.

We're still working out all the problems that we're going to encounter. We're trying to think through this, in advance of things that might occur. We're trying to create more of the need, so that we can create more of what we call midwifery-producing entities, whether they're schools, programs, self-study, or computerized courses. We've got all sorts of ideas out here. But first we have to create the demand. And I think that's what we've gone into, creating a demand so we can move forward faster with our projects.

Another vision that the Carnegie has had, and another step that MANA has promoted, is the development of a Declaration of Independence. I don't think the nurse-midwives would have ever done that. Midwifery, whether reached through a nurse track or a non-nurse track or a direct entry track, is not beholden to or dependent upon any other profession. She is her own entity -- midwife. We felt that we needed to write and declare ourselves

independent practitioners, autonomous within our own group, independent from nursing, from the medical monopoly, from any other group -- declare ourselves independent. Sarah Cohen and Ina May are developing that one. It is going to be a biggie.

The vision that we have as a group is so big that it boggles my mind. The vision is that there will be a midwife in every community, across the United States. In order to do that, and in order to create the need for that, we have to start that process. At the moment what we're doing is creating a public service announcement that will have a 1-800-midwife number. And that 1-800-midwife number has to be ready to give names, schools, childbirth educators, have its own office, everything set up.

I want to talk some about the evolution of Carnegie. I've seen tremendous amounts of changes just in terms of working with the different people on it. Because of my interactions in my state [NY] with the certified nurse-midwives, many times I go in there with trepidations of how I - who am not a legal midwife in the state that I'm living in, even though I'm a direct entry educator - will be received as a midwife. But the check and balance in that group is the consumers. They are the ones that have really helped with the bonding with everybody. They have had us focus on our commonalities, our common goals and our common visions, more than our differences. They are very task-oriented in that they want midwives out in the community. Neither MANA nor ACNM are privilege to these ladies.

The people that I've gone to the last three meetings with have come a long way in their visions. And our visions are closer together. The ACNM representatives are no longer always thinking in terms of nurse-midwifery, but in terms of midwifery, and what is the core in midwifery that makes a midwife. I think that they're having as hard a time with the ACNM as we are with MANA.

I must say that it hurts and astounds me that anyone would think that I or any person who was chosen by MANA would sell midwifery down the road. In this group, we try so hard to keep the vision alive. We have made a difference in the nurse-midwives, who are the upper eschelon in ACNM; their visions have changed. They respect us, and there's a mutual respect. I think that some of them would like to understand more about what we're calling community midwifery, or what a direct entry midwife is. They're really beginning to grok it. We can tell this by statements that Joyce Thompson is making across the States. We get the feedback. They're getting better. And a major step is they're recognizing that we are

MANA Representatives to the Interorganizational Work Group:

	Diane Barnes	Deb Kaley
	Anne Frye	Therese Stallings
	Ina May Gaskin	Sharon Wells
Alternates:	Shafia Monroe	Elizabeth Davis
	Joan McTigue	Alice Sammon
	Peggy Spindel	

competent midwives. It's hard to talk to Ina May and not feel respect for her, whether you're a nurse-midwife or not a nurse-midwife. And Anne Frye. And all the women there. All 18 of these women are so powerful within their own selves and have made such tremendous contributions to the whole process. Even at times when we're ready to kill each other, verbally, there's the sense that we can say these things and reach the middle again. I think that's very important, because that is essential in developing what is the core of midwifery.

We've also had the chance to have input into what the nurse-midwives are looking at. For example, they took nursing skills and broke them down into pages and pages. I went through it, and will recommend - to Joyce Roberts - other women who are educators all over the United States to go through this, and have them evaluate it. But my comment to her was, "These are not nursing skills, these are midwifery skills." That was a whole new mindset for her; she had to come back and say, "Yes, I hear what you're saying." So, I believe that we're broadening their concept of midwifery.

We're in a think tank situation where we're brainstorming all the time. Then we have to step back and wait, because the rest of our groups haven't caught up with our brainstorming yet. I feel like I'm in this game, two steps forward and three steps back. And that's fine. But, you know, we still keep racing with our visions.

Sharon Wells

MANA and the ACNM each got to select three consumers to be on the Interorganizational Work Group. MANA gave that selection process over to

a third party consumer group, and thus did not directly choose their non-midwife representatives. One of those chosen was sociologist Barbara Katz-Rothman.

I think that it's important that midwives gain the political power to practice midwifery, which is what I mean by a profession, which is what sociology means by a profession. And so, ways of organizing politically become really important to me. MANA then functions as a way of organizing politically in the interest of midwives, getting midwives freedom to practice midwifery.

I think that it was really clear in the work group that we were going to talk about those midwives who wanted to be professional midwives. It's plugging into the legal system. I don't want to see it be plugging into the medical system; and I think there's a way of doing it. If you define midwifery as a separate practice that's not obstetrics but is midwifery, then you can free midwives from obstetrical decision-making. Really, for me, the working model is more dentistry, which is totally autonomous and has its orifice of specialization. There's no reason why the mouth is dealt with separately, but there was this little fluke of history; the docs didn't want the mouth and so they didn't stake territory over it. But it left you a model which I think really is the one that you need for midwifery care.

I suppose in this process there's always the setting of the boundaries. You're going to say you want to give midwives freedom to practice midwifery, then you have the ultimate problem of what's a midwife. So you do end up with a certain level of boundary setting. I want to see midwives set their own boundaries. I think it's something that MANA inevitably does, whether it more or less acknowledges it. I think it's something MANA does have to do, to identify midwifery the way they want it identified. Otherwise somebody else is going to identify it, and you could end up with the only acknowledged midwife as a nurse-midwife or somebody else who jumped through medically organized hoops. So if midwifery doesn't take the definition of midwifery into its own hands it's going to be done by docs. And that's very dangerous.

I want to separate two things here. I think that midwives have to define midwifery, to define midwives. And they have to decide how they're doing that. So there's a level at which how I think it ought to be is irrelevant. If I were I midwife I think I'd have a right to say how it ought to be. But to me the important piece of it is that midwives set the definition. What's

happening is that oftentimes, by a refusal to set a definition because God forbid we might leave someone out who wants to be in, you don't set any definition, and then someone else sets the definition and huge sections of midwives that we'd want to see in are out. So I think that the most important piece is that midwives decide what makes a midwife. However they decide to do that, fine. Basically a midwife is someone that other midwives recognize as a midwife, which is how we've defined physicians and dentists and whatever. Midwives have to take control of that process. And there are a variety of ways in which they can do it.

An interesting point is that the very things that make people wonderful, wonderful midwives don't necessarily make them good political actors. Seeing the dialogue, and that we all feel good and can hold hands and sing at the end, as having accomplished something is a very midwifery oriented goal; you know, the process is wonderful. The more political activist types of us could never be midwives because we would never have the concern with the nature of the process. I walk out of there and I say, "And now what? I still can't get midwifery care today." The qualities I value so enormously in a midwife doing midwifery are not necessarily the particular qualities that are going to get this job done. You know, if you have that kind of efficiency orientation and impatience with the process, you wouldn't become a midwife. So there are these temperamental differences that I find very interesting. The four active ones of the non-midwives tend to be these very loud-mouth, 'Let's get this over with,' 'On to the next issue,' 'Move the agenda' types. In the process of the room, that has some interesting ramifications. There are some very active, efficiency-oriented types among the midwives too, but the four of us who are not midwives very clearly focus that way. We got into this because we're politically active and have loud mouths. And so that kind of dynamic is there.

Those who are midwives also are necessarily, understandably, with lots of good reasons, battling to control turf. Against each other sometimes, and against the rest of the world all the time. But you tend to lose sight of the rest of the world. Those of us who are not midwives don't have the same turf to protect. So I think that one of the things that we can sometimes do is just point out, "You people may think there's a world of difference between each other, but as far as the rest of the world is concerned, a pox on both your houses." There's a reality dose offered by those of us who are not midwives, saying, "We've got women dying out there in the halls of Kings County and you're playing games in here;" just putting it in a perspective of the non-turf issues. Now mind you, most of the time the

midwives themselves are perfectly aware of that and rise above it, and the comments come from them as much as from the non-midwives. But the ongoing constant presence of people who have not got a turf to protect is always useful.

