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A Study of the Southern Appalachian Granny-Woman Related
to Childbirth Prevention Measures

A thesis
presented to
the faculty of the School of Continuing Studies
East Tennessee State University

In partial fulfillment
of the requirements for the degree
Master of Arts in Liberal Studies

by
Harriet P. Masters
May 2005

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Keywords: Granny-woman, Midwifery, Midwife, Herbal Remedies, Mildred Haun

ABSTRACT

A Study of the Southern Appalachian Granny-Woman Related to Childbirth Prevention Measures

by

Harriet P. Masters

Documented as serving in the midwife capacity from the 1880s to the 1930s, the “granny-woman,” often was the only line of defense regarding childbirth support practices for many childbearing age women living in the region during the late nineteenth and early twentieth centuries. The early twentieth century saw the granny-women discredited and subject to elimination as a result of a purposeful campaign conducted by the male-dominated medical profession. Using knowledge of herbal remedies, the granny-woman played an integral part in the survival of the inhabitants of the region, especially related to childbirth. These centuries-old, herbal-based ministrations have been explored to aid in dispelling the erroneous conclusions related to the vital community role fulfilled by the Southern Appalachian granny-woman. Possessing knowledge of herbal-based childbirth prevention measures, the Southern Appalachian granny-woman rarely provided specifics related to the use of these measures by the women living in the region during that era.

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ACKNOWLEDGMENTS

I want to express my sincere appreciation to my committee chair and members for their fortitude and guidance in support of my thesis project. Without the expert assistance of Dr. Pinner in his meticulous reading, re-reading, and editing of this manuscript, my thesis would have been less direct than it could have been without his expert tutelage.

My special thanks also go to my daughter Jane and friends, who supported me throughout this undertaking, and put up with my distractions from life, in general. Thank you all, I could not have accomplished this endeavor without your encouragement.

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ABBREVIATIONS

A. D.	After Death or Anno Domini
ARC	Appalachian Regional Commission
B.C.E.	.....	Before the Christian Era
CFMC	.....	Cavender Folk Medicine Collection
CFMS	.....	Cavender Folk Medicine Study
CM or C.M.	.....	Certified midwife
CNM or C.N.M.	.....	Certified nurse midwife
M.A.	.....	Master of Arts
M.S.N.	Master of Science in Nursing
No.	Number
TBC	Thomas Burton Collection

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CHAPTER 1

INTRODUCTION

Foundation of the Study

The Southern Appalachian region is steeped in tradition-rich history. An integral part of this history is that relative to the “granny-woman.” Documented as serving in the midwife capacity from the 1880s to the 1930s, the “granny-woman,” Southern Appalachian vernacular for midwife, often was the only line of defense regarding childbirth support practices for many childbearing age women in the region. However, the early twentieth century saw the elimination of the granny-woman based on stereotypes applied not only to the granny-woman, but also to nearly all inhabitants of the region.

Discredited and excluded from providing healthcare-related practices to those living around her in the early twentieth century, the Southern Appalachian granny-woman often was associated with unsanctioned medical behavior related to childbirth support and childbirth prevention measures. Generally linked to using herbal remedies for a variety of healthcare needs, the granny-woman played an integral part in the survival of the female inhabitants of the region, not only in childbirth support practices, but in prevention measures as well. The thesis of this study is while possessing centuries-old knowledge of herbal-based childbirth prevention measures, the Southern Appalachian granny-woman rarely provided specifics related to the use of these measures by women living in the region during the late nineteenth and early twentieth centuries.

In the early twentieth century negative stereotypes of midwives as “ignorant and dangerous” proved to be fundamental in discrediting the crucial expertise of a vital group of women who performed an indispensable community role. According to documentation included in *Foxfire 2*, the

granny-woman accomplished a medically-related role that “would seem impossible for many of us to undertake today.”¹

Even though there are credible texts, among them *Foxfire 2*, that document (in interview format) the vital role performed by the granny-woman in childbirth support practices; there are few sources that examine the role performed by the granny-woman in regard to childbirth prevention. Although considered then—and now—as a volatile subject, it nonetheless is true that women living in the Southern Appalachian region during the late nineteenth and early twentieth centuries required assistance in the area of childbirth prevention, whether contraceptive or abortive in purpose. One principle aim of this study is to provide insight regarding the use of herbal remedies as childbirth prevention measures. Where did these women acquire information on herbal measures used in childbirth prevention? What did they use and under which circumstances?

Educational opportunities for women in Southern Appalachia were extremely limited. Obtaining information of any sort, whether addressing a medical or non-medical need, occurred within the area where women lived. Moreover, the acute shortage of licensed physicians in the region limited publication and access to medical information. Locating anyone considered “well-educated,” to address medical needs, proved challenging for all inhabitants. As Sandra Barney notes in *Authorized to Heal: Gender, Class, and the Transformation of Medicine in Appalachia, 1880-1930*, communities turned to the lay healer to compensate not for informational deficiencies so much as to compensate for the small numbers of physicians in the region: “Appalachian people maintained these [medical] skills in the twentieth century because, like many rural people across the United States, they had little contact with well-educated, professional physicians before the end of the

¹Eliot Wigginton, ed., *Foxfire 2* (New York: Anchor Press, 1973), 303.

nineteenth century.”² Yet mountain residents turned to physicians when necessity so dictated. Barney states, “Too scattered in small communities and on mountain farms to attract significant numbers of practitioners, mountaineers turned to the few physicians, whether trained or uneducated, who lived in their counties or districts for treatment of illnesses or injuries that seemed beyond the abilities of domestic or lay healers.”³

Information concerning modern prevention measures would have reached isolated areas at an extremely slow pace, if at all. Given the inflated illiteracy rate of the nation at that time, many women could not have taken advantage of this information. This would have been true for the women living in rural and mountainous areas of the Southern Appalachia region, but more than likely not for women living in the towns and urban areas of the region.

However, when examining statistical information for educational attainment rates and illiteracy rates, before and after the turn of the twentieth century, it becomes evident that low attainment rates, as well as illiteracy, affected all women living in the United States during the late nineteenth and early twentieth centuries. A bleak view of educational competence was revealed. As a consequence, women living in isolated areas or small towns/cities (large metropolitan areas excluded) were hampered by severely limited educational opportunities similarly. Study findings, collected from U.S. Census Bureau reports, confirmed this premise.

For women born in the years preceding the turn of the twentieth century and in the early decades of the twentieth century, U.S. Census Bureau analyses of illiteracy rates, as well as the educational attainment rates specific to women, were examined for this study. A Census Bureau

²Sandra Lee Barney, *Authorized to Heal: Gender, Class, and the Transformation of Medicine in Appalachia, 1880-1930* (Chapel Hill: University of North Carolina Press, 2000), 15.

³Ibid.

report titled “Illiteracy in the United States: October, 1947,” discussed the (prolonged) existence of illiteracy in the United States and included a comparative analysis of the illiteracy rates reported in 1920 and 1930 census counts. The report also examined demographic factors, related to the illiteracy rates of the 1940s. Supplying not only statistical information, the 1947 report discussed the urban versus rural-farm influence on illiteracy rates in the United States.⁴

In “Have We Reached the Top? Educational Attainment Projections of the U.S. Population,” a U.S. Census Bureau report produced due as a result of the “growing concern that educational levels in the United States population may stagnate or even decrease in coming decades,” statistics related to educational attainment rates were projected for all white inhabitants.⁵ Statistical projections were included for white inhabitants born in the years 1893 through 1968. Educational attainment rates, specific to white females born during the years referenced, also were projected. Statistical information related to females born 1893 through 1897 and 1903 through 1907 was extracted for this study. The Census Bureau’s educational attainment rate projections were based on population counts obtained during the 1983 census. Educational attainment rates then were projected for white females, born 1893 through 1897 and 1903 through 1907, who were alive and subsequently counted during the 1983 census process. The statistical findings extracted from the U.S. Census Bureau reports follow.⁶

⁴J.C. Capt, “Illiteracy in the United States: October, 1947,” *Current Population Reports: Population Characteristics* (Washington, D.C.: Government Printing Office, 1948): 1, [government document online]; available from U.S. Census Bureau Homepage, <<http://www.census.gov/population/>>, accessed 3 March 2005.

⁵Jennifer Cheeseman Day and Kurt J. Bauman, “Have We Reached the Top? Educational Attainment Projections of the U.S. Population” (Washington, D.C.: Government Printing Office, May 2000): iii, [government document online]; available from U.S. Census Bureau Homepage, <<http://www.census.gov/population/>>, accessed 9 September 2004.

⁶Ibid.

The above-mentioned report confirmed extremely low educational attainment rates for women living in the United States during the late nineteenth and early twentieth centuries. For women born between the years 1893 through 1897, nearly sixty-three percent of the nation's women born during those years did not possess a high school diploma, with only twenty-one percent completing high school.⁷ These statistics do not point directly to inflated illiteracy for women, but they do confirm the limited level of education attained by women living during the late nineteenth and early twentieth centuries. Had these projections included all women born in 1893, the percentage of women not completing high school would have risen across the United States in general, in the Southern Appalachian region, in particular.

Statistics specific to women born in the first decade of the twentieth century revealed little improvement in educational attainment rates. For women born during the years of 1903 through 1907, the educational attainment rates, projected by Day and Bauman, revealed that more than fifty-five percent of the nation's women still did not possess a high school diploma, with only twenty-five percent completing high school.⁸

Illiteracy rates were documented in a U.S. Census Bureau report entitled "Illiteracy in the United States: October, 1947," a report subsequently released in 1948 by the director of the Bureau of Census, J.C. Capt. The illiteracy rates were calculated for persons in the United States who were fourteen years old and over by October 1947. The following excerpt of that report suggests illiteracy was not just problem in the Southern Appalachian region, but a prolonged problem throughout the United States; what the report claims, however, is that considerable progress has been made – except among non-whites and rural-farm areas.

⁷Ibid., 18. (*Note:* The remaining sixteen percent possessed some college.)

⁸Ibid. (*Note:* The remaining twenty percent possessed some college.)

Illiteracy in the United States had declined to a new low by October, 1947, at which time only 2.7 percent of the population 14 years old and over were unable to read and write, according to estimates issued today by J.C. Capt, Director, Bureau of the Census, Department of Commerce. Comparison of the current rate with a 1930 rate of 4.7 percent, and a 1920 rate [for persons 15 years old and over] of 6.5 percent, shows that there has been marked progress in the reduction of illiteracy. The greater enforcement of Compulsory School attendance laws, the extension of educational opportunities, the dying of the relatively numerous aged illiterates, and the special training given illiterates in the armed services during World War II, were all factors in the continuing reduction of illiteracy. However 1947 illiteracy rates of 11 percent among nonwhites and of 5 percent in rural-farm areas indicate where considerable further progress may yet be made.⁹

Addressing factors contributing to the illiteracy rates, the 1948 Census Bureau report targeted geographical influences as contributing to the prolonged existence of illiteracy rates in the United States. One geographic factor, attributed to the prolonged existence of illiteracy rates, dealt with the differences existing in urban and rural areas of the United States. The Census Bureau report provided the following conclusion.

Illiteracy varied greatly among urban and rural areas, the rural-farm rate of 5.3 percent being twice that for either urban or rural-nonfarm areas. These differences reflect, in the main, differences in the convenience of school facilities. Many students in rural-farm areas tend to lose the incentive to attend school regularly because of the greater distances they must travel to reach the nearest school.¹⁰

However, the Appalachian Regional Commission, a federal-state partnership that works with the people of Appalachia to create opportunities for self-sustaining economic development and improved quality of life, recognizes that educational differences between Appalachia and the rest of the country exist today.¹¹ In an analytical overview of Census 2000 results, released by the ARC, the

⁹Capt, "Illiteracy in the United States: October, 1947," 1.

¹⁰Ibid., 2.

¹¹Appalachian Regional Commission, [website online]; available from the Appalachian Regional Commission Homepage, < <http://www.arc.gov/>>, accessed 3 March 2005.

educational attainment rates for the Appalachian region are detailed. The statistics reported reveal the region's educational attainment rates remain lower than the rest of the country.

In 2000, 77 percent of Appalachian residents age 25 and older have completed high school, up from 68 percent in 1990. Likewise, the share of Appalachians with at least a bachelor's degree rose from 14 percent to 18 percent during the 1990s. However, educational attainment remains lower in Appalachia than in the rest of the country. Outside Appalachia, about 81 percent of adults had at least a high school education in 2000; 25 percent had at least a college degree. And although the high school gap between Appalachian and the rest of the country narrowed during the 1990s (from seven percentage points to four percentage points), the college degree gap remained as wide in 2000 as in 1990.¹²

Elaborating on the differences within the Appalachian region, the Commission's report states:

As noticeable as the differences were between Appalachia and the rest of the country, however, they often were more pronounced within Appalachia. For example, 81 percent of northern Appalachian adults had a high school diploma in 2000, compared with 75 percent of southern Appalachians and just 64 percent of central Appalachians.¹³

As evidenced in the current educational attainment rates, provided by the Appalachian Regional Commission, education-related issues continue to be problematic in the Appalachian region today. But, when concentrating on the causative factors emphasizing the need for a strong oral tradition, the education-related issues confronting the region today would not be addressed by the existence of a strong and active oral tradition. However, the inflated illiteracy, which the 1948 census report limited to rural-farm areas and not to Southern Appalachia in particular, and the low educational attainment rates of the late nineteenth and early twentieth century would have reinforced the need for a strong and active oral tradition.

¹²Appalachian Regional Commission, "Appalachia at the Millennium: An Overview of Results from Census 2000" (Washington, D.C.: ARC): 1, [commission document online]; ARC Regional Data and Research, available from the Appalachian Regional Commission Homepage, <<http://www.arc.gov/index.do?nodeId=1844>>, accessed 3 March 2005.

¹³Ibid.

Study findings collected from the U.S. Census Bureau statistical and discursive analyses, confirmed illiteracy was problematic and that educational attainment rates for women were alarming during the late nineteenth and early twentieth centuries. Therefore, it is probable that oral tradition was an important factor in the overall communication process at that time. As a result, it is the contention of this study that the educationally deficient condition of the Southern Appalachian region confirmed the use of the established oral tradition system for information related to medical and non-medical needs. Accordingly, the transference of information related to childbirth support and childbirth prevention measures would have occurred through this communication system.

Even with the documented 1947 decrease in illiteracy rates across the United States that predominately occurred as a consequence of the “enforcement of compulsory school attendance laws,” along with “the dying of the relatively numerous aged illiterates, and the special training given illiterates in the armed services during World War II” during the first half of the twentieth century, inflated illiteracy and low educational attainment rates were serious concerns until well into the first half of the twentieth century for the Southern Appalachian region.¹⁴ When the inhabitants of a region, similar to the Southern Appalachian region, were victims of limited access to educational opportunities, the ‘reading’ and ‘writing’ abilities of those inhabitants were adversely affected thus forcing reliance on established communication systems.

With a large percentage of women, nationwide, victims of limited educational opportunities, established communication systems would have provided women, living during the late nineteenth and early twentieth centuries, with an alternative method for acquiring information specific to their healthcare-related needs. Included among those needs were healthcare-related needs associated with

¹⁴Capt, “Illiteracy in the United States: October, 1947,” 2.

childbirth support and childbirth prevention practices. Received through oral tradition, healthcare information possessed by the granny-woman proved invaluable in her practice.

The following section will outline the goals relevant to this study. Goals established to determine if the Southern Appalachian granny-woman provided information concerning herbal-based remedies used for childbirth prevention.

Goals of the Study

The primary objective of the granny-woman was to aid those of her gender in matters related to childbirth. The limited number of first-person references related to childbirth prevention during the late nineteenth and early twentieth centuries must be recognized as a notable obstacle to this study. However, this exploration, which focuses on herbal-based childbirth prevention measures, has been undertaken in search of documentation that supports the knowledge, and possible usage, of those measures. Were the specifics surrounding those measures concentrated among a select few, specifically the midwife/granny-woman? And if so, were those specifics disseminated to the women living around her and how often? Did specific circumstances trigger dissemination?

Historically, knowledge surrounding most childbirth prevention measures often passes through generations by way of oral tradition, from granny-woman to granny-woman. Frequently, the granny-woman was an initial source regarding information that aided in preventing childbirth for many women living at during the late nineteenth and early twentieth centuries. If, for whatever reason, childbearing age women required such prevention measures, many would have opted to use a measure that was herbal-based because herbal remedies gave women control over their bodies. The granny-woman possessed specifics related to herbal-based options.

