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“Safeguarding the health of mothers and children”: American democracy and maternal
and children’s healthcare in America, 1917-1969

By

Nancy Jane Traylor

A Dissertation
Submitted to the Faculty of
Mississippi State University
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Philosophy
in History
in the Department of History

Mississippi State, Mississippi

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2018

“Safeguarding the health of mothers and children”: American democracy and maternal
and children’s healthcare in America, 1917-1969

By

Nancy Jane Traylor

Approved:

M. Kathryn Barbier
(Major Professor)

Courtney Thompson
(Committee Member)

Alan I. Marcus
(Committee Member)

Matthew Lavine
(Committee Member)

Richard V. Damms
(Committee Member)

Stephen C. Brain
(Graduate Coordinator)

Rick Travis
Dean
College of Arts & Sciences

Name: Nancy Jane Traylor

Date of Degree: August 10, 2018

Institution: Mississippi State University

Major Field: History

Major Professor: Mary Kathryn Barbier

Title of Study: "Safeguarding the health of mothers and children": American democracy and maternal and children's healthcare in America, 1917-1969

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Candidate for Degree of Doctor of Philosophy

This study examines major American maternal and children's healthcare initiatives in the backdrop of international and national crises from 1917 to 1969. During these crises, maternal and child welfare reformers used the rhetoric of citizenship and democracy to garner support for new maternal and child healthcare policies at the national level. While the dissertation focuses on national policies, it also explores how state public health officials from Alabama, Mississippi, and New York implemented these programs and laws locally. The dissertation chapters study regional similarities and differences in maternal and child healthcare by highlighting how economy, culture, and politics influenced how national programs operated in different states.

By utilizing White House Conference on Children and Youth Series sources, state public health records, and newspapers, this dissertation argues that by using rhetoric about protecting mothers, children, and American democracy, the Children's Bureau (CB) members claimed and maintained control of maternal and child health care for over fifty years. CB leaders used World War I draft anxieties as a rallying call to reduce infant mortality and improve children's health. In the following decades, maternal and

children’s healthcare advocates met at the White House Conference on Children and Youth Series to discuss policies and influence legislation relating to maternal and child hygiene. The Sheppard-Towner Program, Title V of the Maternal and Children’s Health Section of the Social Security Act, and the Emergency Maternity and Infancy Care Program reflect policies debated at these White House conferences. By the 1950s, child welfare advocates associated mental health with a child’s overall health and the CB leaders and other child welfare reformers linked happy personalities to winning the Cold War. In the 1960s, the CB members and child welfare advocates’ attention shifted to focusing on low socio-economic mothers and children or children with intellectual disabilities. By 1969, the Children’s Bureau no longer managed national maternal and child healthcare programs and could not “safeguard the health of mothers and children.”¹

¹ “Safeguarding the Health of Mothers and Children” was a reoccurring article in the Children’s Bureau journal, *The Child*.

DEDICATION

In memory of my wonderful mother: Debbie Morgan Traylor (1957-2017)

For my beloved husband: Travis Heard

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She offered valuable critiques and advice. I appreciate you dedicating so much time to my project and challenging me to be bolder. To Dr. Matthew Lavine, thank you for persuading me to study the history of medicine. I appreciate you listening and reading much of my work. Dr. Richard Damms taught the post-1945 United States History course I took and expanded my interest into the early Cold War. He also helped me improve my writing skills. Dr. Alan Marcus encouraged graduate students to present their work at conferences and to develop professionalism. I appreciate him instilling these values in me and for securing funding for graduate school. Dr. Jessica Martucci provided input for the early portion of this project. She helped build my foundation in the history of medicine.

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ACRONYMS FOR ORGNIZATIONS AND EVENTS

Name of Organization or Event	Acronyms
Alabama State Board of Health	ASBH
American Medical Association	AMA
American Red Cross	ARC
Committee on Economic Security	CES
Emergency Maternity and Infant Care	EMIC
Midcentury White House Conference on Children and Youth	MWHCCY
Midcentury White House Conference on Children and Youth Fact Finding Committee	FFC
Mississippi Children's Code Commission	MCCC
Mississippi Minimum Foundation Educational Program	MFEP
Mississippi State Board of Health	MSBH
New York State Committee of One Hundred Education Section	ES
New York State Committee of One Hundred on Children and Youth	NYCOHCY
Social Security Act	SSA
United States Children's Bureau	CB
United States Public Health Service	USPHS
White House Conference on Child Health and Protection	WHCCHP
Woman's Committee of the Council of National Defense	WCCND
World Health Organization	WHO

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CHAPTER I

INTRODUCTION

“THE DRAFT REVELATION HAVE [sic] OPENED OUR EYES.”² When the United States entered World War I, the draft shocked the public because one in four potential draftees suffered from childhood diseases or malnourishment. The Child Health Service Division of the Bureau of Education stated, “We determined that such a situation should not overtake us again in the future.”³ The Child Health Service Division leaders believed that each American school needed a scale and a measuring stick, so teachers could weigh and measure students. The teachers would be on the forefront in detecting malnourishment. The Children’s Year (April 1918-April 1919), a United States Children’s Bureau (CB) sponsored program, launched these efforts to protect future generations of Americans. Many of the maternal and children’s health campaigns of the first half of the twentieth century used the rhetoric that children were the future of American democracy.⁴

² “Wanted Teachers to Enlist for Child Health Service!”³, c. 1919, Folder: “CWC# 36: Red Cross Health Program, January 20, 19,” Box: “905: 15-B-17 Child Welfare Circulars to 15-B19 Manuscripts for Misc. Letters” Series: “7: Records of the Field Division,” Record Group: “62: Records of the Council of National Defense,” National Archives and Records Administration II, College Park, Maryland.

³ Ibid.

⁴ On April 9, 1912, Congress and President Howard Taft created the CB, a government agency to investigate issues regarding child welfare. During the first year, the CB had a paltry budget of \$25,640. In the early years, the CB workers investigated and reported on infant mortality and child welfare. Kriste Lindenmeyer, *A Right to Childhood: The U.S. Children’s Bureau and Child Welfare, 1912-1946* (Champaign: University of Illinois Press, 1997), 1.

This dissertation studies major American maternal and children's health initiatives in the context of international and national crises in the first half of the twentieth century. This dissertation argues that child welfare advocates utilized these crises to generate public interest in their plans to advance maternal and children's healthcare. These advocates included people such as Julia Lathrop, Grace Abbott, Katharine Lenroot, Martha Eliot, Jeannette Rankin, Herbert Hoover, Harry Truman, Felix J. Underwood, and Margaret Mead. Other advocates ranged from teachers to public health nurses. CB leaders politicians, and state public health officials rhetorically linked the health of American mothers and children to the strength of the country and American democracy. From World War I to the early Cold War, some policymakers and social activists such as Montana Representative Jeannette Rankin exploited international and internal struggles by emphasizing fears of deteriorating maternal and child health. By promoting these ideas and images, these activists launched maternal and children's public health reforms. These maternal and children's welfare reformers associated maternal and children's health with larger goals of maintaining democracy, propagating Americanization, citizenship, and the duty of the government to protect the health of its citizens. The CB believed that caring for American mothers and children during times of crisis would help children grow up to be proper American citizens who embraced democratic values. Furthermore, healthcare reform would prevent mothers and children from becoming unfit citizens when the country needed them as adults during an emergency. In the first few decades of the century, the CB and other child welfare activists such as maternalists focused on maternal hygiene and infant care. By the late 1920s and early 1930s, the CB expanded its efforts to include preventative medicine for

children. During World War II, the psychological health of mothers and children on the home front continued to concern many. Shortly thereafter, child welfare advocates began to focus on physical and mental health of children.

This dissertation intersects with many historiographies including the history of public health, maternal and children's history, and the history of the American home front. This dissertation responds to a specific set of works that examine the history of the Children's Bureau and maternal and child healthcare. In addition, the study further explores the concept of scientific motherhood that historians such as Rima Apple and Molly Ladd-Taylor discussed. This dissertation highlights scientific motherhood on both the national and local levels.

Many historians have examined the origins of the CB as an offshoot of the Progressive Era. Historian Kriste Lindenmeyer's book, *A Right to Childhood: The U.S. Children's Bureau and Child Welfare, 1912-46*, explained that Florence Kelley, a Progressive champion of children's welfare, used the rhetoric of citizenship and democracy to promote child welfare. Kelley noted that "the noblest duty of the Republic is that of self-preservation by so cherishing all its children that they, in turn, may become enlightened self-governing citizens."⁵ Lindenmeyer embraced Kelley's phrase "a right to childhood" and argued that from 1912 to 1946, the CB was "the primary voice for children" and wanted to improve conditions for the "whole child."⁶ The CB plays a key

⁵ Ibid., *A Right to Childhood: The U.S. Children's Bureau and Child Welfare, 1912-46*, 1. For more on the rhetoric of democracy see: Gerard Hauser and Amy Grim, *Rhetorical Democracy: Discursive Practices of Civic Engagement* (New York: Routledge, 2004); Andrew Whitmore Robertson: *The Language of Democracy: Political Rhetoric in the United States and Britain, 1790-1900* (Charlottesville: University of Virginia Press, 1995).

⁶ Ibid.

role in this dissertation, which further studies the idea of child welfare advocates using rhetoric about democracy or democratic values to push child healthcare agendas.⁷ CB officials believed that raising healthier American children with middle-class values would benefit the nation by producing a fit citizenry with a uniform belief system—Christian, democratic-minded, and middle-class.⁸

This dissertation emphasizes the importance of The White House Conference on Children and Youth Series. This series has often been overlooked in the history of maternal and child healthcare because many scholars place more emphasis on legislation or specific programs. This study contends that these conferences reflected the concerns of child welfare advocates at the time and are therefore essential sources for understanding contemporary anxieties and policies. Unfortunately, sources from the first two conferences in 1909 and 1919 are scarce. Sources from the third conference, the White House Conference on Child Health and Protection (WHCCHP), highlight the CB members' concerns about the repeal of the Sheppard-Towner Act and the debate between the CB and doctors in favor of the United States Public Health Service controlling maternal and child health programs. By the late 1930s, the nation's leaders and child welfare advocates were concerned with the spread of totalitarian government and the war in Europe. At the January 1940 White House Conference on Children in a Democracy, the delegates emphasized the importance of providing healthcare for mothers and

⁷ From 1918 to the 1950s, child welfare advocates usually use the terms democracy or democratic values rather than republic.

⁸ For more information on the Children's Bureau see: Alice Boardman Smuts, Robert W. Smuts, R. Malcolm Smuts, Barbara B. Smuts, and P. Lindsay Chase-Lansdale, *Science in the Service of Children, 1893-1935* (New Haven: Yale University Press, 2006); Nancy Pottishman Weiss, "Save the Children: A History of the Children's Bureau, 1903-1918 (PhD diss., University of California at Los Angeles, 1974).

children to protect American democracy. By 1950, midcentury delegates worried about the early Cold War. The Midcentury White House Conference on Children and Youth organizers' goal was for American children to have happy personalities. This dissertation shows the significance of the conferences as a place of dialogue where maternal and child healthcare policies developed and expanded and locates these conferences as crucial moments through which historians can trace shifting priorities.