I think that ultimately the group sees that they have to act politically, and will need it at all fronts. If you do the education without doing the regulation, then what have you got? And you can't do the regulation without some kind of definition statement of midwifery, which is going to include some kind of definition statement of how you got there. So I don't think that you can separate them out.

The really hard work that MANA and the ACNM need to be doing is seeing how the Carnegie group's work fits in with the work of their organizations. There's resistance on both ends; there's also support on both ends. You needed some kind of an interorganizational bridge. But as much as that group would then like to say, "Okay, then, let's just do it, and we'll just tell them what to do and that will be that," that doesn't work. You can't legislate for those two groups, you can just keep moving them along. Between groups that have had a long history of distrust, this is not an easy process. That's why the "We all feel good in this room" stuff is nice, but I'm not sure how much weight that carries. If you're not in the room, the lovely, warm vibes and the little flashes of human connection aren't necessarily going to carry a whole lot of weight.

Barbara Katz-Rothman

The work that the Carnegie group is doing is very exciting, very important. It was good to see what a dynamic group this could be, and so it's opened up my vision of that. I'm going to apply some of my newer standards of just how dynamic a group can be to MANA. I think the consumer input makes us strong. And I think once the direct entry midwives and the nurse-midwives start to get a feel for what each other can do, new possibilities are seen that we really couldn't have had a look at without these work group meetings. I think that the chance to just sit around and tell birth stories to each other - to hear about how we became midwives, to see what we really care about, the way that you do, not when you're in a meeting, but when you go out and eat afterwards, in the taxi on the way to the airport, the times when you really are relating to that other midwife as your sister, and someone whose story you're interested in - I think valuable things are coming out of that. Preconceptions are being

dropped, scales are coming off the eyes, that kind of thing, and that always makes for good energy. I'm very excited about that.

I think we're growing in unity. In the ten years of MANA's existence I see a lot of progress. I think that one of the practical effects of the work group may be more states going for a legal status. Once you have the chance for the public to see that you have two different groups of midwives who in effect are embracing each other and claiming each other, that's very powerful. And that is happening, that is happening. We've already felt results from that in some states. One of the chief things on the agenda is to get more midwives; that's one of our primary goals in the work group.

Ina May Gaskin

I have always said that MANA should be a networking organization. It shouldn't have any power, but it should be an organization totally committed to networking and education and communication as opposed to power. And the scary part about the Carnegie thing is that it really sets us up in a power situation.

I was very frightened at the meeting I attended. I felt like we were in great danger of being coopted; that it was exciting to be getting together with the nurse-midwives, but as far as I was concerned it was terrifying. There we sat, 25 or 26 women, and Ernest Boyer ran the show. It was all this big money and this high-falutin' atmosphere. This was at the second meeting in Princeton. Sandra Botting and Lisa Hulette were at the first, and I was at the second one. We barely got to talk about apprenticeship; we got cut off, and I felt there was a lot of steamrolling.

Sandra and I wrote a report about that which got sent out and that caused a lot of furor. When people responded to it, there was a lot of upset about us being too paranoid. I felt that it was good to start talking and good that we got the money together, but I had a huge fear about cooptation. I think that the working group has been working through a lot of that, but I still have some of those fears. Mostly I fear we are inadvertently going to cooperate with making midwives illegal who don't toe the patriarchal line. I don't think anyone will do it on purpose; I just want to be careful. I've been accused of being paranoid, but I think there's a big difference between being paranoid and being cautious and conscious about what's going on. I feel we're at a time when MANA could indeed be participating in its own demise. I think the ACNM has that same fear, but from a different perspective.

When I first read the definition coming out of the work group, it was very upsetting because I couldn't believe that the 'definition of a midwife' question was so poorly understood. Now I am coming to terms with that and am preparing to write (hopefully with a lot of input from others) about my concerns with using the words professional and licensure in the documents. The idea that jurisdictions should provide licensure is so abhorrent to me that I can't stand it! We need, for once and for all, to define the difference between registration, certification and licensure for MANA members so that the meanings and the consequences of these alternatives, both immediate and future, are known. We also need to take a stand about the ideal situation for midwives as we see it and go for that as often as possible. When not going for the ideal, we need to know it and acknowledge the danger, and wonder, at the very least, what effect it will have on the future of midwifery, women and children.

And then there's the issue of 'professional' which is in MANA's by-laws. How can we be professional without excluding others? Isn't the legal definition of profession one that includes exclusion? We have to stop 'professing' and learn to listen, accepting the diversity among us. We have to take a firm, clear stand for freedom and for the birth process as a female bodily function, not a medical condition. It is not something that has to be controlled, it is something that is lived.

We cannot use existing systems to do this. Existing systems on this continent were devised by landed white men to serve and protect landed white men. All the systems have been used to negate and destroy the power of women in community. The existing systems cannot change their original intent and we cannot change them at all. As a matter of fact, when we enter them, they change us.

We must create new/old ways to deal with our lives. We must get together to do that and when we get together we must create safe, conscious atmospheres for ourselves. No one else will do it for us.

Mari Patkelly
Conversation and Excerpts from Personal Correspondance

Personally, I have tried not to be attached to the results of the work group. I'm trying to relate to the process as it goes along, and if nothing more than greater understanding of who each other are comes from it, I don't think that's a problem. But I do think there's great potential. It's a

very power-packed group of women and I don't underestimate that, in terms of the potential good or harm that these meetings could do. One thing that has made me feel okay about participating is knowing that regardless of what comes out of these meetings, it has to be filtered through the MANA board or the MANA membership. If it were just up to us, I would feel much more charge on going in and participating.

Anne Frye

MANA and CNMs

The ACNM and MANA: two different groups representing two points of view...or do they? And what of the certified nurse-midwives within MANA? Do they see each organization as having a specified function? And how do they view their personal roles within the two groups?

The ACNM is a homogeneous organization and does not take into account different types of midwifery background. You have to go to midwifery school to sit the midwifery boards. The schools are changing; there's now a tremendous effort to develop off-campus programs. It's been terrible that we train basic generic midwifery students in tertiary care centers. I work and teach in an institution like that, so I'm acutely aware of that.

When I went to midwifery school, there weren't a heck of a lot of direct entry midwifery services. There hadn't been this awakening to what was wrong with the American health care system yet. The issues were just beginning to evolve. Who went to midwifery school then but nurses? I was an OB nurse and a public health nurse before I went to midwifery school. I saw it as a way to do better, to have more hands-on. I was frustrated as a public health nurse because I was functioning as a social worker and wasn't using my clinical skills.

I think you have to realize that the roots of ACNM were in the public health end. ACNM was started at a public health nurses' meeting in the fifties in New Mexico. And look at the history of the old Maternity Center Association in the thirties, and Frontier and what was going on in the South. They had to have a solid background in primary care, which they didn't know what that was then, and public health issues. So they were nurses, and they had to be. And I understand where those people were coming from.

There's a whole new generation now, some of whom I think like nursing. They don't talk about it, because it's not a popular position, but I can tell,

among students that I see over the years, that that's the way they feel. So, it's mixed. But more and more women are coming in as a stepping stone to midwifery, with a clear identity of themselves as midwives rather than nurses.

ACNM does not police midwives. They don't specify what you should do or what safe practice is. They give you basic guidelines. The ACNM does not tell you where you should give care. They do say that you should have a system that provides for consultation, collaboration -- you know, that care occurs within a system, and the issue is whether a procedure assists the midwife in managing. I just think they're dealing with a more homogeneous group. And there is, by the way, a big difference in philosophy about whether or not nurse-midwifery should be on a graduate level. ACNM has been split from the beginning on that issue, and there are those of us who have fought tooth and nail to keep certificate programs alive in spite of the fact that the National League for Nursing does not recognize specialization as occurring on anything but the graduate level.

There have been changes in the ACNM as a direct result of the existence of MANA. I think that there is increasing recognition that this is a force to contend with. It's not going to go away. If you sit down and think about it, there's got to be some recognition for the fact that there's more than one way to become a midwife and more than one way to give excellent midwifery care. I do believe that more and more people have confronted that issue and are no longer attempting to sweep it under the rug, and are indeed interested in dialogue. I think there is a lot more collaborative effort going on. Look at Washington State -- that's an incredible model, with the collaboration that's gone on between CNM's and direct entry midwives. Granted, it's unique and different because they've had a legal basis for practicing and a school. I think it's forced some recognition of reality of the situation that could no longer be denied, and I think there are some concerns about where energy should be directed. My personal notion is that eventually the two could come together, at some point, and form one confederation.