However, as folk medicine scholar and professor of sociology Anthony Cavender states in his recent study entitled, *Folk Medicine in Southern Appalachia*, “The dearth of information on abortion reflects not only the sensitive nature of the topic, but perhaps also the fact that for ethical reasons the procedure was seldom performed.”¹⁵ Thus, if women used herbal remedies—or remedies of any kind—they would have used them infrequently. Yet, are there specific references that illustrate the knowledge and possible use of specific herbal remedies during this time period? And do some of those illustrations link specific herbal measures to the Southern Appalachian granny-woman?

To validate the existence of knowledge and frequency of use of herbal-based prevention options specifically linked to the Southern Appalachian granny-woman, historic documents, as well as the fiction-based *The Hawk’s Done Gone and Other Stories*, by Southern Appalachian author Mildred Haun, will be assessed. Haun is an acknowledged East Tennessee author of fiction. She infused her writings with ethnographic specifics that detailed actual Southern Appalachian customs and practices utilized during the late nineteenth and early twentieth centuries. Haun’s work reflects a reality for women living in Cocke County, Tennessee.

Illustrating the “bare biographical details” surrounding the life of Mildred Haun, Herschel Gower, in his introduction to Haun’s *The Hawk’s Done Gone and Other Stories*, discloses:

¹⁵Anthony Cavender, *Folk Medicine in Southern Appalachia* (Chapel Hill: University of North Carolina Press, 2003), 131.

At age fourteen she [Haun] decided she would like to come back to Cocke County as an educated granny-woman with a black case so she could doctor the sick, deliver babies safely, and care for the mothers. Trained doctors were scarce; the midwives of Cocke County had begun to get old at the job: the granny-woman whom Mildred know best, who had brought her and her brother into the world, was hard pressed to look after the need off the women and children in the Hoot Owl District. It was time somebody went away, the girl concluded, and learned enough to set about the job with a skilled hand. So in 1927, at age sixteen, Miss Haun was able to start to high school after leaving home and crossing half the width of Tennessee to live with an uncle and aunt at Franklin, Mr. and Mrs. A. J. Haun.¹⁶

Gower, documenting Haun's close relationship with the granny-woman, who delivered her, endorses the high probability for transference of information regarding specific herbal-based remedies. The actual existence of this relationship solidifies the level of credibility for the herbal-related childbirth prevention remedies documented by Haun. Not only are the measures endorsed, but also the relationship between Haun and the local granny-woman, supports the application of Haun's herbal remedies in the literal sense.

In addition, data from a survey instrument used to assess the level of usage related to herbal-based childbirth prevention measures during the late nineteenth and early twentieth centuries. The intent is to seek out herbal-based childbirth prevention measures used by women during the late nineteenth and early twentieth centuries, as well as to determine if the dissemination of those measures can be connected to the Southern Appalachian granny-woman.

Interview and survey data collected during folk medicine studies will be reviewed for information and insight related to herbal remedies used by residents native to the Southern Appalachian region. The archival collections related to herbal remedies are contained in the East Tennessee State University Archives of Appalachia.

¹⁶Herschel Gower, introduction to *The Hawk's Done Gone and Other Stories*, by Mildred Haun (Nashville: Vanderbilt University Press, 1968), xii, available from <<http://lib.etsu.edu/cgi-bin/>>.

The southern Appalachian populations targeted for survey purposes are white lay midwives, currently practicing and native to the region, who may, or may not, possess a direct ancestral link to a Southern Appalachian granny-woman who lived during the 1880s to the 1930s. Also, white women native to the region and in possession of a direct ancestral link to a regional granny-woman (i.e., mother-to-daughter, grandmother-to-granddaughter, aunt-to-niece, great-aunt-to-great-niece) are considered. The third group includes white women who have used the services of a granny-woman native to the region.¹⁷

Controlling childbirth during the late nineteenth and early twentieth centuries was a dilemma facing many women. When contrasted with women living in today's society, women living then were severely limited in the options available to "have power over," or prevent childbirth. And while contraceptive and preventive measures often were controversial, women faced life-threatening physical risks with repeated pregnancies. The inference then can be made that women wanted childbirth prevention information to prevent pregnancies. What type of information is another matter. Did women living in the Southern Appalachian region during the late nineteenth and early twentieth centuries consult a granny-woman in search of childbirth prevention information? And were specifics related to herbal-based childbirth prevention measures provided by the Southern Appalachian granny-woman when consulted?

In today's society, women may seek the services of the lay, or direct-entry, midwife, the current-day equivalent to the granny-woman, but most prospective mothers prefer to give birth within the hospital setting. More importantly, today's women now have access to a wide variety of birth control measures that include not only oral options but safe surgical options as well. Today's

¹⁷(*Note:* All current respondents, interviewed during the course of this study and documented in Chapter 3, reviewed and signed an "Informed Consent Document," as required by the Institutional Review Board at East Tennessee State University, Johnson City, Tennessee.)

lay midwife is armed with the knowledge of these options as well. However, when contemplating conditions facing childbearing-age women in the late nineteenth and early twentieth centuries, quite a different situation is presented. Granny-women often were the only choice for rural, Southern Appalachian women. Tirelessly serving the rural communities of this region, the granny-woman provided childbearing age women with healthcare services, some of which improved their chances for long-term survival.

Rationale for the Study

Women have always been healers. They were the unlicensed doctors and anatomists of western history. They were abortionists, nurses, and counsellors. They were pharmacists, cultivating healing herbs and exchanging the secrets of their uses. They were midwives, traveling from home to home and village to village. For centuries women were doctors without degrees, barred from books and lectures, learning from each other, and passing on experience from neighbor to neighbor and mother to daughter. They were called “wise women” by the people, witches or charlatans by the authorities. Medicine is part of our heritage as women, our history, our birthright.¹⁸

Witches, Midwives, and Nurses: A History of Women Healers

“Gita Sen has defined empowerment of women as ‘altering relations of power . . . which constrain women’s options and autonomy and adversely affect health and well-being.’”¹⁹ Most women, especially those living in rural Southern Appalachia, had little control over options related to personal growth. The middle-class ideology accepted across most of America kept women home-based, taking care of “home and hearth.” Even though rural women and working-class women

¹⁸Barbara Ehrenreich and Deirdre English, *Witches, Midwives, and Nurses: A History of Women Healers* (New York: The Feminist Press at City University of New York, 1973), 3.

¹⁹Anju Malhotra, Sidney Ruth Schuler, and Carol Boender, “Measuring Women’s Empowerment as a Variable in International Development” (June 28, 2002): 5, [paper on-line]; available from *International Center for Research on Women Homepage*, <http://www.icrw.org/docs/MeasuringEmpowerment_workingpaper_802.doc>, accessed 11 November 2003.

contributed to the economic base of the family and household, the responsibilities associated with home and hearth remained. Consumed with child rearing, cooking, cleaning, and many work-related aspects of farm life, little time was left for educational needs.

On a national level, women living in the late nineteenth and early twentieth centuries were barred from acquiring advanced medical education and excluded from applying for licensure, even if already practicing midwifery. Furthermore, educational opportunities of any kind were severely restricted for all inhabitants of the Southern Appalachian region. In a study focused on women entering the medical profession during the nineteenth and early twentieth centuries, women's studies scholar Mary Roth Walsh discussed the plight of "irregular women healers," including midwives.²⁰ In her study, *Doctors Wanted: No Women Need Apply*, Walsh states,

Although irregular women healers were an important part of nineteenth-century medicine, it is difficult to know how freely they chose such medical specialties since their other options were so circumscribed. Moreover, once having embarked on an irregular medical career, they were in no position to demand entrance in to the regular medical schools, hospitals, and professional societies, the institutions, that for better or worse, made up the American medical establishment then as now.²¹

Compounding the educational limitations was the economically depressed condition of the Southern Appalachian region, a condition that especially affected women. This disadvantaged economic status meant that there was little chance of acquiring advanced midwifery training beyond that which was passed down mother-to-daughter, grandmother-to-granddaughter, and through the mentor-to-friend relationships in Southern Appalachian communities.

Along with the depressed conditions of Southern Appalachia that precluded women obtaining information about medical and health issues, was a reproachful ideology that supported

²⁰Mary Roth Walsh, *Doctors Wanted: No Women Need Apply* (New Haven: Yale University Press, 1977), xiii.

²¹Ibid.

disapproval of most childbirth prevention measures. John D’Emilio and Estelle B. Freedman note that in the nineteenth-century South “where both abortion and contraception were strongly condemned, white women rarely mentioned these practices in their personal papers.”²² Although rarely discussed or documented, childbirth prevention measures (whether preventive or abortive in purpose) as they relate to herbal remedies were part of the folk medicine practices specific to the Southern Appalachia region. Even though “few women left records of their abortion experiences, other sources suggest that the incidence of abortion increased significantly in the nineteenth century.”²³ Signifying that American women often ignored the reproachful tactics deployed against childbirth prevention measures—whether Southern Appalachian women ignored those tactics is unclear.

When it came to childbirth, surviving the ordeal became even more critical for many rural-dwelling Southern Appalachian women. Given severe limits relative to accessibility to licensed and trained medical professionals, many women of childbearing age might not have made it through the process without the unwavering support of the granny-woman. Without the assistance and knowledge of the granny-woman, who is characterized in *Foxfire 2* as, “the midwife of former days, who had the strength and courage to do that which was needed to be done,” childbirth support would have been almost nonexistent for women living in the rural, mountainous areas of the region.²⁴

²²John D’Emilio and Estelle B. Freedman, *Intimate Matters: A History of Sexuality in America*, 2d ed. (Chicago: University of Chicago Press, 1997), 65.

²³Ibid.

²⁴Wigginton, *Foxfire 2*, 303.

The Region Defined

Historically considered a barrier to early westward expansion of the United States, the Appalachian Mountains are “many separate mountain ranges located between Quebec’s Gaspé Peninsula and Georgia and Alabama,” according to Appalachian folklife historian Ted Olson, in his study *Blue Ridge Folklife*.²⁵ A more definitive assessment of the southern region can be attributed to educator John C. Campbell, who offered the following interpretation in his cultural study *The Southern Highlander and His Homeland*.

Within the boundaries of this territory are included the four western counties of Maryland; the Blue Ridge, Valley, and Allegheny Ridge Counties of Virginia; all of West Virginia; eastern Tennessee; eastern Kentucky; western North Carolina; the four northwestern counties of South Carolina; northern Georgia; and northeastern Alabama. Our mountain region, of approximately 112,000 square miles, embraces an area nearly as large as the combined areas of New York and New England, and almost equal to that of England, Scotland, Ireland, and Wales.²⁶

Labeled as the Southern Highlands in his study, this definition was Campbell’s personal definition and not one set by geographers. The boundaries set by geographers, Campbell said, limited the Southern Appalachian Mountains “to that part of the Appalachian mountain system lying south of the New River Divide in southern Virginia.”²⁷ Set by geographers, this boundary demarcation in turn reduced the size of the region to about two-thirds of the size indicated by Campbell. For the purpose of this study the East Tennessee segment of the region will be applied as the geographical boundary. Counties included in the East Tennessee segment are Carter, Cocke, Cumberland,

²⁵Ted Olson, *Blue Ridge Folklife*, Folklife in the South series, ed. William Lynwood Montell (Jackson: University Press of Mississippi, 1998), xiii.

²⁶John C. Campbell, *The Southern Highlander & His Homeland*, with a new foreword by Rupert B. Vance and introduction by Henry D. Shapiro (New York: Russell Sage Foundation, 1921; reprint, Lexington: University Press of Kentucky, 1969), 10-11.

²⁷*Ibid.*, 12.

Greene, Hancock, Hawkins, Johnson, Loudon, Monroe, Scott, Sullivan, Unicoi, and Washington counties.

Noted Appalachian scholar, Marion Pearsall, in his cultural study entitled *Little Smoky Ridge: The Natural History of a Southern Appalachian Neighborhood*, best describes the evolution of settlements and civilization in Southern Appalachia, which dates back to the mid-seventeen-hundreds.

In the Southern Appalachians, American civilization expanded along the rivers and streams of a wilderness frontier. It grew and flourished as the frontier filled with people who established an agricultural and commercial economy. Trading centers developed along the principal transportation lines. But between the valleys and in the inaccessible parts of the mountain and plateau provinces progress did not keep pace with the valley sections.²⁸

Blue Ridge Folklife provides a broad view of the origins of the settlers moving to the region identified as the Blue Ridge frontier through the entries of Gabriel Johnston, English governor of the North Carolina Colony in 1751. Johnston wrote, “Inhabitants flock in here daily, mostly from Pennsylvania and other parts of America. They commonly seat themselves toward the West and have got near the mountains.”²⁹ In addition, *Blue Ridge Folklife* author Olson further delineates the ancestry of the region as follows: “The English were not the only European people settling in the Blue Ridge Frontier on the eve of the Revolutionary War: the backcountry of all the colonies from Pennsylvania to Georgia has been settled by a mixed population of English, Scots-Irish, Highland Scots, Welsh, Irish, Dutch, various German Protestants, and Protestant French Huguenots.”³⁰

Cultural geographers Terry G. Jordan and Matti Kaups verified that Swedish and Finnish pioneers settled in the Southern Appalachian region during the eighteenth century. In their

²⁸Marion Pearsall, *Little Smoky Ridge: The Natural History of a Southern Appalachian Neighborhood* (Birmingham: University of Alabama Press, 1959), 28.

²⁹Olson, *Blue Ridge Folklife*, 5.

³⁰Ibid.

geographic study, *The American Backwoods Frontier: An Ethnic and Ecological Interpretation*, Jordan and Kaups discuss the migration of pioneers into the Midland backwoods frontier (the Southern Appalachian region was part of the Midland backwoods frontier). A “backwoods frontier” defined by the authors as extending from the Delaware Valley to the inner Atlantic Coastal Plain.³¹ Jordan and Kaups insist that both Finnish and Swedish immigrants “played a highly significant shaping role” in “the backwoods colonization culture that swept so successfully across forested parts of North America.”³² According to Jordan and Kaups

Backwoods pioneers [Swedish and Finnish ethnicities included] moved rapidly down the Great Valley in the mid eighteenth century, reaching eastern Tennessee by the 1750s. So great was the swarming that many settlers spilled eastward through gaps in the Blue Ridge onto the Piedmont of Virginia and the Carolinas, preempting the very backyard of the coastal planters.³³

Jordan and Kaups did not view the Appalachian mountain range as a barrier to settlement. They state: “The Appalachians did not act as a barrier, but they did channel migration along certain paths.”³⁴ Additional observations made by Jordan and Kaups contend that some of the more treacherous terrain of the Appalachian Mountain range redirected some of the early “backwoods pioneers” entering the Midland Frontier during the first half of the eighteenth century. According to Jordan and Kaups, “Once the Midland backwoods pioneers entered the Great Valley, the orientation of the terrain deflected the major migratory thrust southwestward into the Virginia

³¹Terry G. Jordan and Matti Kaups, *The American Backwoods Frontier: An Ethnic and Ecological Interpretation* (Baltimore: The Johns Hopkins University Press, 1990; reprint, Baltimore: Johns Hopkins University Press, 1992): 235-236.

³²*Ibid.*, xi.

³³*Ibid.*, 234.

³⁴*Ibid.*, 235.

backcountry.”³⁵ But, many of those early pioneers were hardy enough to settle the rural and non-rural areas of upper East Tennessee area and the adjacent area of Southwest Virginia by the mid-eighteenth century. Migration into the region was not hindered to a great extent.

Often a region defined as isolated and economically deficient, the Southern Appalachian region experienced significant industrialization during the nineteenth century. According to sociologist Wilma Dunaway, by the dawn of the nineteenth century the Southern Appalachian region had an established economy, with established trade routes throughout the region, which served to link the region to core trade areas of the world.³⁶ In opposition to the early social and cultural assessments made by some Appalachian historians, Dunaway argues that the Southern Appalachian region was not isolated and economically deficient. In her sociological study *The First American Frontier: Transition to Capitalism in Southern Appalachian, 1700-1860*, Dunaway states:

By 1860, there were 6,019 industrial enterprises in Southern Appalachia, employing 23,357 laborers. However, industrialization as it unfolded in the Southern Appalachian differed fundamentally from the historical process that characterized core regions of the nineteenth-century world economy. Rather, the region’s industrial development was stunted and distorted, as evidenced by three historical trends. Because Appalachian industries were capitalized at lower levels than other American manufactories, these regional enterprises exploited smaller labor forces to generate outputs at the same levels as average medium size firms nationally. Second, regional industries developed unevenly, with heavy concentration into a few geographical areas and few spinoffs outside those small enclaves. Third, the region’s industry developed primarily around the production of export commodities that involved the manufacture of agricultural surpluses and the processing of timber and mineral ores for distant markets.³⁷

Summarizing her study findings related to external trade in the Southern Appalachian region, Dunaway contends:

³⁵Ibid.