This dissertation makes many contentions about regional similarities and differences in maternal and child healthcare. It examines the implementation of the CB national policies and programs at the local level. While the CB remained a key character, state public health personnel and child welfare advocates were necessary to carry out these plans in states. Chapters Three through Six offer case studies of Alabama, Mississippi, and New York. These case studies help provide a better understanding of national maternal or child health programs on the local level. Many scholars have discussed Southern midwives and healthcare, but more attention to the public maternal and child healthcare system in the South provides a fuller picture. This dissertation allows readers to see how southern public health officials implemented national programs, such as the Sheppard-Towner program, to accommodate local customs like racial as segregation. In some chapters, southern examples are compared with New York. The case studies of Mississippi and New York maternal and child health programs highlight the differences between the existing public health infrastructures in each state. In addition, these case studies demonstrate how local demographics, culture, politics, and economy affected the implementation of these programs.

Scholars have also discussed American maternal and child welfare at large.⁹ This dissertation supports the claim that welfare policies were gendered in tone and that child welfare advocates believed that mothers and children needed protection. In *Civilizing the Child: Discourses of Race, Nation, and Child Welfare in America* (2013), Katherine Bullard asserts that from the late nineteenth century to the early twentieth century, American child welfare advocates supported reform for white children, situating this with regard to “larger discourses of race and colonialism.”¹⁰ Bullard’s use of contemporary discourses influenced this dissertation because current rhetoric and events swayed CB members and child welfare advocates, who were developing the maternal and child healthcare programs throughout the first half of the twentieth century. International and national crises shaped the programs that emerged. Bullard also contended that the reformers wanted to provide welfare programs to lower-class white children to promote a stronger nation, both militarily and economically.¹¹ By WWI, the CB’s ideals were to address the health of all American children to protect the country from facing a military draft shortage in the future. Yet, race also factored into the programs, and lower-income

⁹ For more information on American maternal and child welfare consult: Linda Gordon, *Pitied But Not Entitled: Single Mothers and the History of Welfare, 1890-1935* (New York: The Free Press, 1994); Molly Ladd-Taylor, *Mother-Work: Women, Child Welfare, and the State, 1890-1930* (Champaign: University of Illinois, 1994); *Mothers and Medicine*; Rima Apple, *Perfect Motherhood: Science and Childrearing in America* (New Brunswick: Rutgers University Press, 2006); Rebecca Jo Plant, *Mom: The Transform of Motherhood in Modern America* (Chicago: University of Chicago, 2010); Richard A. Meckel, *Save the Babies: American Public Health Reform and the Prevention of Infant Mortality, 1850-1929* (Ann Arbor: University of Michigan Press, 1990); Robyn Muncy, *Creating a Female Dominion in American Reform, 1890-1935* (Oxford: Oxford University Press, 1991).

¹⁰ Katharine Bullard asserted that the Children’s Bureau’s programs were designed to give the appearance of assisting all American children, but, only helped white children. Katharine Bullard, *Civilizing the Child: Discourses of Race, Nation, and Child Welfare in America* (Lanham: Lexington Books, 2013), 1-6.

¹¹ *Ibid.*, 2.

and minority children often had less access to the health services they needed. Even so, public health officials treated thousands of southern African American mothers and infants using funds from CB programs. During the 1910s and 1920s, the American healthcare system reformed, and the state of the public and private health sectors affected maternal and children's health.

The dissertation traces maternal and child healthcare from World War I to the early 1960s. During World War I, the CB leaders portrayed children as the future generation of citizens to garner support for The Children's Year, a yearlong program that sought to improve children's health. From the 1910s to the 1950s, the CB used the idea of citizenship to secure control of maternal and child healthcare programs. Other competing agencies such as the United States Public Health Service wanted to maintain the maternal and infant healthcare programs, but CB leaders fought to continue operating the national policies. During this period, the CB operated their plans within America's dual system of public and private healthcare. The CB members realized that some Americans could afford private medical care for their children, while others relied on public health services. The maternal and child healthcare programs focused on preventative care and treatment of physical ailments. By the 1950s, social scientists began debating childhood personality and child healthcare programs started incorporating mental healthcare for children. These programs focused on the healthcare of all American children, either in the private or public health system. By the 1960s, most children were being vaccinated and preventative medicine campaigns were successful because the children were protected from deadly diseases such as diphtheria. In the 1960s, the CB delegates and the child welfare advocates shifted their focus to specific children with intellectual disabilities and

impoverished women. The CB supported family planning in order to protect women's health and to prevent too many children being born into unstable or low-socioeconomic homes. During this period, the American medical system was in transition and many professionals debated the prospect of socialized medicine. Physicians worried that socialized medicine would threaten medical autonomy and authority. These CB programs fit into the larger context of this debate.

Some historians have focused on important shifts in the American medical system such as professionalization or the rise of the hospital.¹² This dissertation follows many of the transformative periods in American medicine. For instance, the 1930s was a decade of welfare medicine and maternal and children's health officials sought appropriations for their cause.¹³ The CB secured a public health campaign for mothers and children in Title V of the Social Security Act of 1935. As the narrative of this dissertation moves forward in time, public health and mental healthcare fields expanded and pediatrics became a legitimate profession¹⁴

¹² For syntheses of the transforming American medical system consult: Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982); John C. Burnham, *Health Care in America: A History* (Baltimore: Johns Hopkins University, 2015). For the history in the American hospital and hospital maternity care see: Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (Baltimore: Johns Hopkins University, 1995); Richard and Dorothy Wertz, *Lying-in: A History of Childbirth in America* (New Haven: Yale University Press); Judith Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750 to 1950* (Oxford: Oxford University Press, 1988).

¹³ Paul Starr, *The Social Transformation of American Medicine*, 266-275.

¹⁴ For the history of pediatric view: C. Becket Mahnke, "The Growth and Development of a Specialty: The History of Pediatrics," *Clinical Pediatrics* 39, no. 12 (December 2000): 705-714; T.E. Cone, *History of American Pediatrics* (Boston: Little, Brown, and Co., 1979); Jeffrey Baker and Howard Pearson, *Dedicated to the Health of All Children* (Elk Grove Village: American Academy of Pediatrics, 2005). For information on mental health: Edwin Fuller Torrey, *Out of the Shadows: Confronting America's Mental Illness Crisis* (Hoboken: John Wiley, 1997).

The dissertation chapters are two tiered: the examination of the national policies or programs and the implementation of these programs and policies on the local level. Chapter Two explores The Children’s Year, a year-long program to improve the health of children by weighing and measuring children to diagnose malnutrition. The effort derived from the high number of World War I draft rejections, whose health problems could have been corrected during childhood. The Children’s Bureau, a newborn federal agency, created in 1912, used anxieties about World War I and the rejectees to justify the need for a children’s public health campaign. The Children’s Year initiative identified thousands of malnourished children and helped standardize height and weight charts for young children. This chapter contends that the Children’s Year led to the development of maternal and child welfare departments and maternal and child hygiene divisions in many states.

Chapter Three, “The Sister States’ Community Health Programs: The Sheppard-Towner Act in Mississippi and Alabama, 1921-1929,” provides two state case studies into the implementation of the Sheppard-Towner Act, also known as the Promotion of the Welfare and Hygiene of Maternity and Infancy Act of 1921. This nationwide campaign to improve maternal and young children’s health promoted the expansion of southern community health programs. This study asserts that Alabama and Mississippi state public health officials accepted the Sheppard-Towner program because it allowed them to organize maternal and child community health models that represented the Deep South’s peculiar economy, public health infrastructure, culture, and racial politics. To protect the whole community, the state public health officials valued the health of all mothers and children. Under the new law, southern public health agencies grew and began hiring

public health nurses, who treated and educated mothers and infants. Health departments also utilized these Sheppard-Towner nurses to vaccinate and treat many school-aged children. In 1929, funds for the Sheppard-Towner Act ceased, but Alabama and Mississippi were already invested in protecting their mothers and infants. The states would have to turn to other federal sources to supplement their health departments during the early Great Depression.

During the Great Depression years, the federal government created programs to address the many issues created by the financial crisis. Chapter Four, “‘A Tremendous Stimulus’: Maternal, Infant, and Children’s Health during the Great Depression,” outlines three federal actions to improve maternal and infant healthcare from 1929 to the beginning of World War II. This chapter contends that during the Great Depression, the Children’s Bureau and other child welfare advocates focused on needy mothers and children to ensure that maternal and child health programs expanded and improved. After the end of the Sheppard-Towner funds, the Children’s Bureau lobbied to ensure that maternal and children’s healthcare funding was secure. In 1929, President Herbert Hoover announced that his administration would host the White House Conference on Child Health and Protection in 1930. The delegates at this conference studied the status of healthcare for mothers and children throughout the country and recommended public health initiatives. With the data produced at the 1930 conference, the CB’s leaders lobbied the new Franklin D. Roosevelt administration for inclusion in the Social Security Act of 1935. Title V of the act created appropriations specifically for maternal and children’s health. These funds helped state and county health departments expand service during a financial crisis. By the late 1930s, an international crisis, World War II,

threatened the stability of American democracy. Child welfare advocates worried how these events would affect children. The Roosevelt administration asked these activists to consider the relationship of American democracy and children. One aspect of the country's responsibilities was to promote public health programs. In the early 1940s, the government allocated more money for Title V programs.

When America entered the war, many young men traveled throughout the nation to train for military service. Some of the men brought wives with them and other single men quickly married. Many of the soldiers' wives were expecting and the health systems near bases could not support the influx of maternal and infant cases. Chapter Five, "Hot Water on the Home Front: The Emergency Maternity and Infant Care Program, 1943-1949," surveys the program that paid for medical care for over one million American births. This chapter examines both national and local EMIC trends. This chapter argues that the Mississippi EMIC program helped to improve maternal hospital care and that the outcomes of the local program confirmed the shift towards hospital birth throughout the United States. The EMIC program funded statewide plans that paid for the medical care for some enlisted men's pregnant wives and infants under one year old. Although hundreds of thousands of births still took place at home, most EMIC births took place in hospitals. The EMIC helped provide medical care for mothers and infants during the first portion of the baby boom.