I think of the work that's gone on this year - the Carnegie Foundation - why did the Carnegie Foundation happen? What was the interest for all of that? I think that it always takes a combination of factors. It's also my feeling that if you have strong figures in the ACNM world who are positively involved, it's going to accelerate things. People like Dorothea Lang. Dorothea is, as you know, a controversial character. But she's a mover, she's a shaker, she gets involved, and she has never flagged in her

agenda. She's sort of a woman possessed. And I think it takes that. That's the kind of stuff that comes out of a willingness to collaborate, a willingness to work with others. I think it's sparking the work done on the state-by-state level too, adding to the willingness of people to work together. I think that the existence of MANA forces people to acknowledge that it's an entity, that it's meeting a need that's not being met by the existing health care system.

I have a personal perspective on CNMs and their involvement in MANA. I was involved in the beginning, and they wanted me to be the president, and I said, "That's ridiculous." It was early on and we were working by appointment. And it would not smell right to me or anybody else, I think, if it was leadership in that form, coming out of a CNM. I don't think that's the message that I wanted to communicate, that I wanted to be a leader in an organization that really needed to work for the benefit of a group of people who were very diverse within a whole other spectrum. So I think the role of the CNM's should be as grass roots supporters. I think the leadership needs to be primarily non-CNM.

Susan Leibel-Finkle

I think that MANA has a lot to offer nurse-midwives because MANA really knows something about midwifery that ACNM doesn't. I just think that there's something about midwifery that is just not tapped by the ACNM. I'm certainly not one of those people of the opinion that nurse-midwives are not real midwives, but there are probably a lot of nurse-midwives who really don't know about or don't feel midwifery the way that MANA expresses it. And there are plenty of nurse-midwives who do. I think that the pure midwife identity has really been captured by MANA. Even in the name, the nurse midwife identity is a mixed identity; it's watered down. If somebody says "nurse-midwife" to me, I don't turn my head. If they say "midwife," I know what that is; that refers to me.

MANA has always been able to tap the heart of midwifery and to express it. Everywhere you turn, it is there in MANA. The wonderful, lively thing about MANA is it just has the heart of midwifery beating in it. But the head part is not connected. Maybe it's because the ACNM has the head part; I don't know. But there's something not smooth about MANA's brain, something not working right. I don't get it, but I do think it needs fixing. Or it needs developing. Maybe it's just that it needs developing. Maybe it's just not as mature as the heart.

But I certainly do feel committed to MANA relative to the ACNM. The ACNM is dry; the American College of Nurse-Midwives, the American College of Dentistry, the American College of Pharmacology... you're just finding a slot and you push paper around. Now what I don't understand, and what I'm going to try to observe at the next ACNM conference, is what they do with all the wonderful, good, creative stuff that the individual women have. I know the nurse-midwives have that stuff, but what do they do with it? Do they squish it? Do they stick it in slots? Or is it possible that the structure of the ACNM allows those people really to do a lot of neat stuff with that creative juice? I don't know, but I'm interested in finding out.

Peggy Spindel

I always said to other nurse-midwives, "MANA is the soul of midwifery." I think ACNM is more the brains, the practicality, the political, which is very needed. I said, "The soul of midwifery comes from this entry into midwifery, comes from these routes and this background," and I had vowed I would never forget this.

But this got me into a lot of trouble in the nurse-midwifery establishment. I was seen as the radical there. And yet I would come to some of the MANA meetings, and feel a particular pull in both directions. When I was with nurse-midwives, I felt a very strong need to defend what MANA was doing. In the same way, when I'd be at MANA, I sometimes would hear, "Oh we don't want to do that. We're becoming too much like nurse-midwives." I felt very strongly that there was a lot of good in the nurse-midwifery organization, too. My agenda, if I had one, was to see the two groups coming together. I felt that the most important contribution MANA could make would be to bring the two groups together into one; that in bringing the two together in one midwifery organization there would be enormous strength not only to the profession of midwives but to that whole philosophy of birthing. I don't now know that that will ever be possible, but I see what is happening, and I'm hoping it will get together.

Back in the early days, there was a lot of negative energy brought into the organization. I'd gone through a lot of emotional strife, being looked at as the radical at ACNM and then coming here and being treated like the "nurse-midwife," and it was just too much emotionally for me to deal with. I just said, "I don't want to be involved in any more fighting," and my term was up as regional rep, so I just stepped aside and had a lot less to do with the organization.

I think that when any group is new, or any profession is young, everybody feels threatened. The nurse-midwives felt threatened; MANA did too. I remember when we were in Houston and were in a retreat, there was this big to-do about Judith Rooks and what she said at the ICM or what she was going to say, and Judith, who was the president of ACNM, was seen as this terrible person. She came up to me at another retreat of nurse-midwives and said, "You know, I didn't mean to come across as being very anti-lay midwives. I was just trying to defend midwifery."

What's very interesting is that I saw Judith Rooks about two years ago. We were talking about direct entry, which I had always felt very strongly about because it was my first route into midwifery. I felt that I could then say to nurse-midwives that I didn't think I needed to become a nurse in order to get the midwifery education, that I thought people could come with varied backgrounds. I always said this in our open forums at nurse-midwifery conventions. And Judith Rooks came up to me and said, "You know, I'm coming around to seeing the other perspective of direct entry midwifery."

Yes, you can disagree with the other person's point of view, but don't attack them personally. At least be able to see where they're coming from, to understand their perspective and at least respect it. Respect that people can differ with you. One of the French philosophers said, "I might disagree with what you say, but I will defend to the death your right to say it." And that's something that always has stuck with me. Sometimes I'll get accused of arguing and fighting, but that's my right. It's okay, disagree with me, argue back; don't just clam up and in passive-aggressiveness say, "I don't like what she says." We women have to learn that it's okay to argue and disagree and fight, but to do it in a way to recognize that different people come from different perspectives, that we all feel very strongly about midwifery, and about the women that we serve in birth. Even within MANA, my God, there's so many different perspectives. Do you ever get two midwives to agree on anything? But the personal attacks that I used to see at the beginning were what really hurt. I'm seeing that going away. I'm seeing the maturation process beginning amongst both groups.

Fran Ventre

I think all this divisiveness is really not only dumb but dangerous. We have so much to learn from each other. We're not going to go away, and they're not going to. It's the same thing, where the lay midwives think the

nurse-midwives are too medical, and the nurse-midwives think the lay midwives are too Birkenstock, flaky, whatever. Somewhere in the middle there's got to be a realization that we all are working to improve outcome, and that we all have an idea of a midwifery model. It doesn't really matter what your route of entry. It's like religion; it doesn't matter what path you take to get there, as long as you start understanding your role in the larger picture of things.

You know, [my husband] Ken really believed - he was an obstetrician - he really believed that obstetricians are overqualified and overtrained, overspecialized. To save them time and energy, he felt that they really should be on call or around just for complicated stuff, and that midwives should deliver all of the normal babies. That was the dream, to have midwifery care accessible to all women, and obstetricians to be there for what they're trained for -- high risk stuff. That makes sense to me.

So hopefully we'll grow up past this part, and the two groups will start working well together, and move on so we can start offering this more on a mainstream level to women.

Carol Leonard

Our Stories: Personal Experiences of MANA

I love MANA and I've made my best friends in MANA. I've really learned a lot and was thankful to be part of that. The excitement and the personalities and the spice of MANA is something I don't necessarily get the same way here in Canada. I see MANA's role as being that, in a sense. The conferences are just great, so charged and full of information and lots of interesting people with all kinds of different backgrounds. You know, there are so many different ways of being a midwife. I think people need to be aware of them. That's what I've gotten the most out of MANA, that exposure.

Sandra Botting

My relationship with homebirth began in 1976 when I had my first child. I started apprenticing as a midwife when she was nine months old, and spent about three years training and becoming a partner in a group of midwives. This was in Washington State. I felt really isolated, like we were the only people in the world that were doing this. It was fun and it was exciting, we were changing the law and starting up the midwifery school and doing births, but we basically felt isolated. And the only other people that we knew, at that time, were Ina May down at The Farm, because she'd written Spiritual Midwifery, and so there was at least somebody else doing homebirths, and maybe some in Oregon and California. Then I quit doing births in 1980.