³⁶Wilma A. Dunaway, *The First American Frontier: Transition to Capitalism in Southern Appalachian, 1700-1860* (Chapel Hill: University of North Carolina Press, 1996), 157.

³⁷Ibid.

To effect this external trade, layers of markets were connected between small Appalachian towns, regional trading hubs, inland trade centers, and seacoast entrepôts . . . From the frontier years, raw materials and semiprocessed commodities flowed across county, state, and international boundaries in a relatively unimpeded fashion. External trade was increasingly mobilized along regional transportation circuits that linked with established paths to core areas of the world economy.³⁸

Although a region industrialized—but to a lesser extent than the rest of the nation—as Dunaway argues, and inhabited by white settlers since the early nineteenth century, and diverse in its cultural and ethnic characteristics, the Southern Appalachian region nonetheless contained isolated sub-regions particularly in mountain areas. Access to ‘licensed and trained’ physicians, remained an obstacle for many inhabitants, especially those in the mountains. Limited access also placed a serious burden on women of childbearing age. The vital need for the healthcare-related services of the Southern Appalachian granny-woman, especially for women of childbearing age was, thus, a critical issue. The following chapters are dedicated to enhancing the level of respect attached to the role of Southern Appalachian granny-woman, as well as to advancing the history of the healthcare-related contributions of those who diligently served the Southern Appalachian region.

³⁸Ibid., 222-223.

CHAPTER 2
LITERATURE REVIEW

History of Midwifery

Author John Haller, Jr., states in his book *American Medicine in Transition, 1840-1910*, “The history of midwifery parallels the history of mankind and antedates any record of medicine as an applied science. Among the Hebrews, Greeks, and Romans, and later, the Portuguese, Spaniards, and Italians, the term applied to the person attending confinement was feminine.”¹ A word derived from the Latin “*obstetric* and *cummater*, which had no masculine, to the Italian *commere*, to the Spanish and Portuguese *commadre*, and the Anglo-Saxon *midwife* (*mid-wife*, with woman), no language prior to the seventeenth century referred to a male assistant during woman’s confinement.”² Haller’s summary of midwifery agrees with the assessment made by women’s studies scholar Judy Barrett Litoff in *American Midwives, 1860 to Present*. Litoff states, “Midwifery has been the almost exclusive province of women throughout recorded history. Indeed considerable evidence exists which indicates that the management of labor has traditionally been considered the responsibility of women.”³

The early history of midwifery, detailed by William L. Minkowski, M.D., M.P.H., in his article “Women Healers of the Middle Ages: Selected Aspects of Their History,” concurs with Litoff: “Healing has always been regarded as the natural responsibility of mother and wives . . . But

¹John S. Haller, Jr., *American Medicine in Transition, 1840-1910* (Urbana: University of Illinois Press, 1981), 150.

²Ibid.

³Judy Barrett Litoff, *American Midwives, 1860 to the Present* (Westport: Greenwood Press, 1978), 3.

because they were excluded from academic institutions, female healers of the Middle Ages had little opportunity to contribute to the science of medicine. Rather, they served as herbalists, midwives, surgeons, barber-surgeons, nurses, and empirics, the traditional healers.”⁴

Minkowski also discusses oral tradition in his article: “In that pragmatic, nonacademic environment of medical practice before Europe’s first universities, remedies were transmitted from one generation to another, learned by personal experience or from the rare, popular medical treatises that circulated among the few literate healers.”⁵ He adds, “Because the scientific study of human illness had not yet begun, it is not surprising that magic, amulets, and incantations were important elements in the total treatment formulary of all practitioners, including physicians.”⁶ According to Minkowski, one period of history that produced dramatic change occurred during the “profound social and economic dislocations as Europe evolved from scattered, small fiefdoms into larger, increasingly centralized ruling units,” which transpired between the fifth and sixteenth centuries.⁷ Minkowski describes the radical change, and the ramifications that follow.

⁴William L. Minkowski, “Women Healers of the Middle Ages: Selected Aspects of Their History,” *American Journal of Public Health*, 82 (February 1992): 288.

⁵Ibid.

⁶Ibid.

⁷Ibid.

And with the establishment of universities and professional schools, the character of health service changed, too. Early in the thirteenth century, female health workers, long accustomed to the trust and respect of their patients, began to face opposition. Barred from most European universities because of their gender and thus denied academic training in medicine, they were considered ineligible as healers, and those who persisted often met with capricious, even harsh punishment. Yet they stood their ground against the inimical decrees of secular and clerical authorities, and in doing so, they risked heavy fines, flagellations, excommunication, and exile.⁸

Minkowski goes on to offer an observation of female healers: “Then, in the last four centuries of the Middle Ages, female healers became the target of witch-hunting, a program of ruthless persecution that was promoted by the church and supported by both clerical and civil authorities.”⁹ According to Minkowski, even though “midwifery regulations were introduced into Western Europe in the late Middle Ages,” with expectations that practitioners “would refer difficult deliveries to male physicians,” a harsh realization emerged that “men had no training in obstetrics and far less experience with pregnant women than midwives had . . . Thus, midwives were omnipresent, comprising perhaps one third of all female medical practitioners.”¹⁰ Yet, that strong presence would come under attack from clerical and civil entities.

During the Middle Ages, Minkowski verified midwives “moved from the role of revered, if poorly compensated, source of comfort in time of illness and injury to that often-reviled creature in league with the Devil.”¹¹ Minkowski goes on to say that “By the late Middle Ages, the church and civil authorities mandated close supervision of midwives, as expressed in required professional and religious instruction and in oaths that explicitly renounced past and present resort to the black

⁸Ibid.

⁹Ibid.

¹⁰Ibid., 292.

¹¹Ibid., 295.

arts.”¹² While not considered “in league with the Devil,” the American midwife, or granny-woman, also came under attack. Pursued by legislative and medically-related entities, the concerted attack on the healthcare practices provided by all midwives—the Southern Appalachian granny-woman among them—was aimed at her elimination.

The Granny-Midwife Tradition

Katy Dawley states, “In 1900, 50% of infants in the United State were born into the hands of midwives.”¹³ Dawley further goes on to say that “During the late-19th century and early-20th century, it was dangerous to bear children in the United States. Between 1900 and 1930, pregnancy was the second-largest killer of women of childbearing age in this country, with only tuberculosis claiming more lives in this group of women.”¹⁴ Even though Dawley’s article, “The Campaign to Eliminate the Midwife,” focuses on the “significant role of nurses, who joined this campaign in the interest of nursing specialization,” she does assess ramifications of their actions.¹⁵ Dawley states, “When nurses joined physicians in the movement to abolish midwifery, they unknowingly harmed the very specialties they were trying to promote. In an attempt to curb the high incidence of infant and maternal mortality during this period of widespread poverty . . . they discredited the traditional midwife with biased portrayals.”¹⁶ With licensed medical practitioners not readily available in rural

¹²Ibid., 294.

¹³Katy Dawley, “The Campaign to Eliminate the Midwife,” *American Journal of Nursing* 100 (October 2000): 50.

¹⁴Ibid., 50-51.

¹⁵Ibid., 50.

¹⁶Ibid.

Appalachia, this bias placed many inhabitants in a quandary relative to their respective healthcare-related needs.

“At the turn of the century [twentieth century], midwives and physicians attended about an equal number of births. Indeed, although statistics relating to the number of early twentieth-century midwives are not always reliable, conservative estimates indicate that as late as 1910 at least 50 percent of all births were attended by midwives,” according to Judy Litoff.¹⁷ Providing confirmation for her statement, Litoff explains in her reference note, “The Bureau of the Census did not begin publishing statistical information with regard to the attendant at birth until 1937.”¹⁸

In a spirit rooted in devotion, the women who chose to fulfill the role of granny-woman aided and assisted those living around them—a role that was not based on the foundation of financial gain, as would later be the case regarding the educated males who developed and implemented a campaign to eliminate the granny-woman. According to *Authorized to Heal* author Sandra Barney, “Midwives’ practices were relatively brief because, as historians of midwifery have illustrated, midwifery was essentially an art that women fit around their domestic obligations.”¹⁹ Even if chosen as a “career,” it was fulfilled only after the responsibilities at home had been addressed. Barney also notes, “As a number of historians have documented, midwives were the standard of care throughout much of the United States until the first decades of the twentieth century.”²⁰ However, a transformation of medical care—the initial stages traced to the early nineteenth century in the United States—gained momentum during the 1920s and 1930s.

¹⁷Litoff, *American Midwives, 1860 to the Present*, 27.

¹⁸Ibid., 42.

¹⁹Barney, *Authorized to Heal*, 64.

²⁰Ibid., 9.

Delivering insight regarding the role of granny-woman in the Southern Appalachian region, author Mildred Haun, through her main character, Granny-woman Mary Dorthula White, articulates the commitment of this caregiver in providing healthcare ministrations to those living around her. Haun's dramatic imagery, illustrated in her collection of short stories entitled *The Hawk's Done Gone and Other Stories*, characterized the concern some granny-women had regarding changes occurring in medical care. The following passage, located in the opening chapter, provides clarity about significant changes that occur related to medical care in the Southern Appalachian region.

I'll have to go on for a while yet anyhow. Of course, there is that town doctor man that lives in Del Rio. Folks say he don't know much. But them that lives too far away from here have to put up with him sometimes. And have to pay him to boot. I don't want to think about not being any more use. It is my place, seems like, to doctor sick folks and bring babies in to the world, and lay out the dead.²¹

This passage exposes the raw concerns which faced many granny-women practicing in the Southern Appalachian region. And those concerns certainly reveal that not everyone readily accepted the educated physicians that were becoming a part of the southern Appalachian landscape.

As stated earlier, East Tennessee author Mildred Haun infused her writings with ethnographic specifics that detailed actual Southern Appalachian customs and practices used during the late nineteenth and early twentieth centuries. Revealing specifics related to East Tennessee's social, cultural, and medical history, Haun's selection of the granny-woman as the narrator of her collection of short stories implies deliberate action to provide a non-fictional view of one of the most influential and respected members in many mountain communities through a literary work classified as fiction. The inclusion of intricate specifics related to herbal remedies associated with childbirth prevention suggests that Haun's injection of information related to a subject this volatile in nature

²¹Mildred Haun, *The Hawk's Done Gone and Other Stories*, introduction by Herschel Gower (Indianapolis: Bobbs-Merrill Company, 1940, reprint, Nashville: Vanderbilt University Press, 1968), 7, available from <<http://lib.etsu.edu/cgi-bin/>>.

should be examined in the same way that Grace Toney Edwards analyzed the works of Emma Bell Miles. In her essay entitled, “Emma Bell Miles: Feminist Crusader in Appalachia,” Edwards states,

Many local colorists shared her [Miles] seriousness of social purpose and created half-fictional polemic to wage a crusade for one cause of another. Their intentions, then, were multifold: to represent a particular locale in all its beauties, and sometimes its ugliness; . . . The cause might be economic, political, or social, as with Hamlin Garland in *Main-Travelled Roads*. Or it might be a crusade for the illumination and liberation of women, as with Emma Bell Miles in virtually every prose piece she wrote, including her short stories.²²

Edwards contends that “Intentions of this sort require a different kind of reading that is usual for fiction.”²³ Hammering her point home, Edwards insists that “perhaps critics should not be reading the pieces as conventional short stories at all, but rather as quasi-fictional exposition.”²⁴

Edwards further states; “Emma Bell Miles’ stories can be profitably measured by these standards, for her whole body of fiction is a crusade on behalf of women, fettered not only by their gender but also by poverty.”²⁵

Using the methodology of Edwards for this study, the short stories contained within Haun’s *The Hawk’s Done Gone and Other Stories* will be examined to provide a realistic view of the herbal remedies used, as well as the childbirth-related measures available to women living in the Southern Appalachian region during the late nineteenth and early twentieth centuries. By examining Haun’s infusion of folk medicine and childbirth-related specifics within her collection of stories—conveyed through the character of Granny-woman Mary Dorthula White—a level of interaction can be

²²Grace Toney Edwards, “Emma Bell Miles: Feminist Crusader in Appalachia,” in *Appalachia Inside Out*, vol. 2, ed. Robert J. Higgs, Ambrose N. Manning, and Jim Wayne Miller (Knoxville: University of Tennessee Press, 1995), 709.

²³Ibid.

²⁴Ibid.

²⁵Ibid., 710.

established related to the actions taken regarding herbal-based childbirth prevention measures.

Describing the literary works of Miles', Edwards states, "Her fiction does not build from without . . . It grows from within, showing respect for the traditional folkways that have sustained this mountain people, but at the same time crying out against the cultural bonds that restrict, limit, dehumanize the women."²⁶

Many of the works of Mildred Haun should be viewed from the standpoint advocated by Grace Toney Edwards during her examination of the prose of Emma Bell Miles. *The Hawk's Done Gone and Other Stories* is a literary accomplishment that must be assessed by this method. What Edwards said about Miles' fiction can be applied equally to Haun's: "Haun's fiction grows from within, showing respect for the traditional folkways that have sustained this mountain people, but at the same time crying out against the cultural [and one might add, legal] bonds that restrict, limit, dehumanize the women."²⁷

Even so, crippled by the "restrictions" of the recent state mandated healthcare rules and regulations, along with newly-enacted laws related to abortion, midwives, granny-women, and neighbor-women were replaced by educated medical doctors. Sandra Barney states, "If doctors were to be seen as the only legitimate childbirth attendants, they had to encourage mothers, and by extension their families, to reject midwifery and embrace modern, scientific medicine."²⁸ Physicians, addressing medical concerns in the Appalachian region accomplished this goal by enlisting

²⁶Ibid.

²⁷Ibid.

²⁸Barney, *Authorized to Heal*, 9.

“volunteers from their social and economic class to assist them in reshaping expectations about health and healing.”²⁹

Childbirth Prevention: Political Perspective

In the opening lines of his book *Abortion in America: The Origins and Evolution of National Policy, 1800-1900*, James Mohr notes in regard to the social policy on abortion in the early nineteenth century:

In 1800 no jurisdiction in the United States had enacted any statutes whatsoever on the subject of abortion; most forms of abortion were not illegal and those American women who wished to practice abortion did so. Yet by 1900 virtually every jurisdiction in the United States had laws upon its books that proscribed the practice sharply and declared most abortions to be criminal offenses.³⁰

Early federal and state laws regulating abortion, which were enacted in the United States from 1820 to 1840 “retained the quickening doctrine and attempted to protect women from unwanted abortion, rather than to prosecute them.”³¹ D’Emilio and Freedman define the prevalent doctrine of “quickening” as “life did not begin until a woman felt the fetus move within her, usually after about three months.”³² Nevertheless, new laws loomed on the horizon.

According to D’Emilio and Freedman, anti-abortion statutes enacted by individual states also transformed the ideology on established abortion doctrine linked to “the early months of pregnancy,” into a procedure no longer considered acceptable, or legal.³³ D’Emilio and Freedman

²⁹Ibid., 9.

³⁰James C. Mohr, *Abortion in America: The Origins and Evolution of National Policy, 1800-1900* (New York: Oxford University Press, 1978), vii.

³¹D’Emilio and Freedman, *Intimate Matters*, 66.

³²Ibid., 65-66.

³³Ibid., 65.

state, “Between 1860 and 1890 . . . forty states and territories enacted antiabortion statutes, many of which rejected the quickening doctrine, placed limitations on advertisements, and helped transfer legal authority for abortion from women to doctors.”³⁴ This approach was rapid and produced radical change. Also developing on the horizon was a campaign aimed at eliminating the midwife.