Chapter Six, "'For Every Child a Healthy Personality:' Juvenile Mental Health and Cold War Conformity in the Early 1950s," explores the Midcentury White House Conference on Children and Youth (MWHCCY) and its theme to promote the emotional and mental health of all American children. This chapter argues that at the MWHCCY

delegates debated the meaning of childhood personality and determined what characteristics defined an American child with a happy disposition. This chapter examines Mississippi's and New York's conference follow-up work to ensure happy personalities by reevaluating education and child mental healthcare. The early Cold War and the Civil Rights Movement loomed large in the mind of the delegates and they worried about the effect of anxieties on the youth. The conference participants adopted a platform, "A Pledge to Children," that state organizations attempted to honor to ensure a child's healthy personality. One of the goals was to provide equal access to education. In Mississippi, the Mississippi Children's Code Commission (MCCC) addressed the inadequacy of its education. Throughout the 1950s, the MCCC and the State Board of Education changed Mississippi's educational system due to the equalization plan. The goal of the plan was to make African American schools look closer to equal to white schools. Mississippi's program failed to uphold the pledge to children and emotional health for all Mississippi children was not secure. Some progress was made. The MCCC began studying issues that plagued the state's education and planned for Mississippi's educational future. Elsewhere, the New York State Citizens' Committee of One Hundred for Children and Youth was concerned with the emotional health of four million New York children. The committee worked with various state agencies, including the Departments of Education, Health, and Mental Hygiene, and Judeo-Christian religious groups. During the 1950s, the state saw growth in mental health programs ranging from counseling sessions to teachers correcting developmental deficiencies in the classroom. While the state could not publicly fund a mental health program for four million children, the cooperative program allowed more children to have better emotional health.

Finally, the Epilogue concludes in the 1960s, as child welfare advocates began concentrating on women and children from low socio-economic backgrounds. While these activists continued to use current events to persuade government officials to back women and child health initiatives, many focused on improving access to medical care for impoverished and minority children. The epilogue briefly highlights the Social Security Amendments of 1963, 1965, and 1967. These acts intended to advance care for intellectually disabled children, impoverished children, and family planning for low-income women. These amendments stand in stark contrast to earlier campaigns, which claimed to be for all American mothers and children. The advocates of the 1960s did not have to worry about the military rejecting a large portion of draftees because of ignored childhood illnesses or the next generation being fit to save American ideology. The programs from World War I to the 1950s, nurtured a public and private health system that treated children's physical and mental health.

The early twentieth century American maternal and child healthcare programs provided care to a few million American mothers and children. These programs helped reduce infant and maternal mortality, communicable disease, and ensured better physical and mental health for many Americans. CB members and other child welfare reformers guaranteed these programs by arguing that maternal and child hygiene was necessary to protect children as citizens, who were the future generations of Americans. From World War I to the 1950s, child welfare reformers believed that that the government had a duty to safeguard the health of American mothers and children

CHAPTER II

‘THE HEALTH OF THE CHILD IS THE POWER OF THE NATION’: THE 1918-1919 CHILDREN’S YEAR

“The health of the child is the power of the nation.”¹⁵ The Children’s Bureau (CB) and the Woman’s Committee of the Council of National Defense (WCCND) chose this slogan to publicize the goals of the 1918-1919 Children’s Year and encourage Americans to reevaluate the health of the nation’s children.¹⁶ The CB sent this poster (2.1) to state committees and other national organizations in its publicity campaign. In Illinois, the State Council of Defense’s Child Welfare Committee sent approximately 16,500 Children’s Year-related posters and 91,500 window cards to locals to hang at “public buildings, school houses, prominent stores, banks, railway stations, hotels, etc.” These posters and cards reminded the people of Illinois to remember the children.¹⁷ Throughout

¹⁵ F. Luis Mora, *The Health of the Child is the Power of the Nation: Children’s Year, April 1918-April 1919*, (New York, The W.F. Powers Co., 1918), accessed July 3, 2015, <http://loc.gov/pictures/resource/cph.3g09867/>.

¹⁶ On April 9, 1912, Congress and President Howard Taft created the CB, a government agency to investigate issues regarding child welfare. During the first year, the CB had a paltry budget of \$25,640. During the first decades, the CB workers investigated and reported on infant mortality and child welfare. Another government organization was the WCCND, a branch within the Council of National Defense. The WCCND managed women’s issues in regards to the war effort. It did not have the same clout as other divisions of the Council of National Defense, but with the help of the growing CB, the WCCND launched a somewhat successful public health campaign. Kriste Lindenmeyer, *A Right to Childhood: The U.S. Children’s Bureau and Child Welfare, 1912-1946* (Champaign: University of Illinois Press, 1997), 1.

¹⁷ “Report of Child Welfare Department, State Council of Defense, February to October 1, 1919,” 5, Record Group 62: Records of the Council of National Defense, Box 904: “Field Division, 15-B16 Child

the nation, similar posters and cards hung in buildings, and newspapers ran stories of the Children's Year encouraging mothers to get involved in the campaign. A Fargo, North Dakota, newspaper pulled on the heartstrings of mothers in their article, "Mothers, Uncle Sam is Depending on You!"¹⁸ Other newspapers claimed that American children were the top priority. For instance, the *Albuquerque Morning Journal* proclaimed that the "CHILDREN WILL BE [THE] FIRST CONCERN OF GOVERNMENT."¹⁹ Posters, pamphlets, and newspapers helped persuade thousands of Americans to answer Uncle Sam's call to protect the children. Most volunteers were women and mothers, who participated in weighing and measuring campaigns or back-to-school drives. During World War I, American mothers and the government were responsible for protecting children's health to ensure a stronger America. The CB and WCCND spearheaded the efforts to reduce maternal and infant mortality and save at least 100,000 infants by launching the Children's Year, a year-long child-welfare campaign on April 6, 1918, a year after the United States declared war.

Many scholars note that the war provided the backdrop for this massive undertaking.²⁰ The war allowed the CB women to use wartime rhetoric to secure broader

Welfare Memoranda," Folder: "C.W.M. #2 Memorandum, November 1, 18 Enclosures Jessie B. Peixotto," The National Archives at College Park, College Park, Maryland.

¹⁸ Mrs. Max West, "Mothers, Uncle Sam is Depending on You!" *The Nonpartisan Leader*, June 17, 1918, 17.

¹⁹ "Children Will Be First Concern of Government," *Albuquerque Morning Journal*, April 6, 1918, 1.

²⁰ For information on the Children's Year see: Robyn Muncy, *Creating a Female Dominion in American Reform* (New York: Oxford University Press, 1991) 96-102; Kriste Lindenmeyer, "A Right to Childhood," 71-74, 79, 129, 145-149; Gwendolyn Mink, *The Wages of Motherhood: Inequality in the Welfare State, 1917-1942* (Ithaca: Cornell University Press, 1996), 56-59; Julia Grant, *Raising Baby by the Book: The Education of American Mothers* (New Haven: Yale University Press, 1998), 81-82; Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Cambridge: Belknap Press, 1992), 496-497.

interest in the maternalist cause.²¹ Molly Ladd-Taylor defined the maternalist ideology as a movement “founded on new ‘scientific findings about the importance of physical health and play to wholesome child development.” These maternalists focused on using scientific knowledge in childrearing rather than “folk childrearing practices.”²² This chapter will argue that the Children’s Year encouraged child hygiene work, which led to the development of maternal and child welfare departments within state boards of health or child welfare departments. The Promotion of the Welfare and Hygiene of Maternity and Infancy Act of 1921 allowed various states and cities to fund these maternal and child hygiene departments, but the Children’s Year campaign served as the catalyst for the programs. Additionally, the campaign helped the CB’s statistical team to gather the most accurate American growth charts to date, the Woodbury charts. Previous charts were based on regional data and focused on a narrower age range. The Children’s Year created many of the components for maternal and child health work throughout the nation.²³

²¹ Gwendolyn Mink, *The Wages of Motherhood*, 57.

²² Molly Ladd-Taylor, *Mother-Work: Women, Child Welfare, and the State, 1890-1930* (Urbana: University of Illinois Press, 1994), 91.

²³ Kriste Lindenmeyer stated that the Children’s Year allowed the public to learn more about the CB’s mission to improve maternal and child health. She mentioned that thirty-five states had child hygiene unite by 1920. She championed the Sheppard-Towner Act as the national program that standardized maternal and child health (109). Yet, the standards were developed during the Children’s Year and during its closing conference, the White House Conference on Children on Standards of Child Welfare. Many states were working toward these national child welfare standards before the Sheppard-Towner Act passed in 1921. These claims are influenced by the following works: Kriste Lindenmeyer, “*A Right to Childhood*,” 71-74, 79, 129, 145-149; Robyn Muncy, *Creating a Female Dominion in American Reform*, 76; Molly Ladd-Taylor, *Mother-Work*, 89-90; Gwendolyn Mink, *The Wages of Motherhood*, 56-59.



Figure 2.1 “The Health of the Child is the Power of the Nation” served as the promotional poster for the Children’s Bureau’s and Woman’ Committee of the Council of National Defense’s Children’s Year Campaign (April 1918 to April 1919).

F. Luis Mora, *The Health of the Child is the Power of the Nation: Children’s Year, April 1918-April 1919*, (New York, The W.F. Powers Co., 1918), accessed July 3, 2015,<http://loc.gov/pictures/resource/cph.3g09867/>.

When the United States entered World War I, the infant mortality rate was at least 102.9 deaths per 1,000 births, but probably higher. At this time, more than half of the states still did not report at least ninety percent of births and the CB did not have

complete statistics on children in America.²⁴ Many states did not have birth-registration laws. The CB also noted that poor white and minority parents did not register their children at the same rate as white middle class parents.²⁵ America's involvement in World War I exposed the parlous condition of American public health and drew particular attention to children's health. The draft revealed that thousands of men had suffered from childhood illnesses or malnourishment that could have been prevented or treated. By portraying children as future citizens who would protect American democracy, the CB and the WCCND exploited wartime fears and created a year-long child welfare program featuring three campaigns that focused on health, recreation, and education.²⁶ This image of the child-citizen allowed the CB to recruit volunteers and gain support for their program.²⁷ The Children's Year work reduced infant and child mortality by treating malnourished children, emphasized maternal and children's health, stressed the importance of public health nurses, promoted the Americanization of immigrant

²⁴ United States Children's Bureau, *An Outline for a Birth-Registration Test*, Publication 54 (Washington, D.C.: United States Government Printing Office, 1919), 4; United States Bureau of the Census, *Mortality Statistics: 1917* (Washington, D.C.: United States Government Printing Office, 1919), 63-64.

²⁵ United States Children's Bureau, *An Outline for a Birth-Registration Test*, Publication 54, 4-5.

²⁶ A few scholars briefly discussed using World War I as an opportunity for the CB program: Kriste Lindenmeyer, "A Right to Childhood," 71; Robyn Muncy, *Creating a Female Dominion in American Reform*, 97-98; Molly Ladd-Taylor, *Mother-Work*, 89-90; Gwendolyn Mink, *The Wages of Motherhood*, 56. Another scholar, Katherine Bullard noted that the CB following previous child welfare advocates and built a program that "developed an image of an idealized white child who was worthy of the material support of the larger nation." She further explained that this image correlates to American citizenship. Katherine Bullard, *Civilizing the Child: Discourses of Race, Nation, and Child Welfare in America* (Lanham: Lexington Books, 2014), 2.