But in 1988 I came back to midwifery, and when I discovered MANA it was so wonderful. There was this whole network of midwives in North America. You just get this supported feeling, like you're not alone doing what you do. The MANA conferences are so valuable for exchanging information and seeing what other people do, just little tidbits about, "How do you handle this? What do you do in this kind of case? How do you run your practice? What do you charge?" If there's anything that you wonder about, you can ask somebody. And then there's all the information at the booths... It's like a banquet.

I think the issue of empowering and getting birth in the proper perspective is important. We're changing the world, we're not just delivering babies. And you realize that fact at MANA, more than in your day to day work at home. It feels good. It's like being part of an important change in the world, making the world a better place to be born into.

Carolyn Weaver

A lot of what happens in MANA that's exciting to me is the networking. Also the creativity, the willingness to use other forms and formats. For instance these abuse workshops, "speaking out and listening," are being accepted and promoted as opposed to research. The ICM was full of research, research, research. The whole idea that we can actually learn by sharing as opposed to researching more and thinking in a linear way is really exciting. Also, the presentations that we've had with art and dance, just the fact that there was a menstrual lodge in the square of the Hilton, those are the kinds of things that to me are the essence of MANA. Somehow, I can't imagine that the ACNM would put one up. I think that's the difference we bring into the midwifery community,

The other thing is the Sage Femme awards, the way that MANA has taken on the honoring of the ancestral midwives. I've been to two different ACNM conferences and the ICM meeting in Japan. At ICM, all they're trying to do is for really educated people; they don't have any sense of honoring the traditional midwives. As a matter of fact they call them TBAs [Traditional Birth Attendants], and separate themselves name-wise from them. This needs to be talked about, it needs to be changed. The honoring of the midwife is in a totally different context within MANA than it is with any other midwifery organization I've been involved with.

MANA seems to be much more woman identified. I think the reason is because we haven't totally gone to the patriarchal structure. The ICM and the ACNM use patriarchal structures totally in order to organize themselves. I think the difference is that even when we've kind of accepted the structure, like we have in our by-laws at this point, we have always still rebelled against the structure.

And now I do think we have to get out of that structure and get our by-laws straightened out. I think an exciting project is to get ourselves defined the way we really want to be defined. In the process I would love to see the voting thing, the whole structure changed. I would also like to see

us make a commitment to not be a regulatory organization, but to be a networking organization.

I think the other thing I want to talk about is just friendship. One of the most important things is the kind of space at conferences and board meetings to get to know people from different parts of the country and from other countries in ways that you wouldn't ordinarily. I just think that's a huge aspect of the whole thing, whether it's midwives or anybody else. It's pretty wonderful from a woman's perspective. In a way, some of what happens at MANA doesn't even matter that it's midwives. It matters that it's a bunch of women getting together from all different parts of the world and sharing their stuff.

Mari Patkelly

I missed the Denver conference because my husband died, but I think that's really the only one I've missed. I thought I was going to quit midwifery, so when I went back to New Orleans, that was a big, big step for me. I kind of went just to see Therese and my friends. I hadn't done anything public or anything around midwifery at all.

I remember watching this slide show, and just bawling, because I thought that I had quit midwifery. And then it just dawned on me, "Who are you kidding?" I realized that once you're a midwife you're always a midwife.

Carol Leonard

You know, time is on the side of midwives, I think, for reasons good and bad. I've always felt that the way the health care system was going economically, within twenty years women would be abandoned by physicians, because it would no longer be in the physician's financial interest to provide them care - which is the only reason they're doing it now anyway - and that perinatal services would fall into the laps of the midwifery community.

My scream to the ACNM for this last fifteen years was, number one, you're not capable of preparing enough people for the future and, two, you're not recognizing that there's this whole other pool of people here who are ready, willing, able, and doing it already. I put that out there in the late seventies, early eighties, and I think now people are beginning to look at it.

It's all going to happen. I have this vision that in the next century in this country midwives will have to be providing 75% of the care. And we're providing about 5% now. How do you do that? There's no way to do that without recognizing other routes for preparation.

I think the biggest challenge I saw in MANA was dealing with the diversity in the backgrounds of all the midwives. I used to kind of scratch my head about how everybody was included. This is the United States, it's a highly technological culture, and it's very hard in the 1990's to support someone who's illiterate, who can't read, and is out there delivering babies. It's a very, very difficult position to take. I don't have the answers, but I see that as a vulnerability within the organization.

It's been a long time since I sat at a meeting, but I remember a lot of angst about trying to represent everybody equally. And I think it's hard. It's ultimately the issue that causes the most pain.

Susan Leibel-Finkle

MANA is the most important organization in the world, because it allows itself to be visionary. At a time when most provincial and state midwifery organizations have to deal with the practicalities of living up to an image with the medical authorities in order to survive, at MANA we're able to expose ourselves for who we really are and say what we really think without fear of censorship. At MANA we will always meet people who are more radical than we are and more conservative than we are, and balance each other out.

Betty-Anne Daviss-Putt

I think the most important work that MANA has done is just in bringing midwives together to have a forum to meet and just be with each other. I have to say, the one thing about MANA is the conferences; there's nothing like them. It is just a wonderful, spiritually awakening time. You come away from those conferences totally believing in what you're doing. It gives you that shot that you need to face the world. Sometimes it's very hard to get that, because it makes it harder to live in the real world of midwifery. But I just think bringing people together, and the wonderful circle that occurs at the end, is like religion, in a sense, and it makes you value the calling that you have as a midwife. It builds your self-esteem and self-respect, saying, "Well, it is worth it."

I think that I can't see a more pure form of feminism then right there in all the MANA women. What has happened, unfortunately, is that somehow feminists have thought that those of us who are involved in the whole birthing process have nothing to contribute to feminism. I think that birth is very much a feminist issue. I think midwifery is such a feminist issue it is unbelievable. Midwives' relationships with doctors, and I mean female doctors too, so characterize the role of women in relationship to men. Being a midwife is like the microcosm of the frustration that you feel as a woman, because as long as you're a midwife you're in that second class position. You have to deal with that on a daily, constant basis.

There's so much a feminist issue in being a midwife it is unbelievable, and yet midwives have never really been recognized by the feminists. I mean, they give us lip service, on occasion. Even when you read all about Starhawk and goddess religions, there's a little bit of mention of midwives; but sometimes I read those and I say, "All of that is every experience that midwives have had." And when you're a midwife you feel it more profoundly. You almost become paranoid. It's like feeling the paranoia of Naziism anytime you see a skinhead if you come from a certain background. People might say you're paranoid about it, but you say, "No, I'm not paranoid. That's real." I think people have accused midwives of being paranoid. It's because we know. We know what's going on. We know while we're being patronized what the reality is. Yes, I think midwifery is a feminist issue.

I also think birthing's a feminist issue very, very much. Nancy Cohen, for example, my God, she's the biggest - I'm saying this not in a negative way, in a positive - she's the biggest bigmouth and has alienated more of these guys than anybody else. They say, "Well, she could kind of sweeten it up a little." Like if she were only a little more palatable, we could take what she says. But she's not palatable. She says it the way a man would say it. She says it the way it is, and that's why the guys in the establishment hate her guts. They can't take her. "Oh well, if she'd only put it with a little more honey." Yeah, what do you want, her to wear a sexier dress or something while she says it, or say it in a sweeter, nicer way, you guys? But they don't like the way she presents it. She's powerful, she's too powerful for their taste.

You know what's very interesting? When I was in DC, some of the biggest lawyers who helped me get licensed were women from Ralph Nader's group and then from the Center for Law and Social Policy, big feminist type lawyers. What I always found very interesting was that all of

these female lawyers, these really strong women, chose the most patronizing, patriarchal male physicians when they had their own children. It was always amazing to me that these women never brought their feminism to their own health care or to their own birthing. They didn't realize how in everything they did, they were feminists, but in their own bodies, they were not.

That is a hard message to get out there. People will say, "Oh yeah, they're a bunch of tough broads anyway, a bunch of radicals, and they're trying to build their own profession." I would have hoped that the women in the Boston Women's Health Book Collective would do more of that. But I think it could be something that would be addressed by MANA; that would be very appropriate to look at.

The fact is that now, a lot of MANA's founding people are not significantly involved and the organization is strong. That, to me, says the most that it's a good organization. Some people gave me a little picture as a present, one of these framed sayings and it means a lot to me: "There are two things you give your children. One is roots and the other is wings." I think that those of us who were the founding mothers gave MANA the roots and then, the organization found its wings.