Even though newly-enacted laws prohibited all practices and publications connected to contraception and abortion, the knowledge related to childbirth prevention measures remained. Despite the “depressed” condition connected with the region, most Southern Appalachian women received contraceptive– and abortion–related information through oral tradition. D’Emilio and Freedman claim:

In the early nineteenth century, and in rural areas for many later generations, herbal and home remedies for terminating unwanted pregnancies continued to be passed on through oral tradition. Native American healers and midwives prescribed roots or herbs known to induce abortion. In the early part of the nineteenth century, neither doctors, women, nor judges necessarily condemned these practices as long as they were performed within the early months of pregnancy.³⁵

In *Woman’s Body, Women’s Rights: A Social History of Birth Control in America*, a text “stressing the importance of birth control as a social movement” during the late nineteenth and early twentieth centuries, Linda Gordon argues that women across America were faced with arrest and prosecution if found using birth control measures, whether contraceptive or abortive in purpose, following the passage of the *Comstock Act*. Defining the meaning of birth control in the early pages of her book, women’s studies scholar Linda Gordon states: “Birth control means any measure by which birth can be prevented, whether contraceptive or abortive.”³⁶ According to Gordon, “In the nineteenth

³⁴Ibid.

³⁵Ibid.

³⁶Linda Gordon, *Woman’s Body, Women’s Right: A Social History of Birth Control in America* (New York: Grossman Publishers, 1976), 3.

century, when the movement began, birth control had become immoral and illegal with legal dangers so great that propaganda on the subject was written and distributed anonymously. Birth-control advocates were sentenced to jail terms for violation of obscenity laws.”³⁷

On March 3, 1873, the *Comstock Act* was signed into law in the United States. According to historian James Mohr, even though the *Comstock Act* “was destined to curtail the traffic in pornography and is probably best known as a turning point in anti-contraceptive legislation and American censorship policy, was also the closest the federal government ever came to entering the anti-abortion crusade.”³⁸ Observing further Mohr states: “The anti-obscenity movement rose to prominence during the 1870s under the leadership of Anthony Comstock, the well-know head of the New York Society for the Suppression of Vice.”³⁹ Comstock, a staunch anti-abortion crusader, “persuaded Congress to pass ‘an Act for the Suppression of Trade in and Circulation of, Obscene Literature and Articles of Immoral Use.’”⁴⁰ Wording of the *Comstock Act* follows:

³⁷Ibid.

³⁸Mohr, *Abortion in America*, 196.

³⁹Ibid., 196-197.

⁴⁰Ibid., 196.

Be it enacted . . . That whoever, within the District of Columbia or any of the Territories of the United States . . . shall sell . . . or shall offer to sell, or to lend, or to give away, or in any manner to exhibit, or shall otherwise publish or offer to publish in any manner, or shall have in his possession, for any such purpose or purposes, an obscene book, pamphlet, paper, writing, advertisement, circular, print, picture, drawing or other representation, figure, or image on or of paper of other material, or any cast instrument, or other article of an immoral nature, or any drug or medicine, or any article whatever, for the prevention of conception, or for causing unlawful abortion, or shall advertise the same for sale, or shall write or print, or cause to be written or printed, any card, circular, book, pamphlet, advertisement, or notice of any kind, stating when, where, how, or of whom, or by what means, any of the articles in this section . . . can be purchased or obtained, or shall manufacture, draw, or print, or in any wise make any of such articles, shall be deemed guilty of a misdemeanor, and on conviction thereof in any court of the United States . . . he shall be imprisoned at hard labor in the penitentiary for not less than six months nor more than five years for each offense, or fined not less than one hundred dollars nor more than two thousand dollars, with costs of court.⁴¹

As legal reforms spread across the United States, skill-related conflict also arose between the educated physician/obstetrician and the unlicensed midwife. In efforts to discredit the granny-woman/midwife, medical literature depicted an ignorant, dangerous, old, and outdated individual. Judy Barrett Litoff discusses one distinct inconsistency related to the South in her work, *American Midwives, 1860 to the Present*. Litoff states,

Many southern opponents of the midwife also considered it impractical to demand her immediate elimination. They recognized that it would be many years before it would be possible to replace the southern “granny” with properly qualified physicians and maternity hospitals and dispensaries. Realizing that large segments of the population would receive no obstetric care if the midwife were abolished, many southern state boards of health began cautious experiments for her training and regulation during the 1920s.⁴²

Where she practiced the granny-woman had a profound impact on the survival of the women living around her, specifically when that survival was correlated with childbirth and its prevention. Understandably, the granny-woman’s herbal-based childbirth prevention knowledge included crucial specifics needed to aid those women requiring her services. For women living in

⁴¹Ibid.

⁴²Litoff, *American Midwives, 1860 to the Present*, 80.

the Southern Appalachian region during the late nineteenth and early twentieth centuries, one's life span often depended on the skills and knowledge of the granny-woman. How did the Southern Appalachian granny-woman address childbirth prevention issues, whether contraceptive or abortive in purpose, for those women living around her?

Southern Appalachia: Women – Socially and Culturally

During the late nineteenth and early twentieth centuries, the public role of women in the United States was evolving. Still, the role of women primarily centered around the “stay at home” ideology focused on taking care of the responsibilities associated with the care and development of the children, as well as other duties associated with home and hearth. Prior to the 1880s, images present in society regarding white, middle-class women living during the early nineteenth century are aptly described by Barbara Welter in her essay “The Cult of True Womanhood, 1820-1860.” Welter contends that “Woman in the cult of True Womanhood presented by the women’s magazines, gift annuals, and religious literature of the nineteenth century, was the hostage in the home.”⁴³ Even though many American women met the criterion presented by Welter and were appreciated by their families for the actions they performed regarding the care of the family unit, women living in Southern Appalachia often experienced a “harsh, browbeaten existence.”⁴⁴

When considering career options open to women in the region, one distinct career-related role open to women living in mountainous regions was that of granny-woman.⁴⁵ Yes, some

⁴³Barbara Welter, “The Cult of True Womanhood, 1820-1860,” in *Major Problems in American Women’s History*, 2d ed., ed. Mary Beth Norton and Ruth M. Alexander (Lexington: D. C. Heath and Company, 1996), 115.

⁴⁴Barney, *Authorized to Heal*, 62.

⁴⁵Ibid., 65.

Southern Appalachian women worked in factories, and they worked the land alongside their respective kinsmen. But whatever “work” women did outside the “home and hearth,” she still had to fulfill responsibilities associated with the home. The “stay at home” prescription of the early nineteenth century pervaded many levels of American society well into the mid-twentieth century.

According to Ann Douglas, in her study encompassing women rights entitled *The Feminization of American Culture*, the etiquette books of the 1820s and 1830s reinforced the philosophy that “women were to cultivate domestic piety behind closed doors while [males] were to face . . . the competitive world of commerce.”⁴⁶ Douglas further argues that so conditioned, such women “[represent] nothing finally but a state of susceptibility to very imprecisely conceived spiritual values.”⁴⁷

Cemented to those “imprecisely conceived spiritual values” was the ideology that supported disapproval of childbirth prevention measures during the late nineteenth and early twentieth centuries.⁴⁸ Yet, statistical information noted by John D’Emilio and Estelle B. Freedman illustrates that a societal transition was occurring. D’Emilio and Freedman note: “Estimates by reformers show that between 1800 and 1830, one abortion occurred for every twenty-five to thirty live births. By the 1850s, the proportion had increased to as many as one abortion per every five to six live births.”⁴⁹ D’Emilio and Freedman further inject, “By the 1860s, over twenty-five different chemical

⁴⁶Ann Douglas, *The Feminization of American Culture* (New York: Knopf, 1979), 46.

⁴⁷Ibid.

⁴⁸Ibid., and D’Emilio and Freedman, *Intimate Matters*, 65.

⁴⁹D’Emilio and Freedman, *Intimate Matters*, 65.

abortifacients – aloes, iron, and other cathartic powders – could be located through newspaper ads, postal circulars, and pharmacies.”⁵⁰

Even with the increased visibility the availability abortifacients had in the newspapers and circulars of the day, access to this information was limited for women living in Southern Appalachia. Information concerning these prevention measures reached remote areas at an extremely slow pace, if at all. Coupled with the educational deficiencies of the region, many women could not take advantage of this type of information. According to women’s studies scholar Linda Gordon, class differences influenced accessibility issues related to contraceptives. Gordon states,

Class differences in the nineteenth century were important in birth control, but they should not blind us to the basic similarity in women’s experiences. Although infanticide was confined to the very poor, the number of infanticides was tiny compared with the prevalence of other birth-control methods. The desire for and the problems in securing abortion and contraception made up a shared female experience. Abortion technique was apparently not much safer among upper-class doctors than among working-class midwives. The most commonly use contraceptive – douches, withdrawal – were accessible to women of every class.⁵¹

However, in a region not known for providing equality of opportunity for women, demanding safe childbirth prevention measures would have been futile for the women living in the Southern Appalachian region during the late nineteenth and early twentieth centuries. Mary Roth Walsh provides insight regarding the social and cultural influences that affected the liberation of women living at that time. In *Doctors Wanted: No Women Need Apply*, Walsh states,

⁵⁰Ibid., 63.

⁵¹Gordon, *Woman’s Body, Woman’s Right*, 70.

In fact, opportunity for American Women began pretty much where the frontier left off. It was the twin forces of industrialization and urbanization that stimulated at least some women to aspire to equality of opportunity. Although industrialization condemned many women to factory work, while creating a domestic prison for their middle-class sisters, it did liberate some women.⁵²

In contrast, and with the location of this region being considered part of what today is called the 'Bible Belt,' religiously-based condemnations related to childbirth prevention measures, no doubt influenced a number of the women living in the Southern Appalachian region during the late nineteenth and early twentieth centuries. Historian James Mohr provided a religious-based interpretation of the anti-abortion crusade of the nineteenth century in his study *Abortion in America*.

At the onset of the anti-abortion campaign, which began in the early nineteenth century, the unrelenting efforts of the mid-nineteenth century anti-abortion crusader Horatio Storer, M.D., helped the campaign gain momentum across the United States. Discussing the anti-abortion tactics of Storer, Mohr states, "In his prize essay ["Criminality and Physical Evils of Forced Abortions"] Storer had made the standard claim that abortion was 'infinitely more frequent among Protestant women than among Catholic.'"⁵³ Storer's statement leads Mohr to conclude: "There can be little doubt that Protestants' fears about not keeping up with the reproductive rates of Catholic immigrants played a greater role in the drive for anti-abortion laws in nineteenth-century America than Catholic opposition to abortion did."⁵⁴ With his astute observation of Storer's anti-abortion tactics, Mohr provided a sound rationale related to the religious motivation forcing women to relinquish their rights to childbirth prevention measures.

⁵²Walsh, *Doctors Wanted: No Women Need Apply*, xiii.

⁵³Mohr, *Abortion in America*, 167.

⁵⁴Ibid.

Lacking access to information and practices related to childbirth prevention placed women living in the Southern Appalachian region during the late nineteenth and early twentieth centuries in a birth control dilemma. Adding to that dilemma was the number of years women dedicated to giving birth and child rearing. Some women might dedicate forty or more years to giving birth and child rearing. According to Richard W. Wertz and Dorothy C. Wertz, authors of *Lying-In: A History of Childbirth in America*,

The pattern of prolonged childbearing meant that most of a woman's adult life was spent rearing children. The average age of women at marriage was usually around twenty-two, and the first child was born about sixteen months later. The last child, however, was not born until the woman was about forty, which meant that her last child might still be at home when she was sixty years of age, if she were still alive.⁵⁵

While Wertz and Wertz assess the average age of all women in the United States at marriage to be twenty-two, that age was not accurate in regard to women living in the Southern Appalachian region. As reported by D'Emilio and Freedman, late nineteenth century birth rate documentation revealed that "In the southern states, where white women married at a younger age and large families were desired to produce heirs, birth rates remained high."⁵⁶ D'Emilio and Freedman explain that at the beginning of the nineteenth century "a married couple had an average of slightly over seven children . . . and by 1880, only 4.24."⁵⁷

Not only was family size declining, but also with that decline D'Emilio and Freedman insist that some sort of reproductive control was taking place. To elucidate this significant transition D'Emilio and Freedman note, "Abundant historical evidence suggests that nineteenth-century

⁵⁵Richard W. Wertz and Dorothy C. Wertz, *Lying-In: A History of Childbirth in America*, expanded ed. (New Haven: Yale University Press, 1989), 2-3.

⁵⁶D'Emilio and Freedman, *Intimate Matters*, 58.

⁵⁷Ibid.

Americans turned to contraception and abortion in order to limit their families. In the name of preserving women's health and producing happier marriages and healthier children, nineteenth-century Americans both learned about and practiced a variety of forms of family limitation."⁵⁸

Additional research suggested that pinpointing which method most couples used is difficult. "It is most likely that the most commonly used method was *coitus interruptus* . . ." according to D'Emilio and Freedman.⁵⁹ In *Woman's Body, Woman's Rights*, author Linda Gordon contends, "Birth control was responsible."⁶⁰ Also, Gordon insists the declining fertility rates of the late nineteenth and early twentieth centuries could not be linked to celibacy.⁶¹ Substantiating her theory, Gordon states,

From 1800 to 1960, then the average number of births per woman in this country fell from 7.04 to 3.52. In evaluating this change it is also important to realize that throughout this period the vast majority of women married. The percentage of women marrying seems to be increasing, with the highest proportion – 9.52 per cent – counted in 1965, in the generation of women born between 1921 and 1930. But even at the period of the highest number of permanent spinsters, 1865-1875, still 90.4 per cent of all women married, and the figure has never dropped below that. Thus celibacy cannot be a reason for the sharp fertility drop.⁶²

However, as evidenced earlier, a successful anti-abortion crusade removed contraceptives and abortifacients from public access during the 1870s. D'Emilio and Freeman state, "By the 1870s, contraceptive use [and abortifacients] seemed to be growing so rapidly that some Americans organized to oppose its spread. Concerned about declining birth rates, they supported legislation to

⁵⁸Ibid.

⁵⁹Ibid.

⁶⁰Gordon, *Woman's Body, Woman's Right*, 49.

⁶¹Ibid., 49.

⁶²Ibid.

curtail the circulation of contraceptive information.”⁶³ Yet, one cannot prove that rural Southern Appalachian women used contraceptives.

Curtailing the sale of contraceptives, as well as abortifacients, would not have affected most women living in the Southern Appalachian region during the late nineteenth century. While contraceptives may not have been readily available in the Southern Appalachian region, an oral tradition existed, one that provided herbal-based remedy specifics related to childbirth prevention. Sandra Barney states: “Deterred by the cost of medical care and uninterested in the few advantages it seemed to offer, rural mountaineers continued to turn to traditional caregivers, seeking professional medical help only when all other treatments failed.”⁶⁴

Because rural inhabitants of the Southern Appalachian region could not afford physician fees even if they had access to doctors, “knowledge restructured” related to medical, as well as societal and cultural concerns would have occurred within the communities. Moreover, knowledge from outside the region would have been regarded with suspicion. Given limited access to licensed medical practitioners, in an educationally deficient locale, many regional women had few ways to prevent childbirth during the late nineteenth and early twentieth centuries in Southern Appalachia. These social and cultural conditions would have served to increase the Southern Appalachian woman’s reliance on the expertise and skills of the granny-woman.

Folk Medicine: Herbal Remedies

Despite the rapid evolution of medical advancements during the late nineteenth and early twentieth centuries, the tradition-based ministrations of the Southern Appalachian granny-woman

⁶³D’Emilio and Freedman, *Intimate Matters*, 60.

⁶⁴Barney, *Authorized to Heal*, 16.

continued to be used by the regions' inhabitants. According to Erika Brady, associate professor and director of folk studies and anthropology at Western Kentucky University, "Herbal remedies, which are acknowledged as a subdivision of folk medicine, itself a sub-specialty of folklore, has been the focus of controversy since the advent of scientific medicine."⁶⁵ Consequently, the herbal ministrations practiced by midwives that were embedded in folk medicine practices (prevalent in Southern Appalachia at that time), in part, stimulated the motivation behind the campaign to eliminate midwives.

Given the Southern Appalachian region's strong oral traditions, the specifics of herbal remedies often traveled through history by oral transmission. According to Brady, "Oral traditions involve relatively direct communication among individuals who share enough values and meanings for the communication to be accurately and easily interpreted, and for responses to have a direct and immediate impact."⁶⁶ Correspondingly, "folk medical traditions tend to show regional variation and to accommodate specific local conditions, as well as to be closely tied to groups or populations who share important identity-defining features such as . . . common regional influences."⁶⁷ Commenting further, Brady stresses, "What makes some medicine 'folk' is not the particular content of the system of knowledge and practice, but the mode of transmission together with the status of the system by comparison with whatever other medical system is recognized as 'official' in the local context."⁶⁸ Brady enlarges upon Don Yoder's folk medicine definition by stating, "Folklorists generally consider

⁶⁵Erika Brady, ed., *Healing Logics: Culture and Medicine in Modern Health Belief Systems* (Logan: Utah State University Press, 2001), 14.