²⁷ See Emilie Stoltzfus, *Citizen, Mother, Worker: Debating Public Responsibility for Child Care after the Second World War* (Chapel Hill: The University of North Carolina Press, 2003), 161. Stoltzfus examined the role of mothers as citizens and workers. According to Stoltzfus, American mothers' jobs as citizens were to raise their children to be future Americans, who valued American democratic values. While she explored American mothers during World War II, American mothers during World War I also were expected to raise the future generation of American citizens.

mothers and children, and set the standards for maternal and children's health in the early 1920s.

The Children's Year was part of the CB's larger progressive policies of the 1910s including reducing infant and maternal mortality and improving child health and welfare. After progressives Lillian Wald and Florence Kelley lobbied for the creation of a government agency dedicated to protecting American mothers and children for nearly a decade, Congress and President William Taft created the CB. The CB organized in 1912 to study and protect America's children and Taft appointed Julia Lathrop, a progressive child welfare reformer, as its chief. When Lathrop assumed the role of the executive chair of the Child Welfare Department of the WCCND, she used this role to garner wartime interest in the CB and child welfare.²⁸ Other maternalists promoted an agenda that would educate mothers and improve children's health.²⁹ Maternal and children's hygiene remained a concern because these children needed to be healthy citizens in the future, but the CB's vision focused on taking care of mothers and children because they needed better healthcare and education about parenting. Historian Robyn Muncy noted that Lathrop "used this wartime organization of women to broaden the popular base for child welfare reform and to solidify the ties between the base and the Bureau."³⁰

²⁸ Robyn Muncy, *Creating a Female Dominion in American Reform, 1890-1935*, 97.

²⁹ *Ibid.*, 97; Kriste Lindenmeyer, "A Right to Childhood," 76.

³⁰ Robyn Muncy, *Creating a Female Dominion in American Reform, 1890-1935*, 97. Other historians such as Kriste Lindenmeyer and Molly Ladd Taylor explained that the Children's Bureau used World War I as a factor for launching the Children's Year. Kriste Lindenmeyer, "A Right to Childhood," 71; Molly Ladd-Taylor, *Mother-Work*, 89-90. In addition, Ladd-Taylor and Gwendolyn Mink describe the Children's Year as an event within the progressive maternalist movement. Molly Ladd-Taylor, *Mother-Work*, 89-90; Gwendolyn Mink, *The Wages of Motherhood*, 56-59.

Campaigns and conferences during the Children's Year helped define the public health and child welfare projects that the CB would continue after the draftees or volunteers returned home from the war.

On May 18, 1917, President Woodrow Wilson signed into law the Selective Service Act. This act required American men, ages twenty-one to thirty, and later eighteen to forty-five, to register for the draft. Americans saw the draft as meeting an obligation or requirement for wartime citizenship.³¹ Whether out of obligation or due to patriotism, over twenty-four million American men registered for the draft.

Many American men did not meet the physical requirements to be inducted. The local draft boards determined which men would have a physical examination and the doctors recorded information regarding draftees' and rejectees' health. This allowed the War Department to collect and analyze statistical data on World War I draft physicals. According to World War I draft records, 46.8 percent of 2,753,922 American men ranging from eighteen to thirty years old had mental or physical illnesses.³² Local draft boards rejected approximately 550,000 men because of major cognitive disabilities or physical ailments.³³ Some of these men had more than one illness and statistics suggest that the largest deficiencies were related to the "bones and joints and the appendages of

³¹ Christopher Capozzola, *Uncle Sam Wants You: World War I and the Making of the Modern American Citizen* (New York: Oxford University Press, 2008), 21.

³² Albert G. Love and Charles B. Davenport, *Defects Found in Drafted Men: Statistical Information Compiled from the Draft Records Showing the Physical Condition of the Men Registered and Examined in Pursuance of the Requirements of the Selective-Service Act* (Washington, D.C.: United States Government Printing Office, 1920), 28.

³³ Ibid.

the hands and feet.”³⁴ Other issues included over 73,000 men below the required weight for military service and 37,000 men who had weak teeth.³⁵ The Surgeon General’s Office did not release their study of Selective Service draft records until 1920, but the government was aware of the high number of illnesses among soldiers and draft rejectees. A few months after the first draft registration drive, Dr. J.A. Nydegger of the United States Public Health Service noted that the draft examination revealed that rural men had more ailments than urban men. He attributed the difference in health to “the fact that the health of school children is almost entirely neglected in country schools.”³⁶ Before the second and third draft registrations, the military required local medical boards to classify men into one of four categories ranging from fit for military duty to completely rejected for service.³⁷ The second and third waves of draftees also highlighted the status of American health. Many Americans were concerned about the state of American health, further raising concerns about the nation’s plight.

To correct problems in America’s healthcare system, Nydegger suggested that the nation needed to address failures in children’s health as a preventative measure. The CB and the WCCND used the outcomes of the draft as an opportunity to expand their child welfare initiatives.³⁸ Dr. Jessica Peixotto, the Executive Chairman of the Child Welfare

³⁴ Ibid., 29.

³⁵ Ibid., 27.

³⁶ “CITY BOYS STRONGER, DRAFT DATA SHOW,” *The New York Times*, October 8, 1917, 4.

³⁷ “TO CLASSIFY DRAFTED ON PHYSICAL BASIS,” *The New York Times*, March 8, 1918, 20.

³⁸ Molly Ladd-Taylor, *Mother-Work*, 89; Robyn Muncy, *Creating a Female Dominion in American Reform*, 97.

Department of the WCCND, connected the challenges of the World War I draft to their maternal and child health goals. She noted:

Careful investigations continuously prove at least one-third of the deaths of infants unnecessary. The first draft showed that about one-fourth of the defects which sent young men home humiliated by a discharge might have been remedied in childhood.³⁹

The intent of the CB and WCCND was to establish a “sound program of democratic work for children.”⁴⁰ The CB and WCCND linked the “health of the children” to the “power of the nation,” and sought to protect future generations’ health and their ability to serve America in the future.⁴¹

The concept of the Children’s Year did not solely derive from the draftees’ health deficiencies. Many maternal and infant healthcare advocates argued that the Children’s Year movement was linked to an international effort to reduce maternal and infant mortality. Dr. Grace Meigs, a previous director of the CB’s Division of Hygiene, argued that the United States benefited from European countries’ recognition of the importance of children’s lives.⁴² Another member of the CB’s Division of Hygiene, Dr. Anna Rude explained that “it has taken the experience of such countries as France and England and our own entrance into the war, to bring us face to face with national protective health problems.”⁴³ She later claimed that the Allied countries needed to improve and protect

³⁹ Jessica B. Peixotto, “The Children’s Year and the Woman’s Committee,” *Annals of the American Academy of Political and Social Science* 79 (Sept 1918): 260.

⁴⁰ *Ibid.*, 257.

⁴¹ Mora, *The Health of the Child is the Power of the Nation: Children’s Year, April 1918-April 1919*.

⁴² Grace L. Meigs, “The Children’s Year Campaign,” *The Journal of the American Medical Association* 71, no. 4 (July 1918): 244.

⁴³ Anna Rude, “The Children’s Year Campaign,” *American Journal of Public Health* 9, no. 5 (May 1919): 346.

children and infant health to win the Great War.⁴⁴ The CB and the WCCND learned from the European public health campaigns and even mimicked their publicity.⁴⁵ The CB recognized that the United States was also failing to assess and prevent maternal and infant mortality. The Bureau understood that the war would provide the opportunity to improve the health of mothers and children.

The shock of the draftees' health and the efforts of the Allied nations encouraged Americans to examine infant and child care in their country. When the United States entered the First World War, the federal government did not have accurate data about its citizens and the CB did not have complete vital statistics on American children. The CB could only estimate that 300,000 children died before age five each year. This lack of information complicated the ability to assess the conditions of young Americans fully. The CB and WCCND believed that they could save at least 100,000 infant to pre-school age children by improving healthcare.⁴⁶ One year after the United States entered the First World War, the CB and the WCCND organized the Children's Year (April 6, 1918 to April 6, 1919), a nation-wide campaign to save at least one hundred thousand children. Members of the CB and WCCND believed that childhood health was a necessity to protecting American national security.⁴⁷ President Woodrow Wilson viewed child

⁴⁴ Ibid., 347.

⁴⁵ Anna Rochester, letter to Harold J. Howland, August 9, 1918, Record Group 102: Records of the Children's Bureau, 1908-1969, Box 76: "Central File, 1914-1920, 8-2-1-11," Folder: "8-2-1-11 Children's Year Publicity" The National Archives at College Park.

⁴⁶ Grace L. Meigs, "The Children's Year Campaign," 244.

⁴⁷ Julia C. Lathrop, *Save 100,000 Babies: Get a Square Deal for Children*, Publication 36 (Washington, D.C.: Government Printing Office, 1918), 2.

welfare as “second only” to the direct war effort.⁴⁸ These child healthcare advocates looked to British and French child care programs to construct a year-long program that would not only improve infant mortality rates, but also address maternal health and child education. British historian Rosie Kennedy asserts that the British became concerned with children’s health after the South African War (1899-1902) because of “poor performance.”⁴⁹ In America, a small group of female Progressive reformers, including Lillian Wald and Florence Kelley, lobbied for the creation of the CB during the early 1900s. The reformers believed that a bureau needed to be created to protect children from high infant mortality rates, child labor, delinquency, and child abuse.⁵⁰ In addition, these women wanted to Americanize children of immigrant parents.⁵¹ After the first White House Conference on Children in 1909, the reformers gained momentum and in 1912, Congress established the Children’s Bureau.⁵² However, major anxieties about American children’s health did not emerge until the United States entered World War I. The CB and the Child Welfare Department of the WCCND used concerns about children’s health to plan the Children’s Year and develop five areas of work to fulfill their goal.

⁴⁸ H. Anderson, Enclosure to Dr. Anna Rude, April 22, 1919, “For Release Sunday, April 6, 1919,” Record Group 102: Records of the Children’s Bureau, 1908-1969, Box 76: “Central File, 1914-1920, 8-2-1-11,” Folder: “8-2-1-11 Children’s Year Publicity” The National Archives at College Park.

⁴⁹ Rosie Kennedy, *The Children’s War: Britain, 1914-1918* (New York: Palgrave Macmillan, 2014), 6.

⁵⁰ Kriste Lindenmeyer, “*A Right to Childhood*,” 9.

⁵¹ Ibid.

⁵² Ibid., 18-27.