There are all different personnel involved in MANA now, and it doesn't matter who went before them. They were not indispensable, they have made their contribution and now it's time for the next people. The ability to do that, to see that nobody is indispensable, helps ensure that the organization will thrive and that we'll be able to build on it.

Fran Ventre

The first call I got about being involved in MANA was from Sharon Ransom. She was in Vancouver, I believe it was, and she called me on the telephone almost in tears, and she said "You've got to come next year, cause I'm the only one [black woman]." Ina May and I had discussed MANA, and I wasn't really anxious to get involved. Then they were having the SE Regional at The Farm, and she told me that if I could just get there, they would cover everything else. That was my first conference. I got on a bus and I went to Tennessee, and really got turned on at the conference.

I joined then. I was really impressed that there were so many women who thought it was important enough to come from all over the country. I progressed from there to, in West Virginia, sitting in for my first board

meeting. Then the year after that I decided I would take on the Interim Registry Board, and I did that for a couple of years. My mother always said I had more nerve than brains, so I'll get into stuff with both feet and then later on say "God, if I knew it would take this!"

MANA has expanded my scope in ways that it wouldn't otherwise have been expanded. I would have never considered myself an organization person, and being part of some national organization -- I wouldn't even have considered it. Things in this country run on organizations and committees, but these were things that I had no experience with. There's a certain level of confidence that I have achieved in speaking my mind in this closed environment that has given me confidence and skills. I walked into the office of the Department of Human Resources for the State of Georgia, which is something that I would have not have done six years ago, and told them what I thought. Whereas before I would have sat with my friends and my contemporaries and my sisters and talked about saving the world, and, "I don't know why THEY don't do it like this, and I don't know why THEY don't do it like that," now I feel more confident to go to the powers that be and say the same thing.

I'm not going to stop the action and activities that go on within my circle, because that's my primary responsibility. But in the same way I could help take concerns of people with another reality to the MANA board and to MANA membership, I've now been able to project concerns of people within my circle to the state government board membership. I feel that the experiences I've gotten here in MANA have helped to hone those skills. I think that stuff was in there all the time, just the confidence and the knowledge that I could do it wasn't there. The heart that it took to get up at a MANA meeting or at a MANA board meeting gave me more heart to do it the next time, or to say more the next time, and it just kind of washes over in other areas of my life.

Sondra Abdullah Zaimah

Some women came to the last conference with me, one of whom was a direct entry midwife who then became a physician assistant midwife and had never been to a MANA convention before, and another that had done the same and then gone on to be a nurse-midwife. They were both so amazed that you couldn't tell anybody from anybody else. There were no designating markers of what the educational route was; everybody was everybody, and we were all midwives and we were all together. To me,

that's the essence of MANA. I've just always believed since I first heard about this organization that MANA was going to be tremendously powerful and tremendously successful, because the vision is true -- that a midwife is a midwife is a midwife. That's the only thing that will ensure the survival of midwifery.

I also think of what Carol Leonard told us, after she went to the ICM meeting in Australia, about everyone coming up to her and saying that they were looking to MANA to lead the way. That needs to be said. I say it in my speeches all the time. I say it everywhere, because people can't comprehend how a place like the United States where so many midwives are persecuted could possibly be a world leader. But one of the things that we don't appreciate about ourselves is that we do break the law. There are a lot of places in the world where you can't break the law. Here it's almost a tradition. Our country was founded on breaking the law. So we have something really special.

MANA's my organization. I knew that then and I know that now, and it hasn't mattered to me what kinds of changes the board has gone through, because I think the membership has sustained the leadership, and that's how it should be.

Elizabeth Davis

Future Visions

We can see where we've been; now where are we going? When asked their views of what the future holds for MANA, the answers were as varied as the women themselves.

There used to be a day when I would prophesise at the drop of a hat, but the world is getting so crazy that I don't even know if midwifery is going to be in business in another two or three years. I think that this malpractice thing is going to get straightened up and the boys are going to come back home, as they say. I see American society changing. We are not getting near as many women who want to do their own thing. They're just downing the doors demanding their epidurals even when there's really no clear reason for them. They're much more business-like than they used to be. There's just a lot of things going on, and I don't know what society's going to be like five or six years from now. I think a lot will depend on how that is, as to how we will be here. See, the more you have to struggle for your own position, the less you're inclined to be in good shape with someone else. I think right now, in this particular moment, we have a real window of opportunity to do something good with each other, because neither one of us are pressured a lot from the outside into our own personal survival.

Sister Angela Murdaugh

Some MANA members have indicated conscious-raising thoughts that help the members [of the MANA board and the Interorganizational Work Group] to look down the road at the impact of what we're deciding today so that we don't make the same mistakes that we've made in the past. All this activity raises questions about words and subjects, like "professional," "traditional birth attendants," "licensure," "certification," "registration," "standards," "values," "ethics" and "insurance." It all seems to be talking toward the area of accountability. We're warned to remember "autonomy," "individual practice," "apprenticeship," "preservation of the art" along with the practice of midwifery.

I joined MANA because it was an umbrella organization, and I felt a secure feeling that the shelter offered by that umbrella included everybody. They didn't care what my background was, and when I finally got to my first convention I was really surprised and amazed at the amount of diversity that I saw. And I wondered what I would have learned if everyone had been just like me.

I know that future holds a lot of crisis for midwives and that many are stumbling and searching and trying to figure out which is the right path for them to take. We get pulled in on one path and somebody else gets pulled in on another path and we find out that there are still yet six other paths we didn't even know were there. I hope that while we question the various choices, we remember not to condemn those that take the choices that we find unacceptable. As a group, I hope that we can continue to support the diversity that's represented within MANA.

Diane Barnes
Address at General Business Meeting, El Paso, 1991

I would really like to see MANA putting its energy toward a concerted public information campaign on the need to support maternal/infant health in this country. They should put their effort toward promoting public information about the importance of nutrition, of prenatal care, of the need for federal policy to support our children as our investment in the future. There are so many people falling into the cracks that it is just terrifying. It's really impacting very heavily on rural areas. A lot of the federal funding for the rural health care projects has been put on hold or targeted for cities, which were dropping through the cracks when Reagan was president. So I think MANA could really do a lot of good for midwives in general if they put out information that would assist women, educating women about how to take care of themselves during pregnancy, in the chance that there isn't going to be anybody out there to take care of them. I really think that would give the organization quite a bit of leverage. People remember things like that, and at least they would remember that they heard it from midwives.

Tish Demmin

I think that MANA definitely has to be the one holding onto the legitimacy of the non-nurse midwife, and of home birth, and of that whole - I don't want to say 'style of practice' because it trivializes it - that whole

way of birth, really. It has to hang in there and preserve traditional midwifery. I don't know how that's going to end up being defined, but certainly if you just look at who's watching out for what, MANA's the only one who is in the position to do the job of preserving that kind of midwifery; and if MANA doesn't do it, nobody's going to take it up. For me, the organization will be successful if they're able to maintain straight midwifery.

Peggy Spindel

There are a lot of things that we want to happen, especially midwives who are in an area where they're not supported, can't get back-up, or where there aren't any other midwives. They're working under this really horrible emotional strain, so there's really this tendency to want it now. "I want to do this. I want legitimacy. I want to go to a birth and be able to take the lady to the hospital and not get these second looks. And I want to be paid for what I do." So I think the challenge, in the face of a really great need to be fully recognized and legitimized as midwives, is for that to be balanced out with how it's done. And that's hard. That's really difficult. And the need is so great that I can understand it totally.

But I have a lot of faith in how it's going to work out, even with all that is happening. We always have to take a little bit of a long-range view, and think about how things are going to be affecting midwives ten or fifteen years from now.

Valerie Appleton

I'd like to see another movement. I don't know if MANA should take it on or not, but we need some kind of consciousness-raising movement of women. The '70's was a wonderful time for birthing. Women were questioning the system. And all of those women seem to have become midwives.