⁶⁶Ibid.

⁶⁷Ibid., 15.

⁶⁸Ibid., 14.

a heavy reliance on oral transmission to be a definitive feature of all aspect of folk culture. By this standard, folk medical systems are those learned and maintained primarily through oral channels.”⁶⁹

Historians Clarence Meyer and John M. Riddle authored renowned texts that discuss the history of herbal remedies; many accounts were attributed to oral tradition. Clarence Meyer’s *American Folk Medicine*, (a text based on authentic sources) is considered the most complete collection ever published on the subject of herbal remedies. Meyer discusses in depth the herbal remedies deployed through the historically recognized oral tradition maintained throughout the Southern Appalachian region. Supplying folk medicine specifics, which incorporate medicinal recipes handed down through individual families by oral tradition, Meyer included remedies addressing ailments that take into account everything from asthma to childbirth prevention.

Historian John M. Riddle uses early manuscripts of medical and botanical texts, as well as the proceedings of court cases, to examine the use of plants as contraceptives. Exploring the question: “If women once had access to effective means of birth control, why was this knowledge lost to them in modern times?,” Riddle begins with the testimony of young women brought before the Inquisition in France in 1320.⁷⁰ Navigating through history, Riddle discusses how the new intellectual, religious, and legal climate of the early modern period cast suspicion on women who employed “secret knowledge” to terminate or prevent pregnancy. Infused within Riddle’s text are the specifics on the herbs used to regulate the fertility process.

Even though a volatile subject, information will emerge to enhance the granny-women’s role associated with childbirth during the late nineteenth and early twentieth centuries. Moreover, had it

⁶⁹Ibid.

⁷⁰John M. Riddle, *Eve’s Herbs: A History of Contraception and Abortion in the West* (Cambridge: Harvard University Press, 1997), 25.

not been for the tradition-based knowledge of the granny-woman, many Southern Appalachian natives might not be fifth and sixth generation descendants.

CHAPTER 3

THE SOUTHERN APPALACHIAN GRANNY WOMAN, 1880-1930

Overview

The ideology accepted across most of America sanctioning women being kept home-based, taking care of ‘home and hearth,’ especially applied to the women living in the Southern Appalachian region during the late nineteenth and early twentieth centuries. Marriage often came at an early age in the mountains, and a woman more than likely was considered a spinster at the age of eighteen.¹ After marriage a significant amount of responsibility became associated with “home and hearth,” along with the expected role of motherhood and its responsibilities. Women living in this region experienced harsh existences; not only were the tasks inside the home their sole responsibility, but help with annual planting and harvesting tasks was added during the spring, summer, and fall months of the year. All of this left little time for women to contemplate personal growth.

One career option—albeit a temporary one—open to women was the role of granny-woman. Sandra Barney surmised, “Midwives’ practices were relatively brief because, as historians of midwifery have illustrated, midwifery was essentially an art that women fit around their domestic obligations.”² If a woman chose to become a granny-woman or accepted election to the position by her neighbors, she nonetheless had to fulfill that role after she completed domestic tasks.

¹D’Emilio and Freedman, *Intimate Matters*, 26.

²Barney, *Authorized to Heal*, 64.

“At the dawn of the twentieth century, it appeared that the American midwife would soon become a relic of a bygone era. Few, if any, Americans could have predicted that within the ensuing decade the medical community and, to a lesser extent the general public, would become embroiled in a vehement debate over her present and future role,” claims Judy Litoff, in her book *The American Midwife Debate*.³ Shedding additional insight on the motivation fueling the debate, women’s studies and medical historians, James W. Knight and Joan C. Callahan, explain that as the practice of medicine became more professional and technical, physicians claimed the right to control matters pertaining to abortion:

As medical practice was professionalized in the nineteenth century, physicians campaigned to make morally and medically appropriate decisions on abortion a matter of technical judgment. The emerging profession of medicine claimed the expertise to decide when a pregnancy was threatening to a women’s health and could therefore be justifiably terminated. Social acceptance of this position gave individual physicians authority to use their discretion in deciding who would receive a legal abortion. In the United States, the use of physician discretion to decide when abortions would and would not be performed resulted in stark contrast in the numbers of ‘therapeutic’ abortions performed in liberal and conservative settings, with legal abortions in the most liberal setting being performed as much as fifty-five times more frequently than in the most conservative settings.⁴

In addition, other concerns began to arise. One concern was the inflated mortality rates of mothers and their infants. Litoff states, “Coupled with the new visibility accorded the midwife was the recognition that the infant and maternal mortality rates of the United States were alarmingly high.”⁵ Providing clarification as to who was being scrutinized, Litoff states, “In an effort to

³Judy Barrett Litoff, *The American Midwife Debate*, Contributions in Medical Studies, No. 18 (Westport: Greenwood Press, 1986), 27.

⁴James W. Knight and Joan C. Callahan, *Preventing Birth: Contemporary Methods and Related Moral Controversies* Vol. 3, ed. Margaret P. Battin and Leslie P. Francis (Salt Lake City: University of Utah Press, 1989), 200-201.

⁵Litoff, *The American Midwife Debate*, 27.

discover why so many mothers and infants were dying, the qualifications and skills of birth attendants—both midwives and physicians—were carefully examined.”⁶

Nursing history scholar Susan E. Stone provides statistical information based on Litoff's 1986 research. She explains that even with the shift of power from the midwife to the educated physician at the turn of the twentieth century, both physician and midwife attended an equal number of childbirths. Stone reports,

At the beginning of the twentieth century, midwives were attending approximately 50% of the births in the United States, and physicians attended the other 50%. These primarily apprentice-trained women, with no formal education, were often referred to as indigenous, lay or granny midwives. Their principal duties were to provide comfort and care to the laboring woman, “catch” the baby, tie the cord, and deliver the placenta. They often stayed for several days after the birth to provide ongoing care to the family.

In 1909, the Children's Bureau was established for the purpose of investigating and reporting on all matters pertaining to the health and welfare of children. The first investigations revealed appallingly high infant and maternal mortality rates.⁷

Extracted from the U.S. Census Bureau's *Statistical Abstract of the United States: 2003*, the following table contains statistics for total births, deaths, and infant deaths from 1900-1930. Note that statistics for birth counts were unavailable until 1910, after the establishment of the Children's Bureau in 1909.⁸

⁶Ibid.

⁷Susan E. Stone, “The Evolving Scope of Nurse-Midwifery Practice in the United States,” *Journal of Midwifery & Women's Health* 45 (November/December 2000): 522, [journal online]; available from ScienceDirect.com Database, <<http://www.sciencedirect.com/science>>, accessed 19 July 2004.

⁸U.S. Census Bureau, *Statistical Abstract of the United States: 2003*, 123d ed. (Washington, D.C.: Government Printing Office, 2003): 21, [government document online]; available from U.S. Census Bureau Homepage, <<http://www.census.gov/>>, accessed 13 September 2004.

Table 1

Total Births, Deaths, and Infant Deaths: 1900-1930

Year	Total Births	Total Deaths	Total Infant Deaths	Infant Deaths per 1,000 live births
1900	(NA)*	343,000	71,000	(NA)*
1910	2,777,000	697,000	135,000	124
1920	2,950,000	1,118,000	171,000	85.8
1930	2,618,000	1,327,000	143,000	64.6

Source: Aggregated data from U.S. Census Bureau, *Statistical Abstract of the United States: 2003*, 123d ed. (Washington, D.C.: Government Printing Office, 2003): 21.

*NA=Not available

Even though a high infant mortality rate characterized the United States during the early 1900s, women living in the Southern Appalachian region had to rely on whatever assistance was available when awaiting the birth of a child. Southern Appalachian women were more likely than not to have midwives attending their childbirth experiences. As Litoff points out, “Throughout the rural areas of the United States, friends and relative were often called upon to act as midwives. In fact, there was no clear demarcation line between the women who acted in the official capacity of a midwife . . . and the neighbor who occasionally came to the aid of a friend in need.”⁹

The rural population of the state of Tennessee tripled that of the urban population at the turn of the twentieth century. Following are population data extracted from *Tennessee Statistical Abstract 2003*, and compiled by the Center for Business and Economic Research at the University of Tennessee in January 2003. As presented in Table 2, statistics confirm a strong reliance on the local granny-woman/midwife for many women living in Tennessee during the late nineteenth and early

⁹Litoff, *The American Midwife Debate*, 27.

twentieth centuries. The statistics illustrate the rural versus urban population data for the state of Tennessee during the 1880s through the 1930s.

Table 2

Urban and Rural Population, Tennessee 1880-1930, Decennial Census Years

Year	Total Population	Urban	Rural	Urban as percent of total	Rural as percent of total
1880	1,542,359	115,984	1,426,375	7.5	92.5
1890	1,767,518	127,394	1,529,124	13.5	86.5
1900	2,020,616	326,639	1,693,977	16.2	83.8
1910	2,184,789	441,045	1,743,744	20.2	79.8
1920	2,337,885	611,226	1,726,659	26.1	73.9
1930	2,616,556	896,538	1,720,018	34.3	65.7

Source: Aggregated data from University of Tennessee Center for Business and Economic Research, *Tennessee Statistical Abstract 2003*, 18h ed. (Knoxville: 2003): population table 1.1.

The above statistics reveal a steady shift to urban living by the 1930s. Nonetheless, rural inhabitants far outweighed the number of inhabitants considered “urban” in the Southern Appalachian region. Rural areas did not attract doctors. This was especially true in southern Appalachia. “The health care infrastructure in Southern Appalachia, however, was poorly developed prior to and well after the turn of the twentieth century, there were few hospitals and clinics in the region, none in some rural areas,” states anthropologist Anthony Cavender.¹⁰ A statement enunciating the fact had the granny-woman not taken on the responsibility of providing medical care

¹⁰Cavender, *Folk Medicine in Southern Appalachia*, 24.

to those living around her, the survival of some of the inhabitants of the region would not have occurred.

Adhering to the research methodology of the Cavender study, *Folk Medicine in Southern Appalachia*, the present study agrees with Cavender that: “It is generally accepted that rural Appalachia has long had a scarcity of doctors, but it may well be that in some areas the problem was with the distribution.”¹¹ A shortage of licensed physicians would have led regional women to seek childbirth-related support from the ‘designated’ granny-woman or those women living around them who had experience attending childbirths. Any woman who could have provided guidance during a time considered life-giving, as well as life-threatening; would have been an extremely welcome asset for the mother-to-be.

Applying the specifics incorporated within the text, *The Hawk’s Done Gone and Other Stories*, Mildred Haun’s reflections will be demonstrated to be factual and accurate statements concerning childbirth prevention measures of the late nineteenth and early twentieth centuries for this study. Likewise, the candid reflections of Haun/Granny-woman Mary Dorthula White provide this study with literary details of the historical conditions facing childbearing age women at that time. Not only is childbirth and herbal-based prevention knowledge specified, but the isolation for segments of the region is conveyed as well. Haun enumerates, through granny-woman Mary Dorthula, “The end of this hollow is so far from the road. And it is so rough to get into that folks claim the devil’s apron string broke loose here. And nobody much comes just to be coming.”¹²

Realizing that women, especially rural Southern women, often were isolated and did not always have access to preventive measures used to control childbirth, or to other conventional

¹¹Ibid.

¹²Haun, *The Hawk’s Done Gone and Other Stories*, 7.

means of gathering information regarding birth control options, Haun's work provides corroboration that herbal measures existed. Also, these herbal measures appear to fall solely under the health practice purview of the granny-women living during the late nineteenth and early twentieth centuries. As theorized by Catherine Strain in her thesis, "Folk Medicine in Southern Appalachian Fiction," Strain states, "Haun documents diseases common to the Southern Appalachian region and folk medical remedies likely to be used."¹³

Haun's first reference regarding the use of a herbal-based childbirth prevention measure is located in the chapter entitled "Melungeon Colored." Providing details of a specific herbal-based measure, pennyroyal, the following passage supplies the reader with personal insight from the viewpoint of Haun/Granny-woman Mary Dorthula. The inner turmoil over using such a measure and the level of need associated with these measures by the women living around her are realistically depicted. Haun writes,

Cordia come home that evening and brought Mos with her. I tried not to let her see I was worried. But I did talk to her about all the signs there are that a woman is going to have a baby. I made her promise to come right to me and let me know at the first sign she had. I hate to own up to what I was aiming on doing. All the years that I have been a Granny-woman I never have give anybody a thing to knock a youngon. Heaps of women have begged me to. It is just one of the things I always said no to. But with Cordia it was different. What I aimed on doing was to give her a quart of hot pennyroyal tea. Ma told me about it back when she was teaching me to be a Granny-woman.¹⁴

Furthermore, a time frame reference that may have been relied upon by granny-women related to the use of pennyroyal, as a childbirth prevention measure, is included in the following passage:

¹³Catherine B. Strain, "Folk Medicine in Southern Appalachian Fiction," (M.A. thesis, East Tennessee State University, 2002), 58; available from <<http://lib.etsu.edu/cgi-bin/>>.

¹⁴Haun, *The Hawk's Done Gone and Other Stories*, 99.

“Three months?” I knew I mustn't let on. I didn't know what to do. Pennyroyal tea won't do any good after a woman is that far gone. I tried to think it would be a girl baby. I begun saying to myself that I wished Cordia would die before it was born. Of course I didn't wish anything of the sort. I tried to make out like I was proud. “Who are you going to have with you, Cordia?”¹⁵

Providing specific details of an herbal remedy available to women in the Southern Appalachian region, Haun presents a direct inference that the herbal-based prevention measures exist. Haun's inference will be evaluated against the archival studies, textual material, interview, and current respondent information obtained for this study.

These initial study results, along with the following findings, endorse my thesis that the Southern Appalachian granny-woman provided a number of our female ancestors with the much-needed childbirth support practices essential to keeping many of the them, and their babies, alive, both during and after childbirth. Throughout the remainder of this chapter the primary source materials discussed will determine if herbal-based childbirth prevention measures were used and endeavor to prove that those measures were concentrated among a 'select few,' but rarely used. Research completed will target the following: when, or if, those specifics were disseminated and was dissemination made by 'select few'; were there specific circumstances that triggered the use of those measures; and are these herbal-based measures, for all intensive purposes, 'lost' in the collapse of oral tradition.

Herbal-related Findings

“The history of using plants as medicine precedes written documentation. The first written European account of herbs used therapeutically was by the Greek physician Dioscorides in 78

¹⁵Ibid., 103.

A.D.,” according to certified nurse-midwife and phytotherapist Laurel Lee.¹⁶ Lee divulges, “Midwifery and herbalism share historic links: herbs have been used for centuries to aid in pregnancy and childbirth.”¹⁷ Lee claims that “Medicinal plants were described by their properties and use in *De Materia Medica*, a compendium [compiled by Dioscorides] that remains a major reference for herbalists. Herbal healing has often been considered folk medicine because of its empirical roots.”¹⁸ Discussing the professional considerations for today’s midwives who are interested in integrating herbal healing into their clinical practices, Lee states, “In the early 19th century, scientific methods become more advanced and preferred, and the practice of botanical healing went out of favor.”¹⁹ However, Lee’s research reveals that “herbalism, or the traditional approach to herbal medicine” continued to be practiced in the Southern Appalachian region.²⁰

Pennyroyal has been used since ancient times for a variety of medicinal purposes. As noted in 1995 by newspaper columnist Gordon Young, “The Greek playwright/dramatist Aristophanes identified pennyroyal as an abortifacient as far back as 421 B.C.E.”²¹ It could be surmised that much like Haun, Aristophanes used his literary works to comment on the common use of an herb in Greek society in 421 B.C.E.

¹⁶Laurel Lee, “Introducing Herbal Medicine Into Conventional Health Care Settings,” *Journal of Nurse-Midwifery* 44, no. 3 (May/June 1999): 253-254, [journal online]; available from ScienceDirect.com Database, <<http://www.sciencedirect.com/>>, accessed 19 July 2004.

¹⁷Ibid., 253.

¹⁸Ibid., 254.

¹⁹Ibid., 254

²⁰Ibid.