“To save 100,000 babies and get a square deal for children,” the CB arranged a work program with five essential areas.⁵³ First, the CB devoted the year to protecting mothers and young children. This included hiring more public health nurses and providing healthcare to new mothers. A second area of work was addressing inadequate housing and income. The CB relied on WCCND local branches and public health officials to improve hygiene and raising housing standards. Third, the CB sought to regulate child labor further and to encourage school attendance. In addition, the Bureau believed that children should be more active; therefore, the CB focused on building recreation facilities. Finally, the CB wished to identify children who needed special care in order to address their issues. These children might be dependent, neglected, physically disabled, mentally disabled, or delinquent children. Some of these children grew up in single-parent homes, while other children were delinquents.⁵⁴ The CB and WCCND planned three national drives to support these five areas of work. The events included a weighing and measuring campaign, a recreation week, and a crusade for education.⁵⁵ Their events promoted healthier lifestyles for the children and the success of these campaigns relied on state and citizen involvement. By the end of the Children’s Year, workers had organized in forty-six states and four territories, and the CB gave each state a quota of babies and children to protect children from malnutrition and death. Some

⁵³ United States Children’s Bureau, *Children’s Year Working Program*, Publication 40 (Washington, D.C.: United States Government Printing Office, 1918), 3.

⁵⁴ *Ibid.*, 4-12; H. Anderson, Enclosure to Dr. Anna Rude, April 22, 1919, “For Release Sunday, April 6, 1919.”

⁵⁵ Julia Lathrop, “Seventh Annual Report of the Chief, Children’s Bureau to the Secretary of Labor, Fiscal Year Ended June 30, 1919,” 7.

states, such as Nevada, had low quotas. There, the CB only expected to save sixty-six children. In states like New York and Pennsylvania, committees worked to rescue over eight thousand children.⁵⁶ The CB and WCCND wanted to ensure that American children were stronger and healthier.

The CB and WCCND began their campaign by collecting data on children's weight and height. In the months prior to the Children's Year, the CB notified state and local child welfare and health organizations of the Bureau's future plans for the year-long campaign. The Children's Year organizers informed state and local committees that the CB would rely on the local committees and volunteers to collect weight and height statistics. The millions of women volunteering in Children's Year activities exemplified wartime voluntarism. Christopher Capozzola argues that voluntarism was an obligation and an honor.⁵⁷ Julia Lathrop depended on wartime female volunteers and, according to historian Robyn Muncy, Lathrop viewed these women as partners, whom she would recruit to serve in future state maternal and child welfare agencies.⁵⁸ In the meantime, she used these women to carry out a massive weighing and measuring campaign. During the first few days of the Children's Year, the CB-WCCND team mailed out approximately 500,000 cards for doctors or volunteers to complete.⁵⁹ These postcards contained two

⁵⁶ United States Children's Bureau, "State Quotas for Children's Year," February 25, 1918, 2, Record Group 102: Records of the Children's Bureau, 1908-1969, Box 76: "Central File, 1914-1920, 8-2-1-11," Folder: "8-2-1-11 Children's Year Publicity" The National Archives at College Park.

⁵⁷ Christopher Capozzola, *Uncle Sam Wants You*, 85.

⁵⁸ Robyn Muncy, *Creating a Female Dominion in American Reform*, 100.

⁵⁹ Julia Lathrop, "Seventh Annual Report of the Chief, Children's Bureau to the Secretary of Labor, Fiscal Year Ended June 30, 1919," 8.

sections, a parent's record and a section to be returned to the CB for governmental use.⁶⁰ Standards for collecting this data were not strict and in some instances, members of the general population collected it. In some towns and rural districts, public health officials gave the children a more thorough examination, but the CB explained that this campaign did not provide healthcare for these young citizens. The weighing and measuring campaign's mission was to gather information and identify children with health problems.⁶¹ The CB's analysis of the material was supposed to lead to suggestions for future care rather than immediate treatment. Even so, newspapers hailed the weight and height drive. The *Evening Star* of Washington, D.C. noted that the weighing and measuring campaign would "make little brother and sister the healthier and happier and therefore more useful to the nation."⁶² Yet, the CB had much work ahead in order to reach the millions of Americans ranging in age from birth to six years old. The CB weighing and measuring campaign focused on preschool children because the Bureau wanted to detect ill or malnourished children before they entered school to attempt to improve the young children's health. Early treatment helped improve the odds for correcting a deficiency.

Local committees helped by advertising and organizing the weighing and measuring events. In California, the state Children's Year Committee planned the weighing and measuring campaign in thirty-nine counties and the cities of Los Angeles,

⁶⁰ "To Weigh and Measure All American Children," *Carbonate Weekly Chronicle*, Leadville, Colorado, April 22, 1918, 5.

⁶¹ Julia Lathrop, "Seventh Annual Report of the Chief, Children's Bureau to the Secretary of Labor, Fiscal Year Ended June 30, 1919," 8.

⁶² "Public Schools May Serve in Child-Saving Campaign," *Evening Star*, April 21, 1918, 11.

Pasadena, and Richmond with a minimal budget of \$5,000 in June and July 1918.⁶³ During these two months, public health officials and volunteers weighed and measured 53,462 children ranging in age from infancy to six years old. The drive revealed that approximately forty-seven percent had some type of deficiency. In California, doctors often provided physical exams for children. They discovered the most prominent deficiencies were thirty-one percent having issues with their tonsils and adenoids and twenty-nine percent of children being below the appropriate height and weight.⁶⁴ At the national level, approximately one-sixth of young children fell ten percent below the average weight and height.⁶⁵ These were issues that public health officials could attempt to correct during early childhood, but public health organizations and the CB did not have the funds to address all ailments. Alabama's committee carried out its program similarly. Alabama officials weighed over 16,000 children and provided scientific knowledge to mothers. The Alabama committee hosted conferences, free clinics, and in some cities the committee and public health officials gave milk to children.⁶⁶ The weighing and

⁶³ "Report Women's Committee of the State Council of Defense of California to Governor William D. Stephens, Chairman of the State Council of Defense of California, From June 1, 1917 to January 1, 1919," 43-44. According to the Consumer Price Index Inflation Calculator, \$5000 in July 1918 is equivalent to approximately \$81,600 in December 2017. For more information on inflation see: https://www.bls.gov/data/inflation_calculator.htm (accessed January 2017).

⁶⁴ "Report Women's Committee of the State Council of Defense of California to Governor William D. Stephens, Chairman of the State Council of Defense of California, From June 1, 1917 to January 1, 1919," 43-44.

⁶⁵ For more information on national averages, standard deviations, and coefficients of variation by gender and age, see: Robert Morse Woodbury, *Statures and Weights of Children Under Six Years of Age* (Washington, D.C.: United States Government Printing Office, 1921), 28. More than ninety-five percent of children included in the study were white. The national averages reflect white average rather than all American children.

⁶⁶ "Report of the Alabama Council of Defense, Covering Its Activities from May 17, 1917, to December 31, 1918," 57.

measuring drive provided the committees and public health officials with data about children's health conditions in their communities. In return, mothers received instructions in "proper care of their bodies (the children)," and directions on "the diet which would produce the most vigorous physical development."⁶⁷ Children living in cities like Birmingham also had access to free clinics and milk.⁶⁸ The program benefited both the government and its citizens.

For the weighing and measuring test to be successful, the CB believed that that the state committees had to follow-up their efforts. The initial drive allowed public health officials and community leaders to assess the physical condition of small children. The CB recommended that public health officials or child welfare enthusiasts in local committees record all children found underweight and possibly malnourished.⁶⁹ The committees considered children two pounds underweight as malnourished and paid particular attention to these children. They encouraged parents to take the undernourished child to a doctor to determine why he or she was underweight. The CB published articles on nutrition and malnutrition to promote stronger children. The local committees recommended these publications to mothers, and many of the informative pamphlets were available at libraries. One noted the importance of milk, eggs, and leafy vegetables in child development and to prevent malnourishment.⁷⁰ During World War I, the

⁶⁷ Ibid.

⁶⁸ Ibid.

⁶⁹ United States Children's Bureau, *April and May Weighing and Measuring Test: Part 3 Follow-Up Work*, Publication 38 (Washington, D.C.: United States Government Printing Office, 1918), 3.

⁷⁰ United States Children's Bureau, "*Feeding the Child: Are You Feeding Your Family Intelligently?*" 1-4, Record Group 62: Records of the Council of National Defense, Box 905: "Field Division, 15-B17 Child

American government focused on improving nutrition and for the first time the United States Department of Agriculture authors, Carolyn Hunt and Helen Atwater, announced five food groups including fat and vegetables.⁷¹ This provided the public with scientific information about nutrition. The CB and the WCCND utilized the scientific knowledge of the time to promote nutrition and teach the importance of good nutrition to parents and children. The WCCND reminded parents that “well nourished children make the kind of men and women Uncle Sam wants for citizens.”⁷² These committees also recruited the public to take interest in children’s health. The drive organizers informed communities by holding meetings and announcing in newspapers the results of the weighing and measuring tests. In Okolona, Mississippi, the local paper, the *Okolona Messenger*, informed parents that the Lanier Club women would weigh and measure children in mid-June 1918 and that local business owners would give prizes to the six healthiest children.⁷³ Public health doctors and nurses also provided nutrition and child health clinics to address issues within a specific community.

The weighting and measuring drives revealed the lack of public health nurses. According to the CB, the British employed a public health official per five hundred births

Circulars, 15-B18 Manuscripts for Letters, 15-B19 Manuscripts for Misc. Letters,” Folder: “C.W.M. 31: Enclosures (8 Dodgers) Child Welfare Dodgers December 1918,” The National Archives at College Park.

⁷¹ Jessica Mudry, “Nutrition,” in *A Companion to the History of American Science*, eds., Georgina M. Montgomery and Mark A. Largent (Malden: Wiley Blackwell, 2016), 204-205.

⁷² “How Does Your Dollar Go Far or Fast?” 2, Record Group 62: Records of the Council of National Defense, Box 904: “Field Division, 15-B16 Child Welfare Memoranda,” Folder: “C.W.M. #18, April 19, 1919 Transmitting Publicity Material from the States,” The National Archives at College Park.

⁷³ Mrs. L. P. Haley, “Weighing and Measuring Test Postponed,” *Okolona Messenger*, June 6, 1918, 1.

each year, which contributed to the decrease in the British infant mortality rate.⁷⁴ These officials were similar to public health nurses in America and the CB believed that communities needed public health nurses to visit malnourished children. However, the CB and WCCND did not offer funding to the states to hire more public health officials including nurses. Towns and rural communities were responsible for securing funds through charities or government appropriations.⁷⁵ While local committees were aware of the suggestion, many did not obtain funds. Even the populous state of California had very limited results with this call. Dr. Adelaide Brown, the Chairman of the California Children's Year Committee, noted that the committee emphasized the importance of public health nurses to all California counties, but that only three of the fifty-eight counties hired a total of five nurses.⁷⁶ Later, in 1920 the CB reported that, because of the Children's Year, California opened seventeen health centers and employed ten nurses.⁷⁷ Missouri acquired more nurses than California. The Missouri Council of Defense reported, "One of the most important results obtained has been the securing of 11 community nurses in the State."⁷⁸

⁷⁴ United States Children's Bureau, *April and May Weighing and Measuring Test: Part 3 Follow-Up Work*, 5.