But I've seen the general population, and I've seen some of the backlash in the parenting magazines against natural childbirth, breastfeeding, and all of that whole committment. There are more women wanting epidurals, wanting every test in the book, wanting all of the monitoring. Maybe it is MANA's role now to reawaken the movement of women and say, "Wait a minute." People all think that epidurals are 100 percent safe, that there is

no difference between breastfeeding and bottlefeeding. In the last few years, I haven't seen anything coming out that talked about the advantages of breastfeeding. They were saying, "Don't worry. You want to go back to work? Leave your kid. you can love a child as much if you bottle feed. There are no real advantages. Yes, breastfeeding is good, but we don't want to make you feel too guilty if you don't breastfeed." Where's the commitment? Where's the commitment to parenting, to mothering? It's not that you want to lay guilt on people, but there's strength in that. There's power in that for women, for families. Yes, we do have some obligations as we become mothers. There's nothing wrong with saying, "Yes, you do have some obligations to your child."

Now we're looking at our whole health care system and we're saying, "Can we afford it? Can the government afford to take it over?" Well, people want every test, they want everything, and nowhere are we asking, "What about people taking some of the responsibility for their health back to themselves? We don't need every test in order to be healthy." I might be wrong, but I think there might be a role for MANA to play in again bringing out that consciousness.

Fran Ventre

I can see MANA, because of its title, actually being something even bigger than it is now. I can see MANA being an organization like the Pan American Association of Midwifery, part of the World Health Organization. I would like to see the MANA organization be the midwives' alliance of all organizations in North America. And under that umbrella you could have professional midwives and ACNM and other midwives and other midwives and other midwives; there's nothing wrong in having fifteen midwifery associations as long as everybody pays their dues and helps to get along with each other.

Dorothea Lang

I feel that in the next five years midwifery will probably triple in size in terms of the number of midwives in the United States. It's going to be essential with the dropping economy and the health care crisis; of course the women are affected. The midwives are the ones who are going to have to pick up the pieces. And we have to have more midwives, however we get them out there.

I see MANA as the glue that is holding midwifery together right now. Because MANA is all midwives. I see that it's just going to get more powerful and more powerful in itself and be more inclusive in what it's doing. It's a place where all midwives can go. We are changing and shaping the future of midwifery in the United States.

Sharon Wells

I feel like the good news about MANA is that it's a coming together of a broad base of diverse people, and I feel like there's a lot of strength in that. The bad news about MANA is that although a lot of intrinsic respect goes on among those that attend the conferences and among the MANA membership as a whole, some people have unfortunately been alienated from MANA - primarily people that are very straight, very Christian, very conservative. In some ways I think it's bad, but it has also moved them to create the Fellowship of Christian Midwives, and I think it's great that they did that. I think it was probably a direct outgrowth of their disenchantment with certain aspects of MANA.

I think MANA has a lot to offer, but I also see the danger of it eventually becoming the old girl's club. That's my big fear; that MANA will become like that, and a new group of radical young midwives are going to have to go out there and shake it up again. We can prevent that from happening by continuing to foster diversity, continuing to attempt to listen to everybody, and by putting our energy and focus into how we want it to be rather than being afraid. I think that those are essential to keeping it alive.

I feel like our diversity is our strength. Racism and other isms are so ingrained and so unconscious that the best we can do is to try to become conscious. At least MANA's willing to say the words out loud; at least MANA's talking about those things. And the work we do to foster that communication without alienating each other completely is very important.

Anne Frye

Visions for MANA in the next decade; here's a little about mine:

1. The MANA board continues its work on Ethics and The Art of Midwifery in action and theory, using ever more inclusive processes and ever more decentralization of power.

2. That any Definition of a Midwife and/or MANA Member be consistent with the way we function as midwives and with freedom and response-ability in its most lovely form.

3. That MANA maintain its relationship with ICM and ACNM in some form even if goals/philosophy tend to separate us or force us to separate.

4. That our written documents reflect our ongoing growth toward power and freedom as women and that they are shared freely with all women -- worldwide.

5. That the apprentice model of midwifery education be defined/refined and accepted fully by the mainstream culture without serious compromise.

6. That midwives begin to practice "full scope" midwifery and that such practices are supported, encouraged, and facilitated by MANA.

7. That midwives and women start to identify with the sun as well as the moon. That they see themselves as the source of positive energy, not just the ones who hold the reflection of it.

8. That the circle of midwives and women grows strong and has a positive effect on worldwide cultures.

Mari Patkelly
Personal communication

And my vision for the future of MANA? That we learn from the lessons of the past, and not restrict our choices for the future. MANA's uniqueness lies in its ability to include midwives from many backgrounds and nations, to not restrict membership to those who learned on one particular pathway or practice according to one set model. I have learned that there is no "right" direction to head; all our choices have both positive and negative elements. Our greatest challenge still remains respecting those who choose other pathways while finding our common goals.

I, too, believe that we must define ourselves according to how we practice. I hope that in the process of doing so, we can help the ICM expand the International Definition of a Midwife so there are no longer "Traditional Birth Attendants" being robbed of their rightful title of midwife. I would like to see us leave our qualifiers behind us so we can proudly call ourselves midwives, regardless of our route of entry. I would like to see us find creative ways for midwifery to become legalized/ decriminalized throughout the States and Canada, and midwives' services used to the fullest extent. Lastly, I hope we continue to explore new ways of relating to each other to make sure all our voices are heard and respected. Let us truly make MANA the place where all midwives can be at home.

We are sisters on a journey
Shining in the sun
Shining through the darkest night
The midwife's time has come, has come
The midwife's time has come.

Appendix A

The Midwives Alliance of North America's Statement of Values and Ethics (Draft as of 10/92)

We, as midwives, have a responsibility to educate ourselves and others regarding our values and ethics and reflect them in our practices. Our exploration of ethical midwifery is a critical reflection of moral issues as they pertain to maternal/child health on every level. This statement is intended to provide guidance for professional conduct in the practice of midwifery, as well as for MANA's policy making, thereby promoting quality care for childbearing families. MANA recognizes this document as an open, ongoing articulation of our evolution regarding values and ethics.

First, we recognize that values often go unstated and yet our ethics (how we act), proceed directly from a foundation of values. Since what we hold precious, that is, what we value, infuses and informs our ethical decisions and actions, the Midwives Alliance of North America wishes explicitly to affirm our values[1] as follows:

I. Woman as an Individual with Unique Value and Worth:

A. We value women and their creative, life-affirming and life-giving powers which find expression in a diversity of ways.

B. We value a woman's right to make choices regarding all aspects of her life.

II. Mother and Baby as Whole:

A. We value the oneness of the pregnant mother and her unborn child -- an inseparable and interdependent whole.

B. We value the birth experience as a rite of passage; the sentient and sensitive nature of the newborn; and the right of each baby to be born in a caring and loving manner, without separation from mother and family.

C. We value the integrity of a woman's body and the right of each woman and baby to be totally supported in their efforts to achieve a natural, spontaneous vaginal birth.

D. We value the breast feeding relationship as the ideal way of nourishing and nurturing the newborn.

III. The Nature of Birth:

A. We value the essential mystery of birth.[2]
B. We value pregnancy and birth as natural processes that technology will never supplant.[3]
C. We value the integrity of life's experiences; the physical, emotional, mental, psychological and spiritual components of a process are inseparable.
D. We value pregnancy and birth as personal, intimate, internal, sexual, and social events to be shared in the environment and with the attendants a woman chooses.[4]
E. We value the learning experiences of life and birth.
F. We value pregnancy and birth as processes which have lifelong impact on a woman's self esteem, her health, her ability to nurture, and her personal growth.

IV. The Art of Midwifery:

A. We value our right to practice the art of midwifery. We value our work as an ancient vocation of women which has existed as long as humans have lived on earth.
B. We value expertise which incorporates academic knowledge, clinical skill, intuitive judgment and spiritual awareness.[5]
C. We value all forms of midwifery education and acknowledge the ongoing wisdom of apprenticeship as the original model for training midwives.
D. We value the art of nurturing the intrinsic normalcy of birth and recognize that each woman and baby have parameters of well-being unique unto themselves.
E. We value the empowerment of women in all aspects of life and particularly as that strength is realized during pregnancy, birth and thereafter. We value the art of encouraging the open expression of that strength so women can birth unhindered and confident in their abilities and in our support.
F. We value skills which support a complicated pregnancy or birth to move toward a state of greater well-being or to be brought to the most healing conclusion possible. We value the art of letting go.[6]
G. We value the acceptance of death as a possible outcome of birth. We value our focus as supporting life rather than avoiding death.[7]
H. We value standing for what we believe in the face of social and political oppression.