²¹Gordon Young, “Lifestyle on Trial,” *Metro* (December 14-20, 1995), [database online]; available from Metro Online Newspaper Homepage, <<http://www.metroactive.com/papers/metro/>>, accessed 7 November 2003.

Further research documentation, which targeted pennyroyal's use as a remedy for "obstructed or suppressed menses," was included in Clarence Meyer's *American Folk Medicine*.²² The recipe, attributed to practicing physicians of 1848, follows:

In cases of sudden suppression of the menses, a tumbler full of pennyroyal tea with a level teaspoon of black pepper pounded fine, sweetened, and drunk warm after soaking the feet in weak lye, will rarely fail of producing the desired effect.

G. Capron, M.D., and C. B. Slack, M.D., 1848.²³

As stated previously, pennyroyal was drunk as a tea. Although the reference is associated with the "suppression of menses," as might be suspected, suppressed or obstructed menses, more often than not, usually meant a child was on the way. Concurring with this supposition, Catherine Strain states, "It seems highly possible that 'sudden suppression of the menses' could be a euphemism for an early sign of pregnancy, and the rarity of abortifacients in collected remedies and the fiction point to a reluctance to discuss this controversial issue."²⁴

History has offered nominal examples attesting to the actual use of herbal abortifacients. According to women's history scholar, Cornelia Hughes Dayton, "Most accounts, of induced abortions among seventeenth- and eighteenth-century whites in the Old and New Worlds consist of only a few lines in a private letter or court record book: these typically refer to the taking of savin or pennyroyal-two common herbal abortifacients."²⁵

²²Clarence Meyer, *American Folk Medicine* (New York: Thomas Y. Crowell Company, 1973), 172.

²³Ibid.

²⁴Strain, "Folk Medicine in Southern Appalachian Fiction," 62-63.

²⁵Cornelia Hughes Dayton, "Taking the Trade: Abortion and Gender Relations in an Eighteenth-Century New England Village," *The William and Mary Quarterly* 48 (January 1991): 19-20. JSTOR. Available from <<http://www.jstor.org/jstor/>>, accessed 15 August 2004.

Dayton continues with an in-depth discussion of a rare, documented case involving abortifacients that resulted in the death of Sarah Grosvenor in 1742. Even with charges placed against her married lover, Amasa Sessions, he escaped further prosecution. In conclusion Dayton states,

What is most striking about the Grosvenor-Sessions case is that an entire community apparently forgave Sessions for the extreme measures he took to avoid accountability for his bastard child. Although he initiated the actions that led to his lover's death, all charges against him were dropped. Moreover, the tragedy did not spur Sessions to leave town; more dramatically than excusing young men from the crime of fornication, the treatment of Amasa Sessions confirmed that the sexually irresponsible activities of men in their youth would not be held against them as they reach for repute and prosperity in their prime.²⁶

Archival and Textual Findings

East Tennessee State University's Archives of Appalachia maintains two collections that were assessed for this study. Studies reviewed were the Cavender Folk Medicine Collection and the Thomas G. Burton Collection. Both studies, though different in some respects, focused, in part, on the collection of folk remedies and folk medicine practices in Southern Appalachia.

Completing extensive research in the area of Southern Appalachian folk medicine, Anthony Cavender, Scott Beck, and their students completed over one hundred and fifty interviews between the years 1996 and 2002. The collection of interviews forms the Cavender Folk Medicine Collection. Most interviews are unpublished. The interview participants were residents of East Tennessee, southwestern Virginia, and western North Carolina and information gathered focused on folk medicine and the history of medicine in the Southern Appalachian region.

Cavender and Beck devised three questions concentrated on women's health issues. All respondents were provided with the following prompt: "I'd like to ask you about some health

²⁶Ibid., 22.

related topics that some people feel uncomfortable talking about. These topics, however, are important in terms of understanding women's health, past and present. Any information you could provide would be greatly appreciated."²⁷ During the interview process most respondents were asked:

1. What advice did you receive from your mother and other women about dealing with problems related to menstruation?
2. What did people in your generation do for contraception?
3. What did people in your generation do for abortion?²⁸

For the present study, I selected participants based on their being seventy-eight years of age or older. All participants were selected to provide information on what types of contraceptive and abortion-related information that passed on to them through oral tradition. These participants, some of whom declared they had a relative who had been a practicing midwife/granny-woman, are the best source of information that we have on herbal-based birth control and abortifacient practices of the Southern Appalachian granny-woman. Table 3 provides a snapshot of findings obtained as related to questions 2 and 3.

²⁷Cavender Folk Medicine Collection (Hereafter cited as Cavender Collection), CFMS interview form, East Tennessee State University Archives of Appalachia, Johnson City, Tennessee.

²⁸Ibid.

Table 3

Contraception and Abortion Remedy Information for CFMS Interview Participants Born in the
Year 1922 or Earlier

Catalog No.	Year Interviewed	Sex	Age	Residence	Occupation	Contraception	Contraception Remedy	Abortion	Abortion Remedy
CFMC 4	2000	M	84	Washington County, Tenn.	Iron worker	ND		RC	Ride horses
CFMC 5	2000	M	93	Washington County, Tenn.	Night watchman	OTH	Condoms	ND	
CFMC 6	2000	F	85	Washington County, Tenn.	Hairdresser	OTH	Alcohol sponge	OTH	Quinine
CFMC 7	2000	F	83	Unicoi County, Tenn.	Housewife	WND		OTH	Woman sent away
CFMC 10	2000	F	84	Washington County, Tenn.	Housewife	OTH	It wasn't required	WND	
CFMC 12	2000	F	84	Washington County, Tenn.	Nursing assistant	WND	Kept in the dark	WND	
CFMC 18	2000	F	93	Carter County, Tenn.	Housewife	NR	Ginger tea, menstrual only	NR	Confirmed abortion took place
CFMC 22	2000	F	78	Carter County, Tenn.	Housewife	RC	Paregoric	OTH	
CFMC 23	2000	F	84	Washington County, Tenn.	Housewife	OTH	Insertion of pennies Was not practiced by family	NR	
CFMC 25	2000	F	90	Washington County, Tenn.	Biology teacher	OTH	Ginger tea, menstrual only	NI	
CFMC 31	2000	F	90	Sullivan County, Tenn.	Housewife	NI		NI	
CFMC 32	2000	F	83	Washington County, Tenn.	Housewife	NI		NI	
CFMC 33	2000	F	89	Cumberland County, Tenn.	Sales	OTH	Diaphragm	NI	
CFMC 38	2001	F	88	Loudon County, Tenn.	Bank teller	NR		NI	
CFMC 45	2001	F	88	Carter County, Tenn.	Housewife	NI		NI	
CFMC 60	2001	F	83	Washington County, Tenn.	Nurse	NR		WND	
CFMC 65	2001	F	81	Sullivan County, Tenn.	Pharmaceuticals	NR		ND	
CFMC 69	2001	F	84	Washington County, Tenn.	Nurse	OTH	Condoms	OTH	Doctors performed People wanted children
CFMC 70	2001	F	91	Cumberland County, Tenn.	Housewife	OTH	Abstinence	ND	
CFMC 77	2001	F	81	Cumberland County, Tenn.	Retired, sales	NR		WND	
CFMC 84	2001	F	81	Sullivan County, Tenn.	Home healthcare	OTH	Abstinence	OTH	Confirmed abortion by doctors May apple tea, blows to abdomen
CFMC 87	2001	F	81	Monroe County, Tenn.	Housewife	NI		RC	
CFMC 90	2001	F	92	Scott County, Tenn.	Clerical	NR		ND	
CFMC 91	2001	F	85	Scott County, Tenn.	Business owner	OTH	Condoms	ND	
CFMC 96	2001	F	81	Greene County, Tenn.	Sales, clerical	WND		WND	
CFMC 100	2001	F	94	Carter County, Tenn.	Homemaker	NR		NR	

Source: Aggregated data from Cavender Folk Medicine Study, Cavender Folk Medicine Collection, East Tennessee State University Archives of Appalachia, Johnson City, Tennessee.

Note: The ages of all interview participants correspond with the year they were interviewed.

Abbreviations:

ND= Not accepted option, not done
 NI= No information supplied
 NR= No recourse available
 OTH= Other
 WND= Not discussed by family

At first glance, it can be conjectured that a noticeable percentage of family discussions did not include communication surrounding childbirth prevention measures. Taking into account the participants' oft-repeated sentiments of never discussing any issues related to contraception or abortion, this failure to discuss affirms a breakdown in oral tradition. Nearly thirty percent supplied the answer of "no recourse."²⁹ For those participants who signified there were no measures available for contraception. Seventy-three percent of the participants selected, either provided responses indicating a contemporary contraceptive measure, such as "condoms" or "diaphragms," or they responded to question 2 in the form of; no information, "not discussed by my family," or "no recourse."³⁰ More telling were the sentiments of CFMS participant no. 18. A ninety-three year-old native of Carter County, as well as a lifetime homemaker, participant no. 18 stated, "In her day if you got pregnant that was just it, you was and there weren't nothing you done about it except have it."³¹

Contradicting the information supplied by participant no. 18, CFMS participant no. 69, an eighty-four year-old native of Washington County, Tennessee, stated, "Doctors gave abortions while I was in nursing school."³² CFMS participant no. 84, an eighty-one year-old former healthcare practitioner, provided additional insight on the abortion-related practices of physicians. A native of Sullivan County, Tennessee, participant no. 84 states, "Abortions were common though none

²⁹Cavender Collection, personal interviews, CFM-18, CFM-38, CFM-60, CFM-65, CFM-77, CFM-90, CFM-100.

³⁰Ibid., personal interviews, CFM-4, CFM-5, CFM-7, CFM-12, CFM-18, CFM-31 CFM-32, CFM-33, CFM-38, CFM-45, CFM-55, CFM-60, CFM-65, CFM-69, CFM-77, CFM-87, CFM-90 CFM-91, CFM-96, CFM-100.

³¹Ibid., personal interview, CFM-18.

³²Ibid., personal interview, CFM-69.

discussed it. Doctors would give one to a 'little mother' who was worn out and couldn't go any further or make it through another pregnancy."³³ Confirming "doctors performed abortions," CFMS participant no. 69 and participant no. 84, both healthcare professionals, dispel an accusation present during the elimination campaign; an accusation that enforced midwives/granny-women participated in the abortive surgical process.³⁴

My research uncovered some information that confirmed the use of herbal-based measures for contraception or abortion. Most often the remedies recalled by the participants of the Cavender study addressed question 1. CFMS participant no. 18 and participant no. 31 stated that "ginger tea" was prescribed for menstrual problems.³⁵ Even though their mothers provided these Cavender study participants with this remedy, neither mother supplied a formula nor did she provide specifics surrounding the effects this herbal measure would have on a pregnant woman. A remedy cited by Susun S. Weed, in the *Wise Woman Herbal for the Childbearing Year*, warns the user that "If you become nauseated by drinking Ginger, you have a strong indication that you are pregnant."³⁶ Regarding the level of potency for ginger root Weed says, "Cultivated *Zingiber* [ginger root] is one of the strongest and fastest acting of the emmenagogues."³⁷ One participant, not included in Table 3, CFMS participant no. 122, an eighty-one year-old native of Hancock County, Tennessee, confirmed using

³³Ibid., personal interview, CFM-84.

³⁴Ibid., personal interviews, CFM-69 and CFM-84.

³⁵Ibid., personal interviews, CFM-18 and CFM-31.

³⁶Susun S. Weed, *Wise Woman Herbal for the Childbearing Year* (Woodstock: Ash Tree Publishing, 1986), 7-8.

³⁷Ibid., 7.

“pennyroyal tea for menstrual problems.”³⁸ Survey findings, which again illuminate the lack of evidence related to the existence of a formula/recipe. Also, any intricate details one might need if deciding to use an herbal measure for childbirth prevention, again, were not provided.

Much of the information gleaned from the interviews completed for the Thomas G. Burton Collection was further legitimized by the findings of the Cavender Collection. Thomas Burton and his students completed interviews on various folklife topics with residents of East Tennessee and southwestern Virginia in 1986. The collection includes personal interviews on life experiences related to Southern Appalachian folklife. However, when participants discussed their medical experiences, midwifery at times entered into the exchanges.

The Burton collection interview participants selected for examination in the present study were born prior to 1914. The following excerpts from those interviewed provide an enlarged view of the practices of midwife/granny-women and physicians during the late nineteenth and early twentieth centuries in the Southern Appalachian region.

Following is a portion of a Burton Collection interview completed June 28, 1986, by N. Rhea with V. Ray. The interview participant was seventy-three years of age at the time of the interview and a native of Drill, Virginia. Ray moved to Church Hill, Tennessee, in 1930, and is a homemaker.

N = N. Rhea

V = V. Ray

N: What kind of medicine and medical care did your family have?

³⁸Cavender Collection, personal interview, CFM-122.

V: Well, my daddy was a herb doctor. He didn't only doctor our family, he doctored for other families. He knew some kind of root to dig for everything. He knew what it was he had to dig. They came and got him one night. A woman was bleeding to death [not childbirth related] and they come and got him, one night in the night. He took a lantern and went and dug this root – whatever it was. I don't know the name of it. Lord, they was so many. But he took this root and made her a tea. In two hours that woman was better. Cause they didn't have no doctors. You couldn't get no doctors but he knew a root to dig for every disease they had back then. If you wanted to break out the measles, there was two kinds. Pennyroyal was one of them. I forgot the other. But they was two kinds of tea he made to break out the measles on you. He knew what everything was cause he studied it. He was a regular doctor, too. He went to see people all the time . . . But he had a tea for everything just about it. Of course the new diseases come along. Of course they had doctors for them.³⁹

Following is a portion of a Burton Collection interview completed June 20, 1986, by L.

Martin with B. Hines. The interview participant was eighty years of age at the time of the interview and a native of Wise, Virginia. Residing in Kingsport, Tennessee at the time of the interview, Hines had inhabited Shady Valley, Tennessee, prior to moving to Kingsport. Hines was employed as an apple packer, along with her duties as homemaker.

M = Martin

H = Hines

M: What if people got sick at your house? What did you do for that?

H: Well, they usually doctor them with some type of homemade medicine. They'd get herbs and stuff that growed. It just depends on what was wrong with them.

M: Can you give us some examples?

H: Seldom ever went to a doctor and got medicine unless they got pretty sick. That weed we were talking about, sheep sorrel or sour grass or whatever they wanted to call it, they'd beat that up and make a poultice out of it and put it on a sprain where you'd sprained your ankle or something that way.

M: You have children?

³⁹V. Ray, interview by N. Rhea, 28 June 1986, Interview TBC 1-13, transcribed by N. Rhea, transcript, Thomas G. Burton Collection (Hereafter cited as Burton Collection), East Tennessee State University Archives of Appalachia, Johnson City, Tennessee.

H: Two boys.

M: Did you have them in the hospital?

H: No, maam. I had them at home.

M: Did you have a midwife?

H: No, I had a doctor.

M: Do you know anything about midwifery in those days?

H: Oh, yeah. I know about them a lot. My brothers and sisters and their children had a midwife. Rosalie had a midwife with her first one. My oldest sister had a midwife. I was at home still single and lived at the house. They came back to Mommy's when their babies were born. They had a midwife. Most people did back a little earlier than my kids. They started having doctors a little more when I had my kids. We never thought about going to a hospital. I was in Shady when I had my kids. They didn't have nary hospital in Shady either. Both my kids were born in Shady Valley, Tenn.

M: What about what they ate. Did you have formula? Did you nurse them?

H: I nursed them.

M: Did you have to eat certain things?

H: No, I just ate like I always ate, and I had plenty of milk for the babies . . . I just ate anything I wanted.⁴⁰

The above interviews illumine the types of medical-related services available to the inhabitants of the Southern Appalachian region during the late nineteenth and early twentieth centuries. Typifying the lack of hospitals and scarcity of physicians, along with inhabitants' reliance on "homemade medicine" and the local midwife, these interviews demonstrate that the region's inhabitants used the limited avenues open to them regarding medical care, and they did not appear to suffer any ill effects due to that reliance.

⁴⁰B. Hines, interview by L. Martin, 20 June 1986, Interview TBC 1-8, transcribed by L. Martin, transcript, Burton Collection.