⁷⁵ *Ibid.*, 5.

⁷⁶ "Report Women's Committee of the State Council of Defense of California to Governor William D. Stephens, Chairman of the State Council of Defense of California, From June 1, 1917 to January 1, 1919," 43-44.

⁷⁷ United States Children's Bureau, *Children's Year: A Brief Summary of Work Done and Suggestions for Follow-Up Work*, Publication 67 (Washington, D.C.: United States Government Printing Office, 1920), 9.

⁷⁸ "Final Report of the Missouri Council of Defense, 1917-1919," 77.

Public health nurses were vital to maternal and infant public health projects. Charles-Edward Amory Winslow, the leading authority in public health in the early twentieth century, praised the work of public health nurses in child welfare campaigns. The community nurse was the public health professional who brought knowledge to mothers at home and who determined the cause of illness by using science. Winslow argued that she was the “central figure in the modern public-health campaign.”⁷⁹ The nurse also played an important role in teaching immigrant mothers about nutrition and child care techniques as part of the scientific motherhood movement. Historian Rima Apple defined scientific motherhood as “the insistence that women require expert scientific and medical advice to raise their children healthfully.”⁸⁰ In California, the state university offered extension courses for mothers on scientific motherhood techniques.⁸¹

The national and state committees and public health officials saw the Children’s Year as an opportunity to make immigrant mothers and children more American.⁸² The California committee published pamphlets and brochures in different languages such as Italian and Spanish, so immigrant mothers could learn the appropriate nutrition for their children and how to nurture their adolescents. The California committee exclaimed, “The

⁷⁹ C.-E.A. Winslow, *The Public Health Nurse: How She Helps to Keep the Babies Well*, Publication 47 (Washington, D.C.: United State Government Printing Office, 1918), 5.

⁸⁰ Rima Apple, “Constructing Mothers: Scientific Motherhood in the Nineteenth and Twentieth Centuries,” in *Mothers & Motherhood: Readings in American History*, eds. Rima D. Apple and Janet Golden (Columbus: Ohio State University Press, 1997), 90.

⁸¹ United States Department of Labor, *Reports of the Department of Labor*, 1919 (Washington, D.C.: United States Government Printing Office, 1920), 728.

⁸² For a scholarly examination of fears about immigrant mothers during World War I see: Kathleen Kennedy, *Disloyal Mothers and Scurrilous Citizens: Women and Subversion During World War I* (Bloomington: Indiana University Press, 1999).

Children's Year, dear to every woman's heart, was, and still is, the most potent of all the Americanization movements as it goes to rich and poor, to native and foreign born with its safe and sane standards."⁸³ At the weighing and measuring clinics, public health officials and volunteers distributed pamphlets and fliers about improving children's health and scientific motherhood.⁸⁴ Scientific motherhood was an ideology that portrayed motherhood as "women's chief duty and function," and these women as mothers sought advice from scientific and medical experts to raise their children at home.⁸⁵ The California committee distributed over 120,000 copies of nutrition booklets in English, Italian, or Spanish.⁸⁶ The Nevada committee also wanted to reach immigrant mothers and children. Mrs. Bertha Nordhaus, the State Chairman on the Child Welfare Committee, wrote to Julia Lathrop asking for 10,000 weighing and measuring cards printed in Spanish. Lathrop replied that the Bureau could not offer Spanish cards but suggested that the Nevada committee print "a small leaflet in Spanish" at a "cheap rate."⁸⁷ The efforts in California and Nevada highlight progressivism and the Americanization efforts of the Children's Year.

⁸³ "Report Women's Committee of the State Council of Defense of California to Governor William D. Stephens, Chairman of the State Council of Defense of California, From June 1, 1917 to January 1, 1919," 41.

⁸⁴ For more information on scientific motherhood: Rima Apple, *Perfect Motherhood: Science and Childrearing in America* (New Brunswick: Rutgers University Press, 2006); Ladd-Taylor, *Mother-Work*, 4,6-7,33,45,83.

⁸⁵ Molly Ladd-Taylor, *Mother-Work*, 4. Also, see: Rima Apple, *Perfect Motherhood*.

⁸⁶ *Ibid.*

⁸⁷ Julia C. Lathrop, letter to Mrs. Max Nordhaus, August 7, 1918, Record Group 62: Records of the Council of National Defense, Box 620: "Field Division, Committee on Women's Defense Work, Child Welfare Department, 13G-A1 Correspondence (Jessica Peixotto) July-October 1918, 13G-B1 Child Welfare Circulars, Health & Recreation Dept. (Reports 13H-A1) April-August 1918," The National Archives at College Park.

The weighing and measuring campaigns also helped the American government register American citizens. The Bureau realized that the United States was “behind” Europe in birth registration rates. Many states did not require parents to register births. During the weighing and measuring drives, local health officials and volunteers registered American children citizens by asking parents if their children were recorded.⁸⁸ Officials realized that many were not registered because only twenty states and Washington, D.C. reported ninety percent birth-registration rates.⁸⁹ In the other states, many children were never recorded or the parents did not know about registration. According to the CB, one town weighed and measured six-hundred-and-sixteen children and only one-hundred-and-ninety-two children had definitely been registered.⁹⁰ The weighing campaign allowed local communities to reach out to immigrant, poor, rural, and African-American parents to record their children.⁹¹ The CB valued registration because it created more information on the children whom they attempted to protect. Bureau leaders knew that public health officials and Bureau workers needed to continue working on birth registrations after the campaign ended.⁹² The Children’s Year helped to register several millions of children, but the campaign did not reach all American children under six, especially African American children.⁹³

⁸⁸ United States Children’s Bureau, *An Outline for a Birth-Registration Test*, 4-5.

⁸⁹ *Ibid.*, 4; United States Bureau of the Census, *Mortality Statistics 1917*, 63-64.

⁹⁰ *Ibid.*, 4.

⁹¹ *Ibid.*, 5.

⁹² *Ibid.*, 5-7.

⁹³ Based on sample size, the Children’s Year program under-represented African American children. Robert Woodbury, *Statures and Weights of Children Under Six Years of Age*, 14.

By the end of the Children's Year the CB and the WCCND had mailed 7,606,303 cards throughout the nation to evaluate the basic health of American children from birth to six years old.⁹⁴ The local committees and parents had completed and returned over 1,500,000 cards.⁹⁵ The CB determined that this weighing and measuring campaign created "new measures for child health."⁹⁶ The weighing and measuring drive led to opportunities for communities to promote Americanization projects and the importance of freedom and democracy, while at the same time teaching mothers about scientific motherhood. The efforts from the campaign also determined that hundreds of thousands of small children had physical and sometime mental defects. Consequently, the CB recommended the employment of more public health officials, especially nurses, to provide care. The drive promoted public health campaigns that targeted young children and encouraged birth registrations, so the Bureau could better track children's health.

The Children's Year's Weighing and Measuring campaign helped public health officials and statisticians to better understand the weight and height of white American children and to a lesser extent African American children. Robert Morse Woodbury, an economist who received his PhD from Cornell in 1915, led a team who compiled statistical data for the Children's Year.⁹⁷ Woodbury used the weighing and measuring

⁹⁴ United States Children's Bureau, *Children's Year: A Brief Summary of Work Done and Suggestions for Follow-Up Work*, 7.

⁹⁵ Robert Woodbury, "Heights and Weights of Children Under Six," 1. Record Group 102: Records of the Children's Bureau, 1908-1969, Box 76: "Central File, 1914-1920, 8-2-1-11," Folder: "8-2-1-11 Children's Year Publicity" The National Archives at College Park.

⁹⁶ United States Children's Bureau, *Children's Year: A Brief Summary of Work Done and Suggestions for Follow-Up Work*, 9.

⁹⁷ "Dr. Robert Woodbury, Served International Labor Office," *The New York Times*, January 30, 1970, 45.

cards received by the CB to determine average weights and heights for girls and boys under six years old.⁹⁸ The parents received half of the card with the child's weight and height and a growth chart that allowed parents to compare their child's stature to average children. This chart was based on three different sources, but Woodbury pointed out that none of the sources were "complete series covering all ages."⁹⁹ In 1916, L. Emmett Holt determined average measurements based on 2,000 private practice examinations for three-month-old boys and girls. In 1916 and 1917, Frederick S. Crum conducted the most geographically comprehensive study of 10,423 American preschoolers aged six to forty-eight months. Finally, Woodbury considered Henry Pickering Bowditch's 1872 study of 24,000 Boston schoolchildren (ages five to sixteen) of both native and foreign parents. In 1918, the CB considered these three studies the best data available studies on child growth. However, each study had its limitations ranging from geographic scope to sample size.¹⁰⁰

The CB collected approximately two million cards with preschool children's weight, height, sex, and parents' nationality from throughout the nation. This was the largest data set for American children's stature to-date.¹⁰¹ From this data, Woodbury's team decided to calculate averages and standard deviations for a select set of data. The study only used cards with physician signatures, the children had to be weighed and

⁹⁸ Parents also received a card with the child's height and weight, so the parent could track the child's growth Woodbury, *Statures and Weights of Children Under Six Years of Age*, 9.

⁹⁹ Ibid.

¹⁰⁰ Ibid., 9-10.

¹⁰¹ Ibid., 10.

measured without clothes, the child could not have a defect that would affect height and weight, and the card had to be complete and accurate.¹⁰² The team determined that 167,024 white children's and 4,976 black children's records met the qualifications for the study. Woodbury noted because of the lack of African-American records, the study mainly focused on the averages of white children. These data sets allowed Woodbury and his colleagues to create the most elaborate American growth charts and tables that included variations from sex to color. The study concluded that nearly two-thirds of all American children would fall approximately one standard deviation above or below the average. This information allowed physicians and public health officials to determine which children were not developing or growing as quickly as they should. It also helped them to pinpoint which children were malnourished. Woodbury's work, which was published in 1921, set the standards for American child growth charts during the following decades. In 1945, Physician Robert L. Jackson and Helen G. Kelly reported that Woodbury's study, *Statures and Weights of Children Under the Age of Six* (1921) and Thomas Wood's *Height and Weight Table for Girls and Boys* (1918) were "widely used" and helped "appraise physical status or nutrition."¹⁰³ The Woodbury charts were beneficial for the child hygiene movement, but the data set did not include a large sampling for African American children and did not address Native American children. Public health workers used white norms to classify the status of children's health.

¹⁰² Ibid., 11-13.

¹⁰³ Robert L. Jackson and Helen G. Kelly, "Growth Charts for Use in Pediatric Practice," *The Journal of Pediatrics* 27, no. 3 (September 1945), 216.

Chart IX.—Comparison of children's year averages with Dr. Crum's, Dr. Holt's, and Bowditch's averages; girls' statures.