V. Woman as mother:

A. We value a mother's intuitive knowledge of herself and her baby before, during and after birth.[8]
B. We value a woman's innate ability to nurture her pregnancy and birth her baby; the power and beauty of her body as it grows and the awesome strength summoned in labor.
C. We value the mother as the only direct care provider for her unborn child.[9]
D. We value supporting women in a non-judgmental way, whatever their state of physical, emotional, social or spiritual health. We value the broadening of available resources whenever possible so that the desired goals of health, happiness and personal growth are realized according to their needs and perceptions.
E. We value the right of each woman to choose a care giver appropriate to her needs and compatible with her belief systems.
F. We value pregnancy and birth as rites of passage integral to a woman's evolution into mothering.
G. We value the potential of partners, family and community to support women in all aspects of birth and mothering.[10]

VI. The Nature of Relationship:

A. We value relationship. The quality, integrity, equality and uniqueness of our interactions inform and critique our choices and decisions.
B. We value honesty in relationship.
C. We value caring for women to the best of our ability without prejudice against their age, race, religion, culture, sexual orientation, physical abilities, or socioeconomic background.
D. We value the concept of personal responsibility and the right of individuals to make choices regarding what they deem best for themselves. We value the right to true informed choice, not merely informed consent to what we think is best.
E. We value our relationship to a process larger than ourselves, recognizing that birth is something we can seek to learn from and know, but never control.
F. We value humility in our work.
G. We value the recognition of our own limits and limitations.
H. We value direct access to information readily understood by all.
I. We value sharing information and our understanding about birth experiences, skills, and knowledge.
J. We value the midwifery community as a support system and an essential place of learning and sisterhood.

K. We value diversity among midwives; recognizing that it broadens our collective resources and challenges us to work for greater understanding of birth and each other.
L. We value mutual trust and respect, which grows from a realization of all of the above.

Making decisions and acting ethically:

These values reflect our feelings regarding how we frame midwifery in our hearts and minds. However, due to the broad range of geographic, religious, cultural, political, educational and personal backgrounds among our membership, how we act based on these values will be very individual. Acting ethically is a complex merging of our values and these background influences combined with the relationship we have to others who may be involved in the process taking place. We call upon all these resources when deciding how to respond in the moment to each situation.

We acknowledge the limitations of ethical codes which present a list of rules which must be followed, recognizing that such a code may interfere with, rather than enhance our ability to make choices. To apply such rules we must have moral integrity, an ability to make judgments, and we must have adequate information; with all of these an appeal to a code becomes superfluous. Furthermore, when we set up rigid ethical codes we may begin to cease considering the transformations we go through as a result of our choices as well as negate our wish to foster truly diversified practice. Rules are not something we can appeal to when all else fails. However, this is the illusion fostered by traditional codes of ethics.[11] MANA's support of the individual's moral integrity grows out of an understanding that there cannot possibly be one right answer for all situations.

We acknowledge the following basic concepts and believe that ethical judgments can be made with these thoughts in mind:

- Moral agency and integrity are born within the heart of each individual.
- Judgments are fundamentally based on awareness and understanding of ourselves and others and are primarily derived from ones own sense of moral integrity with reference to clearly articulated values. Becoming aware and increasing our understanding are on-going processes facilitated by our efforts at personal growth on every level. The wisdom gained by this process cannot be taught or dictated but one can learn to realize, experience and evaluate it.

- The choices one can or will actually make may be limited by the oppressive nature of the medical, legal or cultural framework in which we live. The more our values conflict with those of the dominant culture, the more risky it becomes to act truly in accord with our values.
- The pregnant woman and midwife are both individual moral agents unique unto themselves, having independent value and worth.

We support both midwives and the women and families we serve to follow and make known the dictates of our own conscience as our relationship begins, evolves and especially when decisions must be made which impact us or the care being provided. It is up to us to work out a mutually satisfactory relationship when and if that is possible.

It is useful to understand the two basic theories upon which moral judgments and decision making processes are based. These processes become particularly important when one considers that in our profession, a given woman's rights may not be absolute in all cases, or that in certain situations the woman may not be considered autonomous or competent to make her own decisions.

One of the main theories of ethics states that one should look to the consequences of the act (i.e. the outcome) and not the act itself to determine if it is appropriate care. This point of view looks for the greatest good for the greatest number. The other primary ethical theory states that one should look to the act itself (i.e. type of care provided) and if it is right, then this could override the net outcome. This is a more process oriented, feminist perspective. Midwives weave these two perspectives in the process of making decisions in their practice. Since the outcome of pregnancy is ultimately an unknown and is always unknowable, it is inevitable that in certain circumstances our best decisions in the moment will lead to consequences we could not foresee.

In summary, acting ethically is facilitated by:

- Carefully defining our values.
- Weighing the values in consideration with those of the community of midwives, families and culture in which we find ourselves.
- Acting in accord with our values to the best of our ability as the situation demands.
- Engaging in on-going self-examination and evaluation.

There are both individual and social implications to any decision making process. The actual rules and oppressive aspects of a society are never exact, and therefore conflicts may arise, and we must weigh which choices or obligations take precedence over others. There are inevitably times when resolution does not occur and we cannot make peace with any course of action or may feel conflicted about a choice already made. The community of women, both midwives and those we serve, will provide a fruitful resource for continued moral support and guidance.

Notes:

1. The membership largely agrees with the values that follow. However, some may word them differently or may leave out a few. This document is written to prompt personal reflection and clarification not to represent absolute opinions.
2. Mystery is defined as something that has not or cannot be explained or understood; the quality or state of being incomprehensible or inexplicable; a tenet which cannot be understood in terms of human reason.
3. Supplant means to supersede by force or cunning; to take the place of.
4. In this context internal refers to the fact that birth happens within the body and psyche of the woman: ultimately she and only she can give birth.
5. An expert is one whose knowledge and skill is specialized and profound, especially as the result of practical experience.
6. This addresses our desire for an uncomplicated birth whenever possible and recognizes that there are times when it is not possible. For example, due to problems with the birth, a woman may be least tramatized to have a surgical delivery. If a spontaneous vaginal birth is not possible, then we let go of that goal in order to achieve the possibility of a healthy mother and baby. Likewise, the situation where parents choose to allow a very ill, premature or deformed infant to die in their arms rather than being subjected to multiple surgeries, separations and ICU stays. This too, is a letting go of the normal for the most healing choice possible within the framework of the parent's ethics given the circumstances. What is most healing will, of course, vary from individual to individual.

7. We place the emphasis of our care on supporting life (preventive measures, good nutrition, emotional health, etc.) and not pathology, diagnosis, treatment of problems, and heroic solutions in an attempt to preserve life at any cost of quality.

8. This addresses the medical model's tendency to ignore a woman's sense of well-being or danger in many aspects of health care, but particularly in regard to her pregnancy.

9. This acknowledges that the thrust of our care centers on the mother, her health, her well-being, her nutrition, her habits, her emotional balance and, in turn, the baby benefits. This view is diametrically opposed to the medical model which often attempts to care for the fetus/baby while dismissing or even excluding the mother.

10. While partners, other family members and a woman's larger community can and often do provide her with vital support, in using the word potential we wish to acknowledge that many women find themselves pregnant and mothering in abusive or otherwise unsafe environments.

11. Hoagland, Sarah, paraphrased from her book Lesbian Ethics.

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Appendix B

MANA Core Competencies for Basic Midwifery Practice
(Draft as of 6/8/91)

I. The entry level midwife provides midwifery care with an understanding of the following guiding principles:

A. Midwives respect the dignity and rights of their clients;
B. Midwives respect that pregnancy, childbirth and the postpartum are normal physiologic processes;
C. Midwives recognize women's empowerment inherent in childbearing, and strive to protect and promote this opportunity;
D. Midwifery is an autonomous profession, working interdependently with other health and social service professions;
E. Midwives strive to avoid the unnecessary use of interventions;
F. Midwives understand the importance emotional and psycho-social factors which may affect the childbearing cycle and reproductive health; and,
G. Midwives synthesize clinical observations, theoretical knowledge and intuitive judgement as components of a competent decision-making process.