Examining published interviews completed since the mid-sixties on Southern Appalachian midwives/granny-women, the following excerpts express the critical need for the granny-woman and the high level of respect that many women accorded this healthcare practitioner. *Foxfire 2*, one volume in an extensive series of books covering all aspects of Southern culture, is perhaps one of the first texts to document, in interview format, the role of the midwife/granny-woman. A collection edited, and spearheaded, by Eliot Wigginton. Wigginton states:

For many people, however, midwives were the ideal solution: and for some, they were the only solution. Women were having babies faster than doctors could get to them, and they simply had to have help. The midwives were there, and in the course of their heyday, they touched an amazing number of lives.⁴¹

Quotes attributed to women relying upon the midwife/granny-woman, consented to the inclusion of their viewpoints in the *Foxfire 2* text. All women native to the Southern Appalachian region, direct insight regarding the access to “licensed physicians” and the level of service provided by the midwife/granny-woman can be found in the following excerpts.

Mrs. Robert Avery: It used t’be all they had nearly back in my early days. About all my family was delivered that way.

Mrs. Andy Webb: I’d rather have a midwife anytime as a doctor. They know their business, and a doctor don’t care. You *got that*, did ya? I ain’t no hand fer a doctor. I want ya’ to know and understand it. I ain’t. He might do somethin’ t’help your back, and then he’ll reach out and get your pocketbook and that’s all he wants. When I get in pain and get t’hurtin’ or get sick, th’midwife’s th’one I go to. That’s th’only one will help anybody if they ain’t got a big pocketbook.

Mrs. Jan MacDowell: My mother was a granny woman for about all of th’community. They come after her ‘cause she was their doctor. People’d come after her, and she’d just always go. They just depended on her same as th’d doctor.⁴²

⁴¹Wigginton, *Foxfire 2*, 282.

⁴²Ibid.

Foxfire 2 also represented divergent viewpoints regarding the role fulfilled by the midwife/granny-woman. Elizabeth Patterson's quote in *Foxfire 2* underscores one of those viewpoints from the perspective of a woman serving in the role of granny-woman.

Mrs. Elizabeth Patterson, whose mother was a midwife, carried a number of things with her whenever she made a call. A story that Mrs. Patterson told us about her mother not only detailed the materials she carried, but also gave some insight into why her mother was so careful and conscientious: 'She said one reason what started her to being a midwife – she'd had children, and once she had a midwife that really let her suffer a lot. After that, she had a good midwife – *Aunt Lizzzie* Keason they called her. And she was such a good midwife, Momma copied her, and said, 'Well, when she's not here, I'll help th'ladies. I won't let'em suffer.' She said right then she made up her mind she was going to help th'poor women if she could.⁴³

Archival and textual findings have revealed many specifics, as well as beliefs, associated with the role of granny-woman. The most discernible illustrate the elevated role the Southern Appalachian granny-woman played in rural communities across the region. The childbirth-related practices of the granny-woman, when evaluated against the documented evidence, do not reveal an erratic, nor dangerous, healthcare professional providing childbirth support services. Committed to the performance of these critical medical-related services for those living around her, the archival and textual findings endorse a high level of respect for this "unlicensed" healthcare practitioner who served the region during the late nineteenth and early twentieth centuries.

Current Respondent Findings

As stated earlier, interviews conducted for this study included white women who are native to the region and in possession of a direct ancestral link to a regional granny-woman (i.e., mother-to-daughter, grandmother-to-granddaughter, aunt-to-niece, great-aunt-to-great-niece). Also targeted were white lay midwives in current practice and native to the region, who may, or may not, possess a

⁴³Ibid., 283-284.

direct ancestral link to a Southern Appalachian granny-woman who provided healthcare from the 1880s to the 1930s. White women who have used the services of a granny-woman native to the region also were included. The first interview, considered minimal, provided insight regarding the relationships many practicing granny-women had with practicing physicians.

The interview participant, M. Mayo, is a sixty-three year-old massage therapist residing in Elizabethton, Tennessee. A native of Carter County, Tennessee, Mayo's maternal grandmother, Martha (Mattie) Lokey, served as a midwife/granny-woman in northern Alabama, an area considered part of the Southern Appalachian region. The recollections supplied by Mayo were brief, but insightful. Conducted on August 5, 2004, the interview took place in Johnson City, Tennessee.

Masters: What do you remember from your childhood about the assistance, or services, that were provided by your grandmother, who was a granny-woman/midwife?

Mayo: I really do not remember much, other than I know she provided assistance to many of the women, in her community, when it came to giving birth. Also, she always traveled [early twentieth century] with the local country doctor. That was one distinct point that I remember. My grandmother practiced in northern Alabama. As whether all midwives traveled with a doctor, I am unsure. But, I do remember that she accompanied the doctor on his rounds; and the mode of travel was horse and buggy.

Masters: Do you have any insight or information on any herbal remedies that she might have utilized in her "practice," especially related to childbirth prevention measures?

Mayo: No, I was young at the time; plus specifics surrounding those matters were not discussed with me, or with anyone else for that matter. And I didn't pick up any details along the way.⁴⁴

Though furnishing scant information regarding the hands-on practices of a midwife/granny-woman, Mayo did provide information integral to understanding the relationships of midwives/granny-women and physicians. Her recollections reveal that relationships between the midwife and the physician were not always tense. Additional study findings revealed boundaries

⁴⁴M. Mayo, interview by author, transcript, Johnson City, Tennessee, 5 August 2004.

occasionally formed between the midwives and the licensed physicians, a group rapidly encroaching on the territory midwives once had all to themselves.

The second interview conducted for this study was with N. Miller. A retired eighty-five year-old homemaker, Miller is a native of Sullivan County, Tennessee, and resides there today. The mother of four children, born between 1936 and 1950, Miller's second and third births were attended by Sullivan County Granny-woman Lou Ford. Miller entered the workforce, for the first time in 1967, after all her children were grown and moved to their own homes. Conducted on November 4, 2004, the interview took place in Blountville, Tennessee.

Masters: Do you have direct or indirect knowledge of obtainable herbal-related childbirth prevention measures during the 1880s-1930s?

Miller: No.

Masters: Do you have knowledge of herbal-related childbirth prevention measures being directly utilized by any of your peers?

Miller: No, but later in years I was told that if you missed a period hot ginger tea was good. And I was like I say married and had one child before I heard that. If you were married and there was any birth control protection talked about, I didn't know about it. It wasn't discussed.

Masters: Did your mother ever discuss any of this stuff with you?

Miller: Nothing. See when we were growing up you didn't discuss things like this. My mother didn't even discuss a pregnant woman with me before I was married.

Masters: How about friends? Was there any discussion of this [childbirth] with any of your friends or was it considered taboo, also?

Miller: No, it was taboo there also. This was something that just wasn't talked about. Sex, or anything about birth control, we just didn't know about it.

Masters: Are you aware of any of the local physicians, at that time, ever prescribing herbal remedies? Or did they prescribe "produced" medicines?

Miller: No.

Masters: Or did they prescribe "produced" [synthetic] medicines?

Miller: Oh yes, they always dilled out their little pills, you know, when you went to the little country doctor.

Masters: What year would you have started going to the doctor?

Miller: Well, my first remembrance of going to the doctor, when I was about five year old. My daddy took me on horseback. And I rode on a pillow, up front on the horse. I had an abscess in my groin and I rode on a pillow to Blountville. It was about four miles from my home to the doctor house, at Blountville. And he lanced that abscess. And I remember I had a little beaded purse with a chain handle and I carried that on my arm. He put a nickel in it. The doctor put a nickel in my little purse and I thought I was in seventh heaven. And his wife brought me a piece of cake in and gave it to me. I can remember that and I was about five years old. He said, 'Now you be a good girl and don't cry and maybe we'll give you something after this was over.'

Masters: Which of the following herbal-related measures do you have knowledge of being utilized during the 1880s-1930s? Such as the ginger tea.

Miller: I don't even know who told me that. But I just remember someone told me that if you missed a period, and you was pretty sure you weren't pregnant, you was just late for some reason, to drink hot ginger tea one and your period would come on.

Masters: Now that was in regard to late menses. Did anyone ever tell you about the herbal measures that you could use to literally to prevent the birth of a child?

Miller: No. I was never told any could be used for anything other than the colds, flus, and the chills.

Masters: OK, so all herbal measures were basically used to either change the obstructed menses problem or everyday ailments, not to aid in preventing the birth of a child.

Miller: No, because back then that was kind of an unheard of thing [reference to 1930s and later]. You didn't do that [abort a child].

Masters: Tell me about this list of herbal measures you have pulled together.

Miller: Catnip, then I had a bement tea. We went out and gathered it along the branch. Then we had cherry bark, we always made that. And then there was sassafras and pennyroyal.

Masters: The bement, the sassafras, and the cherry bark herbs, were they used in relationship to female problems or other things?

Miller: They were used for other things. Such as upper congestion, chills, colds.

Masters: What was pennyroyal used for?

Miller: It was just a hot tea that they made. They thought it was good for children – and babies, maybe for the colic.

Masters: Whenever that you were told about these herbs, what kind of recipes were you given or did somebody just reel this off?

Miller: They just went to stove and boiled it up, strained it, and then some sugar put in to make it drinkable.

Masters: You had no idea what the strength was?

Miller: No, but people survived it all those years. And we didn't go to the doctor, they never took us children to the doctor. Momma always had a remedy. The only time I went was for something that couldn't handle.

Masters: You have how many children?

Miller: Four, and now two of those were born with the doctor not there [1941 and 1944].

Masters: You had a midwife?

Miller: The doctor showed up later on.

Masters: Was there evidence that they might have traveled together at times, or did she leave when the doctor arrived?

Miller: No. When my first child was born, I was at my mother's home and my neighbor acted kind of as a midwife and she told Momma she'd come over there to be with her, and me, when the boy was born. And she came and Dr. Cole was my doctor and he had to come from Piney Flats. And the baby was born before he got there. She delivered the baby, our neighbor did. With my third child, born before Dr. Cole arrived again, Lou Ford was getting ready to tie the umbilical cord when Dr. Cole said, 'I'm too late.' Lou replied, 'I saved the tying of the cord for you.' Dr. Cole replied, 'Why don't you just go ahead and do it, you gotten through the hard part.'

Masters: Even if you had wanted to discuss something about some sort of contraceptive measure, how would that have been accomplished?

Miller: You wouldn't have dared mention this to your mother. It was just something you didn't talk about. And why was it such a secret? Why was that so taboo?⁴⁵

⁴⁵N. Miller, interview by author, transcript, Blountville, Tennessee, 4 November 2004.

The final interview conducted for this study was achieved with the assistance of M. Greene. An offset-press operator, Greene is a Johnson County native, and currently resides in Johnson City, Tennessee. Sixty-four years-old, and the mother of two sons, Greene is the granddaughter of a former Southern Appalachian midwife/granny-woman, Elizabeth E. Greene. Elizabeth Greene was born prior to 1880. Conducted on November 10, 2004, the interview took place in Johnson City, Tennessee.

Masters: Do you have knowledge of herbal-related childbirth prevention measures being directly utilized by any of your peers?

Greene: Regarding 'obstructed menses', the following was relayed to me by my cousin who is 78 years old. As a child she overheard my grandma talking to some other women and she was instructing them about a tea. If their period was late, they was to make this tea. I don't remember exactly what all you put in it; I do remember my grandmother mentioning ginger. And this tea would make them sick, but it would make them start their period.

Masters: Did your grandmother pass along any other specifics and had she selected one of her children, or anyone else, to follow in her footsteps?

Greene: Possibly, but I am not sure. I do have an aunt that is eighty-nine years-old and she might have been chosen by my grandma.

Masters: Are you aware of any formulas, or recipes, for any of the remedies utilized by your grandmother?

Greene: My grandmother knew all kinds of things though. If there was any formula, grandma would have known it. She might have been afraid to use it herself, because grandpa really ruled the roost. Grandma let him think he run everything, but Grandma was real cagey. If one of her daughters had gotten pregnant and she didn't need to be pregnant, and Grandma knew a formula, definitely she would have used it.

Masters: I am assuming out-of-wedlock is what you are talking about. Marriage-wise if you had gotten pregnant you would have had the baby.

Greene: Yes, that's right.

Masters: What do you think Grandma's philosophy would have been on married women should they have asked about herbal-based childbirth prevention measures?

Greene: If a married woman though she was pregnant and she did not want the child, maybe had two in diapers already, if it had been her own daughter Grandma would have helped her. I have an idea that she had one daughter that she probably did.

Masters: Then there may have been a usage of an herbal remedy in this case; you are just not sure what was used in this instance. I realize she ‘doctored’ the family, helped deliver babies; did she do this when she was having children of her own or did she start her ‘career’ later?

Greene: That I don’t know. The only thing I know for sure is we had a family that lived in the neighborhood as my Grandmother. There were rumors that one of the young girls was pregnant, about 14 or 15. And there were always rumors there was incest in the family. I remember Momma telling me they didn’t want anyone to know that the girl was pregnant. Grandma went to her house, I don’t know who she helped, but she delivered that baby. As to whether she was labeled as a midwife, I’m not sure, but she helped deliver that baby.

Masters: Do you know if she ever had a relationship with any of the local country doctors?

Greene: Grandma shunned doctors like the plague. Grandma seemed to have the opinion you only went to a doctor if nothing else could be done for you.

Masters: Do you know how she acquired this healing information?

Greene: No, but now with Grandma, there were stories that her mother was part Indian. But at that time people were real quiet about being Indian.⁴⁶

The personal interview process has been most enlightening. When considering the alternatives available to women during the late nineteenth and early twentieth centuries, choosing a herbal-based childbirth prevention measure may have been one of the least invasive measures available to women at that time. Yet, as documented in the current respondent interviews, there were definite limitations as to what herbal measures could be used for childbirth prevention because of the lack of information specific to those measures. The breakdown in oral tradition also is reinforced with the current respondent information.

Faced with societal condemnations related to childbirth prevention measures, choices were restricted, and if not restricted, controlled by those who did not require the use of those measures. According to Mary Roth Walsh control was held by the male-dominated “medical schools, hospitals,

⁴⁶M. Greene, interview by author, transcript, Johnson City, Tennessee, 10 November 2004.

and professional societies, the institutions, that for better or worse, made up the American medical establishment then as now.”⁴⁷

⁴⁷Walsh, *Doctors Wanted: No Women Need Apply*,” xiii.

CHAPTER 4

ANALYSIS AND CONCLUSIONS

In a March 1961 article, which discusses the changing role and function of the “granny” midwife, Beatrice Mongeau, Harvey Smith, and Ann Maney proposed viewing the practice of midwifery and its activities in the social context of the late nineteenth and early twentieth centuries. When “the practice and activities are caught in their social context in the telephoto lens, another institution emerges: simple, but nonetheless exhibiting a reasonably enduring, moderately complex, integrated pattern of behavior through which is met a basic social need for a specific group of people in a limited locale in a distinctive cultural environment, influencing and influenced by the surrounding institutionalized pattern of childbirth, yet maintaining its own distinctive characteristics.”¹ Accordingly, a viewpoint adhered to throughout the research process for this study.

“From classical antiquity onwards, we know that some form of birth-control has been practiced. Some of the ancients such as Plato, Aristotle and Polybius, specifically state that there were ways to control population, but failed to specify the means,” according to John Riddle.² Because the major responsibilities of pregnancy, birth, and child rearing fell on women, they found methods for controlling fertility and aborting unwanted children. Much of the knowledge surrounding those methods passed down through oral tradition. Nevertheless, as noted, in finding

¹Beatrice Mongeau, Harvey L. Smith, and Ann C. Maney, “The ‘Granny’ Midwife: Changing Role and Functions of a Folk Practitioner,” *The American Journal of Sociology* 66 (March 1961): 498. JSTOR. Available from <<http://www.jstor.org/jstor/>>, accessed 15 August 2004.

²John M. Riddle, “Oral Contraceptive and Early-Term Abortifacients during Classical Antiquity and the Middle Ages,” *Past and Present* 132 (August 1991): 32. JSTOR. Available from <<http://www.jstor.org/jstor/>>, accessed 22 November 2004.

after finding, very little of the knowledge possessed by the Southern Appalachian granny-woman concerning herbal-based birth control and abortion measures survived. At first glance, some of the study results may appear unrelated, but there are links among the findings. Foremost, however, research revealed women's approval regarding services provided by the Southern Appalachian granny-woman.