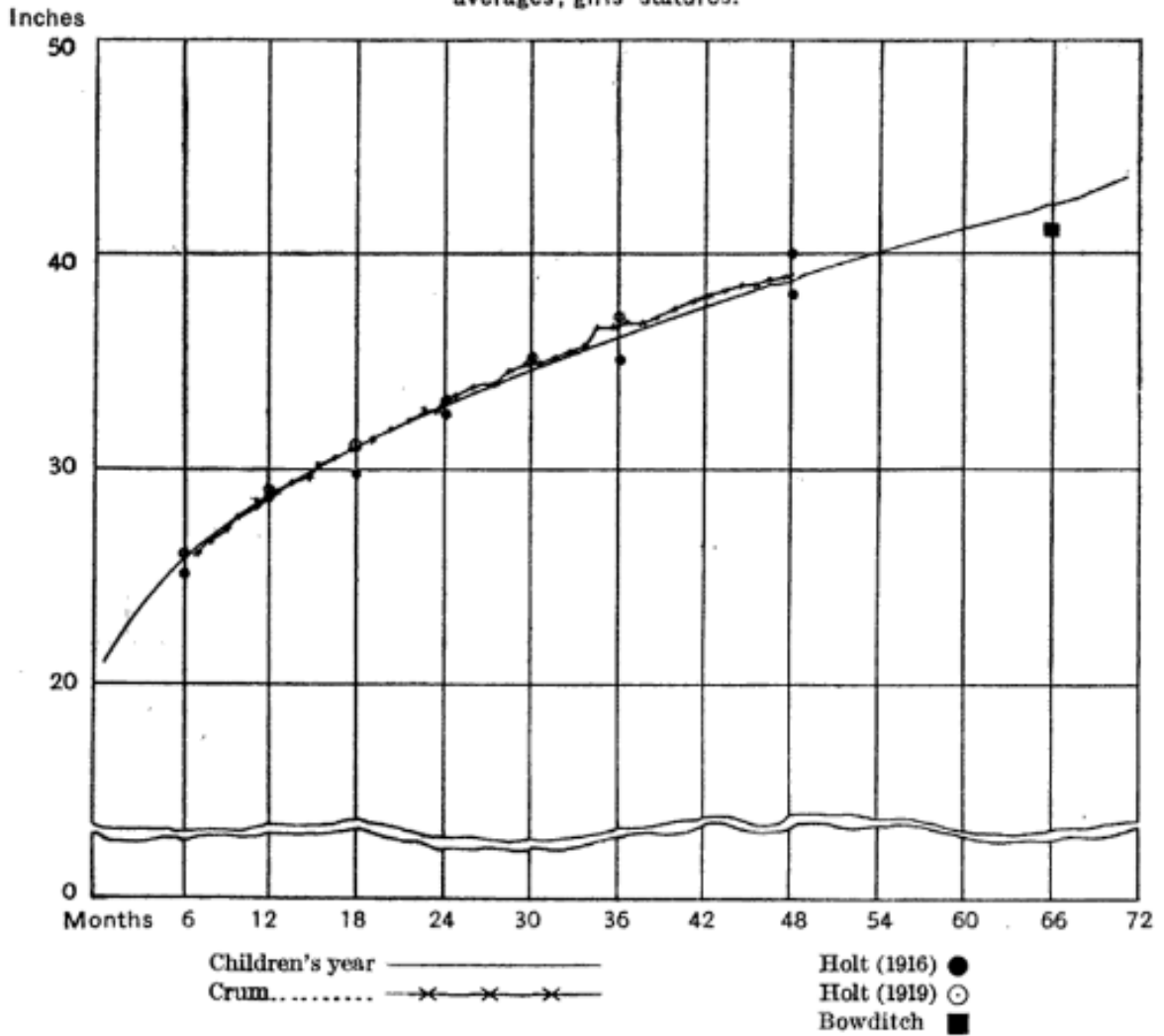


Figure 2.2 “Comparison of Children’s Year Averages with Dr. Crum’s, Dr. Holt’s and Bowditch’s Averages, Girls’ Statures.”

Robert Morse Woodbury, *Statures and Weights of Children Under Six Years of Age* (Washington, D.C.: United States Government Printing Office, 1921), 37.

Figure 1.2 (continued)

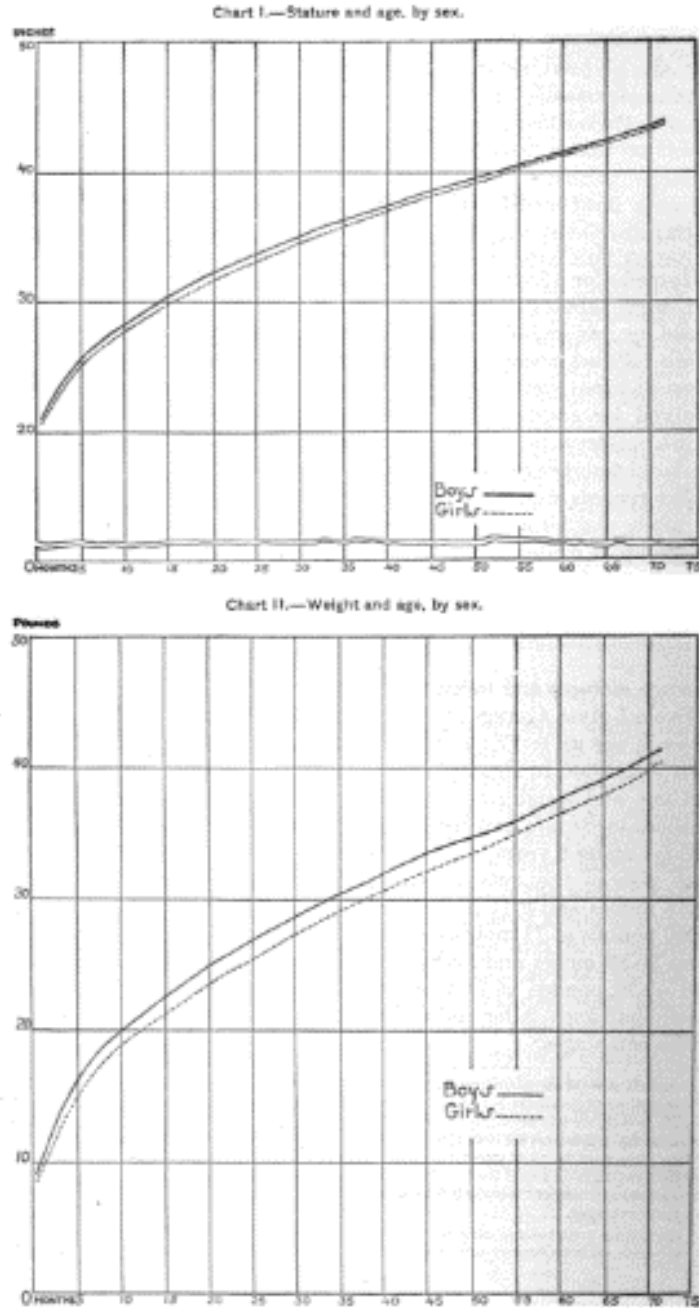


Figure 2.3 “Stature and Age, by Sex” and “Weight and Age, by Sex.”

Robert Morse Woodbury, *Statures and Weights of Children Under Six Years of Age* (Washington, D.C.: United States Government Printing Office, 1921), 16.

TABLE V.—Twelve months' growth in stature and weight, by sex and age: white children.

Age.	Difference in average at specified age and 12 months older.			
	Boys.		Girls.	
	Stature (inches).	Weight (pounds).	Stature (inches).	Weight (pounds).
Under 1 month.	8.2	12.1	7.9	11.3
1 month, under 2.	7.2	10.8	7.2	10.3
2 months, under 3.	6.6	9.4	6.4	9.0
3 months, under 4.	5.9	8.3	5.9	8.2
4 months, under 5.	5.5	7.7	5.5	7.8
5 months, under 6.	5.2	7.0	5.2	6.8
6 months, under 7.	5.1	6.6	5.1	6.5
7 months, under 8.	4.9	6.4	5.0	6.1
8 months, under 9.	4.7	5.8	4.9	5.9
9 months, under 10.	4.6	5.8	4.7	5.5
10 months, under 11.	4.5	5.7	4.5	5.4
11 months, under 12.	4.3	5.3	4.3	5.2
12 months, under 13.	4.2	5.3	4.2	5.2
13 months, under 14.	4.2	5.1	4.1	5.0
14 months, under 15.	3.9	4.9	4.1	5.1
15 months, under 16.	3.9	4.4	3.9	4.9
16 months, under 17.	3.7	4.8	3.8	5.0
17 months, under 18.	3.7	4.8	3.8	4.8
18 months, under 19.	3.5	4.6	3.6	4.7
19 months, under 20.	3.5	4.5	3.6	4.7
20 months, under 21.	3.5	4.9	3.5	4.4
21 months, under 22.	3.4	4.6	3.4	4.4
22 months, under 23.	3.1	4.3	3.4	4.3
23 months, under 24.	3.3	4.3	3.2	4.4
24 months, under 25.	3.1	4.3	3.2	4.5
25 months, under 26.	3.0	4.0	3.2	4.4
26 months, under 27.	3.0	3.1	3.1	4.2
27 months, under 28.	3.0	4.1	3.1	4.3
28 months, under 29.	3.0	4.1	3.0	4.0
29 months, under 30.	2.9	4.1	3.0	4.1
30 months, under 31.	2.8	3.9	3.0	4.1
31 months, under 32.	2.8	4.0	2.8	4.0
32 months, under 33.	2.8	3.7	2.8	3.8
33 months, under 34.	2.8	4.0	2.8	3.9
34 months, under 35.	2.8	4.0	2.7	3.6
35 months, under 36.	2.7	3.7	2.7	3.5
36 months, under 37.	2.6	3.6	2.8	3.7
37 months, under 38.	2.6	3.7	2.7	3.6
38 months, under 39.	2.6	3.8	2.7	3.6
39 months, under 40.	2.6	3.5	2.4	3.3
40 months, under 41.	2.4	3.4	2.5	3.5
41 months, under 42.	2.4	3.3	2.5	3.3
42 months, under 43.	2.4	3.4	2.4	3.2
43 months, under 44.	2.4	3.7	2.5	3.4
44 months, under 45.	2.4	3.2	2.5	3.8
45 months, under 46.	2.2	3.2	2.5	3.3
46 months, under 47.	2.3	3.3	2.5	3.6
47 months, under 48.	2.3	3.5	2.5	3.7
48 months, under 49.	2.4	3.6	2.4	3.6
49 months, under 50.	2.4	3.9	2.6	4.0
50 months, under 51.	2.4	4.1	2.4	3.4
51 months, under 52.	2.2	3.3	2.6	3.9
52 months, under 53.	2.4	3.9	2.4	3.7
53 months, under 54.	2.1	3.5	2.4	3.4
54 months, under 55.	2.3	3.9	2.3	3.9
55 months, under 56.	2.5	4.3	2.2	3.9
56 months, under 57.	2.2	3.6	2.0	3.2
57 months, under 58.	2.1	3.7	2.3	4.5
58 months, under 59.	2.2	3.7	2.3	4.1
59 months, under 60.	2.4	3.6	2.4	4.0

Figure 2.4 "Twelve Months' Growth in Stature and Weight, by Race and Age, White Children."