II. Certain concepts, skills and knowledge from health and social sciences and health and social services permeate all components of midwifery practice. The following have been been identified:

A. Communication, counseling and teaching techniques, including the areas of client education and inter-professional collaboration;
B. Human anatomy and physiology relevant to human reproduction;
C. Community standards of care, including midwifery and medical standards for women during the childbearing cycle;
D. Inter-professional communication and collaboration with community health and social resources for women and children;
E. Significance of and methods for thorough documentation of client care through the childbearing cycle;
F. Informed decision making;

G. Health education, health promotion, and self care;
H. The principles of clean and aseptic techniques, and universal precautions;
I. Psychosocial, emotional and physical components of human sexuality, including indicators of common problems and methods of counseling;
J. Ethical considerations relevant to reproductive health;
K. Epidemiologic concepts and terms relevant to perinatal and women's health;
L. The principles of how to access and evaluate current research relevant to midwifery practice;
M. Family centered care, including maternal, infant and family bonding;
N. Identification of an appropriate referral of disease in women and their families;
O. The importance of accessible, quality health care for all women that includes continuity of care.

III. Components of Midwifery Care. Implicit in midwifery knowledge base is the ability to perform skills and/or have a working knowledge of the following areas:

A. Antepartum Care
1. The entry level midwife provides health care, support and information to women throughout pregnancy, determining when it is necessary to consult and refer;
2. The midwife uses a foundation of knowledge and/or skills which includes the following:
   a. Preconceptional factors likely to influence pregnancy outcome;
   b. Basic genetics, embryology and fetal development;
   c. Anatomy and assessment of the soft and bony structure of the pelvis;
   d. Identification and assessment of the normal changes of pregnancy, fetal growth, and position;
   e. Nutritional requirements for pregnant women and methods of nutritional assessment and counseling;
   f. Environmental and occupational hazards for pregnant women;
   g. Education and counseling to promote health throughout the childbearing cycle;
   h. Methods of diagnosing pregnancy;
   i. The etiology, treatment and referral, when indicated, of the common discomforts of pregnancy;
   j. Assessment of physical and emotional status, including relevant historical and psycho-social data;

k. Counseling for individual birth experiences, parenthood, and changes in the family;
l. Indication for, risks and benefits ofscreening/diagnostic tests used during pregnancy;
m. Etiology, assessment of, treatment for, and appropriate referral for abnormalities of pregnancy;
n. Identification of, implications of and appropriate treatment for various STD/vaginal infections during pregnancy;
o. Special needs of the Rh negative woman; and,
p. Identification and care of women who are HIV positive, have hepatitis or other communicable and non-communicable diseases.

B. Intrapartum Care
1. The entry level midwife provides the appropriate health care, support and information to women throughout labor, birth and early postpartum, attending deliveries on her own responsibility, and assessing the need for consultation and referral.
2. The midwife uses a foundation of knowledge and/or skills which includes the following:
a. Normal labor and birth processes;
b. Anatomy of the fetal skull and its critical landmarks;
c. Parameters and methods for assessing maternal and fetal status including relevant historical data;
d. Emotional changes and support during labor and delivery;
e. Comfort and support measures during labor, birth and immediately postpartum;
f. Techniques to facilitate the spontaneous vaginal delivery of the baby and placenta;
g. Etiology, assessment of, appropriate referral or transport of and/or emergency measures (when indicated) forthe mother or newborn for abnormalities of the 4 stages of labor;
h. Anatomy, physiology, and supporting normal adaptation ofthe newborn to extrauterine life;
i. Familiarity with medical interventions and technologies used during labor and birth; and
j. Assessment and care of the perineum and surrounding tissues.

C. Postpartum Care
1. The entry level midwife provides the appropriate health care, support, and information to women during the postpartum period determining the need for consultation and referral.

2. The entry level midwife uses a foundation of knowledge and/or skills which includes the following:
   a. Anatomy and physiology of the postpartum period;
   b. Anatomy and physiology and support of lactation, and appropriate breast care and assessment;
   c. Parameters and methods for assessing and promoting postpartum recovery;
   d. Etiology and methods for managing the discomforts of the post-partum period;
   e. Emotional, psycho-social and sexual changes which may occur postpartum;
   f. Nutritional requirements for women during the postpartum period;
   g. Etiology, assessment of, treatment for and appropriate referral for abnormalities of the postpartum period; and
   h. Methods to assess the success of the breastfeeding relationship and identify lactation problems, and mechanisms for making appropriate referrals.

D. Neonatal Care
   1. The entry level midwife provides health care to the normal newborn during the first 6 weeks of life, assessing the need for consultation and referral. In addition, the entry level midwife provides support and information to parents regarding newborn care.
   2. The midwife uses a foundation of knowledge and/or skills which includes the following:
      a. Anatomy and physiology of the newborn's adaptation and stabilization in the first hours and days of life;
      b. Parameters and methods for assessing newborn status, including relevant historical data and gestational age;
      c. Nutritional needs of the newborn;
      d. Community standards and state laws for and administration of prophylactic treatments commonly used during the neonatal period;
      e. Community standards for, indication, risks and benefits of, and methods of performing common screening tests for the newborn; and,
      f. Etiology, assessment of (including screening and diagnostic tests), emergency measures and appropriate transport/referral or treatment for neonatal abnormalities.

E. Family Planning/Well Woman Care
   1. The entry level midwife provides health care, support and information to women in matters of reproductive health and family planning, determining the need for consultation and referral.
   2. The midwife uses a foundation of knowledge and/or skills which includes the following:
      a. Information relating to steroidal, mechanical, chemical, physiological, and surgical conception control methods;
      b. Issues involved in decision making regarding unplanned pregnancies, and resources for counseling and referral;
      c. Etiology, assessment of, and treatments for and appropriate referral for abnormalities of the reproductive system and breast;
      d. Methods of pregnancy testing on urine and blood; and
      e. Assessment of physical and emotional status, including relevant historical data.

F. Professional, Legal and Other Aspects
   1. The entry level midwife assumes the role and responsibilities of the professional midwife,
   2. The midwife uses a foundation of knowledge and/or skills which includes the following:
      a. MANA's Standards, Functions, and Qualifications for the Practice of Midwifery;
      b. The purpose and goals of MANA and local (state or provincial) midwifery associations;
      c. Familiarity with the principles and process of peer review, chart review, case presentation, and developing midwifery protocols;
      d. The principles of data collection and analysis as relevant to midwifery practice;
      e. Laws governing the practice of midwifery in her local jurisdiction;
      f. The history of midwifery, medicine and health care in the United States;
      g. The organization of and factors affecting maternal and infant care in the United States;
      h. Various sites, styles and modes of practice within midwifery;
      i. Awareness of the responsibility of the midwife to participate in the education of midwives, and to support legislative contributions to high quality maternal and child health services.

Circle of Midwives:
Organized Midwifery in North America

leads us step-by-step through the evolution of the Midwives Alliance of North America, and in doing so examines the roots of current midwifery political thought. The compelling tale unfolds through the eyes of the participants – the midwives who have worked to organize independent midwifery upon the North American continent. **Circle of Midwives** is also a chronicle of the struggle of women to move beyond the scope of a "professional organization" to include a diverse group of women with a common calling. **Circle of Midwives** will help you understand both the unique position of today's midwife and the challenges which lay before her.

About the Author:

Hilary Schlinger has been a midwife in independent practice since 1982. Her first exposure to homebirth and midwifery was in 1980, when she was a student at Cornell University. A year after graduation, she attended The Maternity Center midwifery training program in El Paso, Texas; in May 1982 she became a Licensed Midwife in New Mexico. She returned to upstate NY, where she practiced as a homebirth midwife for the next 14 years. During this time she helped to start the Midwives Alliance of New York, worked on midwifery legislation, and was the North Atlantic Regional Representative to the MANA board. She sat for the first NARM examination in 1991, and became a CPM in 1994. When she applied for licensure in NY under the comparative education clause of the NYS Professional Midwifery Practice Act in 1993, she and all other non-CNM applicants were denied licenses. In 1996 she received a cease-and-desist order from NYS. Hilary chose to move to NM, but to continue petitioning NYS to deem educational equivalency; during this time she earned additional degrees – an RN from Regents College, and an ASM from National College of Midwifery – and built a thriving homebirth practice. She succeeded in her petition with NY in 2001; in November of that year she took the AMCB examination, and thus became a CNM. She subsequently earned a Master of Science in Midwifery from Philadelphia University. She currently lives in Albuquerque, NM, where she has a women's health practice.

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