Damaged by negative innuendos, verbal and written, during the early twentieth century, the Southern Appalachian granny-woman was rendered defenseless in many ways. Attacks regarding the ministrations of these women served to damage the oral tradition adhered to by the granny-woman; a tradition that carried the preponderance of the knowledge held by these healthcare practitioners. Providing one insight for the success of these attacks Ina May Gaskin, founder and director of the Farm Midwifery Center, states,

The anti-midwife propaganda campaign carried out by organized medicine was not countered by any collective argument from midwives. This is why medicine was able to destroy midwifery with so little expense and effort. Even though there were tens of thousands of midwives at the time, their lack of state or national organization and the lack of midwifery schools meant that when each of the midwives dies, there was no one to replace her. Young women no longer saw midwifery as a possible career.³

Concurring with Gaskin's assessment to an extent, the results of this study revealed no signs of any "collective argument from midwives."⁴ Assessing discussions with current interview participants, as well as those interviewed for the Burton and Cavender collections revealed that it is highly unlikely that Southern Appalachian midwives would have launched a retaliatory effort because they were not organized.

³Ina May Gaskin, "A Vision for Midwifery in the United States," *Midwifery Today*, 60 (Winter 2001): 22. OneFile Plus, InfoTrac. Available from <<http://web5.infotrac.galegroup.com>>, accessed 15 October 2004.

⁴Ibid.

Adding to that lack of organization was the philosophy some granny-women had about physicians in the region. A small number of the personal interview results provide contrasting viewpoints regarding the cooperation between the granny-woman and ‘trained’ physician. Some interview responses revealed minimal encounters with the local practicing physician, while other responses depicted a respectful working relationship between the two factions. As detailed in the Greene interview, some midwives/granny-women serving the Southern Appalachian region “shunned doctors like the plague.”⁵

The lack of a positive co-existence with local physicians served to hasten the demise of granny-women choosing this path of resistance. Discussing midwifery practices of her midwife-grandmother, Elizabeth E. Greene, M. Greene states, “Grandma seemed to have the opinion you only went to a doctor if nothing else could be done for you.”⁶ Without a like-minded woman to continue on in the capacity of a midwife—a midwife avoiding interaction with the rapidly changing medical world—most healthcare practices would be lost with their deaths, in part explaining the loss of herbal-based practice knowledge.

Assisted at the births of two children by Southern Appalachian Granny-woman Lou Ford, interview participant N. Miller did not provide any herbal-based childbirth prevention information, which would have come directly from her relationship with Ford, rather than her mother. Miller vehemently stressed that people living during the early part of the twentieth century did not discuss childbirth prevention or contraception, especially with their mothers. “See when we were growing up you didn’t discuss things like this. My mother didn’t even discuss a pregnant woman with me

⁵M. Greene, interview by author.

⁶Ibid.

before I was married,” stated Miller.⁷ Interview participant Greene concurred with the statements of Miller regarding family discussions surrounding childbirth or sexual relationships.

Here it must be noted Miller provided insight regarding the relationship of Granny-woman Lou Ford with the local country doctor, Dr. Cole. Ford and Cole provided childbirth support practices in tandem. The “respect factor,” relayed by Miller, proved to be equal. As Miller detailed in her interview, often Dr. Cole arrived after the birth had occurred, suggesting a reversal of roles did not produce conflict. Stretched by severely limited number of trained physicians, the local physician in this case depended heavily on the expertise of the granny-woman.

The expertise of the granny-woman related to herbal remedies also emerged during the research and interview processes. As stated by D’Emilio and Freedman, “In the early nineteenth century, and in rural areas for many later generations, herbal and home remedies for terminating unwanted pregnancies continued to be passed on through oral tradition. Native American healers and midwives prescribed roots or herbs known to induce abortion.”⁸ However, both Greene and Miller, for example, stated that herbal remedies were used regularly when they were children, but neither participant had any idea of how the midwife obtained information about the remedy! In Greene’s case, a practicing granny-woman, as well as Greene’s grandmother, did not pass on, or reveal specifics for the herbal remedies she used.

The specifics of folk medicine practices detailed in the Haun text *The Hawk’s Done Gone and Other Stories*, support the idea that granny-women received specific herbal remedies through oral tradition, and that a midwife in training received information through an apprenticeship with an elder midwife. Endorsing the limited transfer of herbal-related knowledge the Haun text further

⁷N. Miller, interview by author.

⁸D’Emilio and Freedman, *Intimate Matters*, 65.

indicated prevention measures were used only in certain circumstances. Haun's illustration targeted using the herbal prevention measure pennyroyal. The incident portrayed revealed use of pennyroyal to induce a miscarriage in order to prevent the birth of a mixed-race child. This illustration did target a specific circumstance where the Southern Appalachian granny-woman might have provided herbal-based remedy details, if consulted.

Interjecting specific information related to a prevention measure this volatile, Haun underscores the level of caution used by the Southern Appalachian granny-women regarding the use of this herb as a birth control measure. A text published in 1940, discussing an area of women's health [especially childbirth prevention in detailed format], signifies a much broader agenda. Initially highlighting the level of caution, Haun's inclusion of folk medicine reinforced the existence of knowledge surrounding such prevention measures within the confines of one specific group—granny-women. Haun also managed to emphasize accurately the lack of control women had regarding the prevention of childbirth during the late nineteenth and early twentieth centuries. Thus, many regional women were left with few choices for childbirth prevention.

However, ginger root tea surfaced during the respondent interview process, as well as findings gleaned from the Burton and Cavender Collections for the "suppression of menses." Study results endorsed ginger tea being used, primarily, for the "suppression of menses." Documented specifics associated with this herb lead this researcher to conclude that ginger tea's medicinal properties could produce much the same results as pennyroyal. According to *Wise Woman Herbal for the Childbearing Year* author, Susun Weed when "you become nauseated by drinking Ginger, you have a strong indication that you are pregnant."⁹ Established earlier, both Greene and Miller stated in their respective interviews that herbal remedies were used, regularly, when they were children, but

⁹Weed, *Wise Woman Herbal*, 7-8.

neither participant recalled specific ingredients. During the interview process, both women endorsed the use of a ginger tea remedy related to menstrual concerns. The Greene interview revealed the following:

As a child she [cousin] overheard my grandma talking to some other women and she was instructing them about a tea. If their period was late, they were to make this tea. I don't remember exactly what all you put in it; I do remember my grandmother mentioning ginger. And this tea would make them sick, but it would make them start their period.¹⁰

Because current-day author Susun Weed explains that nausea indicates pregnancy when using ginger tea as an emmenagogue, the dual use of this herb strongly suggests that certain herbal remedies were prescribed by both granny-women and physicians, that would accomplish both, whether it was “suppression of menses” or childbirth prevention. Both groups logically deduce that “suppression of menses” might indicate a child was on the way, in some cases.

Specific details for ingredient measurements related to the use of pennyroyal for the “suppression of menses” are documented in historical studies, such as Clarence Meyer's *American Folk Medicine* and linked to physician-based intervention. While the excerpted passages of *The Hawk's Done Gone* documented the use of pennyroyal as birth control, additional study results revealed the use of pennyroyal for the “suppression of menses.” Again, a herb that has been demonstrated to have dual use—whether used for “suppression of menses” or childbirth prevention—pennyroyal may have accomplished both.

Additional corroboration of physician intervention related to childbirth prevention surfaced during examination of the interviews conducted for the Cavender Folk Medicine Study. CFMS participant no. 69 and participant no. 84, verified abortion occurred. Insight on the occurrence of abortion-related practices, stipulated by CFMS participant no. 84, a native of Sullivan County,

¹⁰M. Greene, interview by author.

revealed that abortions were “common,” yet rarely “discussed.”¹¹ This reference of ‘common’ is not quantifiable; however, CFMS participant no. 84 did confirm that the medical procedure occurred. How many women living during the late nineteenth and early twentieth centuries fit into this category is unknown. It is logical to conclude that even physicians performed the procedure rarely. Many female inhabitants of the Southern Appalachian region produced large families. By 1880 most families were producing 4.24 children; many regional women far surpassed the U.S. average.¹²

Confirmed earlier by D’Emilio and Freedman, and referencing the beginning of the nineteenth century: “a married couple had an average of slightly over seven children . . . and by 1880, only 4.24.”¹³ Applying these statistics to women of the Southern Appalachian region, most were producing children at the same rate in the first-half of the twentieth century as all United States women in the early part of the nineteenth century, a rate uncommon for much of the United States. These statistics suggest childbirth prevention measures were secondary concerns for many regional women. Granted, most of the women would not have chosen to use childbirth prevention measures, but provided with the knowledge of an available measure some women might have chosen to control childbirth.

If attempting to prevent childbirth, women during the late nineteenth and early twentieth centuries often faced using prevention measures that would be considered highly offensive and unpleasant by women today. Yet, as discovered throughout this study, access to knowledge surrounding herbal-based childbirth prevention measures was limited for Southern Appalachian women living during the late nineteenth and early twentieth centuries. Study interviewees, who

¹¹Cavender Collection, personal interview, CFM-84.

¹²D’Emilio and Freedman, *Intimate Matters*, 58.

¹³Ibid.

used a granny-woman during childbirth, were not provided with any specifics about herbal-based remedies for childbirth prevention. When reviewing the study findings regarding a healthcare support role too often associated with abortion, research results reveal a much different picture of that aspect. Interview information obtained in the Cavender Folk Medicine Study reveals, in more than one interview, that a number of Appalachian inhabitants support the belief that local physicians performed abortions.

Even though the issues examined throughout the study may seem commonplace to some, [for the time frame discussed in this study] the ability to make “planned” choices of any sort seemed unattainable for women living then. It cannot be denied that the Southern Appalachian granny-woman often served as the first “line of defense” for women awaiting the birth of a child, but these women rarely, if ever, supplied specific information regarding herbal-based birth control or abortive measures. The interviews conducted for this study support this conclusion, as do the Burton and Cavender interviews.

For the majority of women today being empowered is associated with the “ability to make decisions and affect outcomes of importance to themselves and their families,” particularly in regard to childbirth and its prevention.¹⁴ To be in control of one’s physical well-being permeates health-related concerns confronting women living in today’s society. On the average, women who choose motherhood today will give birth once or twice in their lifetimes. Today’s women do have options, choices, and control over when, and if, to have children that were not available to Southern Appalachian women living in the late nineteenth and early twentieth centuries.

¹⁴Malhotra, Schuler, and Boender, “Measuring Women’s Empowerment as a Variable in International Development,” 5.

In current society, a woman may spend only eighteen to twenty years dedicated to birth and child rearing—one-half of the time spent by women in the late nineteenth and early twentieth centuries.¹⁵ Today women are provided with many avenues that can be used to make “planned” choices regarding birth control; moreover, women perform very different roles in the overall care of the family unit. Most American women are empowered with a level of control through current birth control and abortion measures that, in effect, allows predetermining the addition of children to the family unit. For women living in the late nineteenth and early twentieth centuries, a much different atmosphere existed.

As discussed earlier, the enactment of abortion laws, the proposed elimination of the granny-woman/midwife, and the lack of communication surrounding the subject of childbirth among women living during the late nineteenth and early twentieth centuries, produced results that offered them little control. Unable to control the political and societal changes, many regional women were left without the healthcare practices of the Southern Appalachian granny-woman. With the elimination campaign denigrating the healthcare practices of the Southern Appalachian granny-woman, women were left with little control over a reproductive function that today is controlled by the majority of American woman. When considering alternatives available to women during the late nineteenth and early twentieth centuries, an herbal-based remedy for childbirth prevention may have been one of the few measures available.

Today, midwifery has regained a respected place in the medical world and continues to evolve into a profession dedicated to supporting one of life’s most memorable moments—the birth of a child. Women today choosing to use the services of a certified nurse-midwife/certified midwife have the option of considering abortion-related measures. According to Deborah Narrigan, C.N.M,

¹⁵Wertz and Wertz, *Lying-In: A History of Childbirth in America*, 2-3.

M.S.N., “The safety of first-trimester abortion provided by nurse practitioners and physician assistants has been established.”¹⁶ In “Early Abortion: Update and Implications for Midwifery Practice,” Narrigan states certified nurse-midwives and certified midwives received “collegial support for providing abortion in 1994, when the American College of Obstetricians and Gynecologists’ Board of Directors issued a statement encouraging programs to train physicians and other licensed health care professionals to provide abortion services in collaborative settings.”¹⁷

Considered “an integral part of the reproductive health care continuum,” the practices and services provided by today’s midwife have come full circle.¹⁸ Allowed to provide “childbirth prevention measures,” today’s midwives have choices the “granny-women” of the late nineteenth and early twentieth century did not have due to the medical profession’s campaign to eliminate them. The “granny-women” of the late nineteenth and early twentieth centuries should be commended for providing healthcare for those living around them, particularly during a time when they faced unjustifiable criticism aimed to abolish midwifery.

¹⁶Deborah Narrigan, “Early Abortion: Update and Implications for Midwifery Practice,” *Journal of Nurse-Midwifery* 43 (November/December 1998): abstract, [journal online]; available from ScienceDirect.com Database, <<http://www.sciencedirect.com/science>>, accessed 19 July 2004.

¹⁷Ibid., 498.

¹⁸Ibid., 492.

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APPENDIX

EAST TENNESSEE STATE UNIVERSITY
INTERVIEW/SURVEY OUTLINE

“A Study of the Southern Appalachian Granny-Woman related to Childbirth Prevention Measures”

MALS-5960/Thesis Research

Fall Semester 2004

1. Name _____
Address: _____

Phone: _____
2. Interview date, time, and place: _____
3. Age: _____
4. Birthplace, birth date _____
5. Nationality: _____
6. Occupation: _____
7. Do you have direct or indirect knowledge of obtainable herbal-related childbirth prevention measures during the 1880s-1930s?
 - a. yes
 - b. no
 - c. unsure
 - d. N/A
8. How did you acquire knowledge related to these herbal-based childbirth prevention measures?
 - a. through oral tradition from other midwives
 - b. through written format [i.e., diary, journal, text]
 - c. through oral tradition from other source
 - d. N/A
9. What was the frequency these measures were utilized, overall?
 - a. frequently utilized
 - b. occasionally utilized
 - c. never utilized
 - d. N/A
10. Do you have knowledge of herbal-related childbirth prevention measures being directly utilized by any of your peers?
 - a. yes
 - b. no
 - c. unsure
 - d. N/A

Participant's initials _____

11. Do you have knowledge of this information being requested from a granny-midwife practicing during the 1880s-1930s by childbearing age women?
 - a. yes, as a prevention measure
 - b. no
 - c. yes, but for a birth control measure, not a prevention measure
 - d. N/A

12. Do you have knowledge that this information was provided to the women seeking herbal-related assistance in childbirth prevention?
 - a. yes
 - b. no
 - c. unsure
 - d. N/A

13. Which of the following herbal-related measures do you have knowledge of being utilized during the 1880s-1930s?
 - a. tea derived from pennyroyal
 - b. tea derived from Queen Anne's lace
 - c. other
 - d. N/A

14. What was the marital status of the childbearing age women requesting information regarding herbal-related measures used to prevent childbirth?
 - a. married
 - b. single
 - c. unknown
 - d. N/A

This interview/survey format was developed as a research tool for MALS 5960 -Thesis Research, completed during Fall Semester 2004. Dr. Michael Pinner, Ph.D., Thesis Advisory Chair, East Tennessee State University. Designed by: Harriet P. Masters, July 7, 2004.

Participant's initials _____

VITA

HARRIET P. MASTERS

- Personal Data: Date of Birth: December 31, 1955
 Place of Birth: Bristol, Tennessee
 Marital Status:
- Education: Public Schools, Sullivan County, Tennessee
 East Tennessee State University, Johnson City, Tennessee
 Law Enforcement, A.S.L.E. 1976
 East Tennessee State University, Johnson City, Tennessee
 General Studies and Business Management, B.G.S. 1996
 East Tennessee State University, Johnson City, Tennessee
 Liberal Studies, M.A.L.S. 2005
- Professional
Experience: Information Research Technician, East Tennessee State University,
 Alumni Relations, 1979-1989
 Office Supervisor, East Tennessee State University,
 Office of University Relations, 1989-1992
 Information Research Technician, East Tennessee State University,
 Alumni Relations, 1992-1994, and Pirate Club, 1995-1998
 Director, East Tennessee State University, Women's Resource Center,
 1999 to present
- Honors and
Awards: Omicron Delta Kappa National Leadership Honor Society,
 East Tennessee State University, 2004
 Phi Kappa Phi Honor Society, East Tennessee State University, 2005