Robert Morse Woodbury, *Statures and Weights of Children Under Six Years of Age* (Washington, D.C.: United States Government Printing Office, 1921), 27.

The CB and WCCND believed that healthy children were physically fit. To promote fitness, the team launched its second Children's Year drive, a summer recreation campaign. The CB and the WCCND recruited several groups, including the Playground and Recreation Association of America, the Boy Scouts, the Camp Fire Girls, and the Junior Red Cross, to inspire children to participate in recreational activities. The goal of the summer recreation campaign was to "increase the physical vigor among the children of the United States."¹⁰⁴ The CB's promotion of physical activity was tied to the health deficiencies revealed by the draft. The CB and the WCCND claimed that "the Recreation Drive aims to promote the games which increase physical adeptness and skill, which train the eye, and develop the ability to respond instantly not only to the direction of the leader but to the need of the game."¹⁰⁵ Furthermore, Charles Weller, the Associate Secretary of the Playground and Recreation Association of America, asserted that the recreation drive would reduce the influence of "wartime hazards" such as "increased delinquency, over-taxed nerves and weakened bodies."¹⁰⁶ If children were active during adolescence, they would grow into physically fit Americans. In addition, the activities fostered patriotism and taught children to follow directions from leaders.

The CB and WCCND knew that school children and teenagers also needed to improve their health. Children throughout the United States participated in the recreational activities arranged by local women and child welfare workers. The games

¹⁰⁴ United States Children's Bureau, *Patriotic Play Week: Suggestions to Local Child-Welfare Committees*, Publication 44 (Washington, D.C.: United States Government Print Office, 1918), 3.

¹⁰⁵ Ibid.

¹⁰⁶ Charles Frederick Weller, "Patriotic Play Week and the War-Time Recreation Drive," *The Playground* 12, no. 4 (July 1918): 175.

and physical tests motivated children to show leadership and organizational skills and develop patriotism.¹⁰⁷ Scholar Dixie Grimmett argued that during the early twentieth century, American fitness centered around games and sports, while Europeans valued calisthenics exercise.¹⁰⁸ Games and sports emphasized teamwork over individual training. During the summer, boys and girls throughout America challenged their physical strength in various athletic tests with the possibility of receiving badges. Local committees planning Patriotic Play Week requested information on testing from the Playground and Recreation Association of America and the association provided certificates for children who achieved the national standards.¹⁰⁹ In Honolulu, Hawaii, a group of sixty-seven boys ages eight to eighteen took physical exams including chin-ups, a broad jump of at least five feet nine inches, and a sixty-yard dash. All the boys passed at least the chin-up test, with thirty-four passing the sixty-yard dash in eight-and-three-fifth seconds.¹¹⁰ Standards for girls varied from boys, but they still emphasized the importance of being a fit citizen for the country. The girls participated in volleyball serving competitions and a balancing game that required the girls to balance a book or a bean-bag on their head while walking twenty-four feet.¹¹¹ The tasks were not as strenuous as the boy's activities and helped train girls to be poised. The young Americans who met these physical standards earned a

¹⁰⁷ "The First Celebration of Patriotic Play Week," *The Sunday Star* (Washington, D.C.), September 8, 1918, 5.

¹⁰⁸ Alan Henderson and Sally Champlin, editors, *Promoting Teen Health: Linking Schools, Health Organizations, and Community* (Thousand Oaks: Sage Publications, 1998), 24.

¹⁰⁹ United States Children's Bureau, *Patriotic Play Week*, 5.

¹¹⁰ "The World at Play," *The Playground* 13, no. 5 (August 1919): 163.

¹¹¹ "Activities for Girls," *The Playground* 13, no. 6 (September 1919): 237.

certificate and qualified for a badge from the Playground and Recreation Association of America.¹¹²

During the first week of September 1918, the summer recreation drive concluded with a festive Patriotic Play Week. During the week, communities celebrated physical fitness and American history and values. In New Orleans, Mr. L. di Benedetto, the Superintendent of the Playground Commission, worked with the local woman's committee to plan the recreation drive. At the end of the summer, New Orleans children participated in Patriotic Play Week activities that stressed the importance of the American war effort, such as a flower parade, which had thirty-eight floats dedicated to war-time efforts ranging from Lady Liberty to The Fourth Liberty Loan.¹¹³ The flower parade represented Americanization efforts made during the Children's Year. New Orleans children also participated in athletic events including swimming for boys which signified the importance of American youth being physically fit and well-trained for future service to the nation.¹¹⁴ Other large cities, such as New York also celebrated the week with parades and games. Local leaders such as Judge Franklin Chase Hoyt of the New York City Children's Court, supported the recreation activities. Hoyt proclaimed, "If we neglect the proper training of our future citizens, we cannot make the 'World Safe for Democracy.'"¹¹⁵ Although Patriotic Play Week ended the recreation drive, the week

¹¹² Ibid.

¹¹³ "Patriotic Play Week at New Orleans," *The Playground* 13, no. 1 (April 1919): 19-20.

¹¹⁴ Ibid.

¹¹⁵ Committee on Health and Mayor's Committee of Women on National Defense, "Patriotic Play Week: New York City, September 2 to 8, 1918), 7, Record Group 62: Records of the Council of National Defense, Box 620: "Field Division, Committee on Women's Defense Work, Child Welfare Department, 13G-A1

served as a reminder to Americans that a “national program in the conservation of child-life” was necessary.¹¹⁶



Figure 2.5 “Children’s Play Week.” In one of New Orleans’ Patriotic Play Week (September 1-7, 1918) Parades, a boy dressed as Uncle Sam and a girl portrayed Betsy Ross.

John Tibule Mendes, “Children’s Play Week,” September 1, 1918, John T. Mendes Photograph Collection, The Historic New Orleans Collection, Gift of Waldemar S. Nelson, New Orleans, Louisiana.

Correspondence (Jessica Peixotto) July-October 1918, 13G-B1 Child Welfare Circulars, Health & Recreation Dept. (Reports 13H-A1) April-August 1918, The National Archives at College Park.

¹¹⁶ Ibid., 3.



Figure 2.6 “Girl and Boy on Flower Parade Float.” A sailor boy pulls a boy and a girl on a patriotic float on September 8, 1918 at Taylor Playground in the Broadmoor and Central City area of New Orleans. These children were celebrating the end of Patriotic Play Week (September 1-7, 1918).

John Tibule Mendes, “Girl and Boy on Flower Parade Float,” September 8, 1918, John T. Mendes Photograph Collection, The Historic New Orleans Collection, Gift of Waldemar S. Nelson, New Orleans, Louisiana.



Figure 2.7 “Battleship Float, Taylor Playground.” Taylor Playground boys serving as sailors on a battleship.

John Tibule Mendes, “Battleship Float, Taylor Playground,” September 1, 1918, John T. Mendes Photograph Collection, The Historic New Orleans Collection, Gift of Waldemar S. Nelson, New Orleans, Louisiana.



Figure 2.8 “Boy Scouts Playweek Parade.” Boy Scouts march on Canal Street to celebrate Patriotic Play Week (September 1-7, 1918).

John Tibule Mendes, “Boy Scouts Playweek Parade,” September 1918, John T. Mendes Photograph Collection, The Historic New Orleans Collection, Gift of Waldemar S. Nelson, New Orleans, Louisiana.

As the summer recreation drive came to an end, the CB and WCCND continued their child conservation campaign with a Back-to-School drive. The CB and WCCND were concerned about children not coming back to school in the fall. Local committees of

the WCCND held rallies and published articles in papers. One paper relied on patriotism to entice parents to encourage teenagers to stay in school. “Boys and girls, be patriotic! Stay in school and train for the future.”¹¹⁷ The CB and the WCCND sought to reduce child labor and foster the education of young citizens. After vacations from school, many children did not return because they were needed at home or because they entered the labor force. According to the CB, wartime job opportunities increased absenteeism in schools and after the war, these working adolescents would not fare as well on the job market because they lacked education. During the 1918-19 school year, the CB advertised the importance of schooling. The Bureau even ensured that parents and young Americans saw a reminder to go back to school on the movie screen.¹¹⁸ Millions of women volunteered in the Back-to-School campaign and the Stay-in-School drive to encourage school attendance and learning.

The CB and the volunteers learned from the Allies and their educational programs and considered the Allies’ labor policies when drafting legislation. For instance, the CB turned to French and British examples to address school attendance. Many European educational officials knew that the education of children was essential to their nations in the future, but the war threatened their educational systems. Many French schools were in the middle of a war zone and the French government and local officials thought of creative ways to continue school. For instance, “schools of war” opened in French wine

¹¹⁷ United States Children’s Bureau, *Back-To-School Drive*, Publication 49 (Washington, D.C.: United States Government Printing Office, 1919), 3.

¹¹⁸ Ina J.N. Perkins, letter to the State Chairmen of Child Welfare, January 31, 1919, Record Group 62: Records of the Council of National Defense, Box 904: Field Division, 15-B16 Child Welfare Memoranda,” Folder: “C.W.M. #9 Movie Slides, Jan. 21, 19,” The National Archives at College Park.

cellars to ensure that the future generation would gain the education they needed to succeed.¹¹⁹ The French Minister of Public Instruction, Louis Lafferre, argued that the children of World War I would encounter a “double task” and that they needed an education to be prepared.¹²⁰ Great Britain also faced difficulties in maintaining its educational system. At the beginning of the war, many British youth sought the new job opportunities created by the wartime job shortage. British educational officials found that child labor had negative effects on teenagers’ health.¹²¹ During the first few years of the war, the British were plagued with absenteeism within schools, and many children completely dropped out to enter the labor force. In August 1918, the British government attempted to solve this problem by passing the Education Act of 1918, also known as the Fisher Act, which required all children under fourteen to attend school regularly and required fourteen-to-eighteen year olds to attend school at least three-hundred-and-twenty-hours per annum.¹²² The CB saw the efforts of the French and the British as a “new inspiration.”¹²³ The CB and WCCND recruited eleven million American women to safeguard American education.¹²⁴ The goal of the Back-to-School Drive was to eliminate child labor and enhance children’s education.

¹¹⁹ United States Children’s Bureau, *Back-To-School Drive*, 8.

¹²⁰ *Ibid.*, 3.

¹²¹ *Ibid.*, 6.

¹²² *Ibid.*, 7.

¹²³ *Ibid.*, 8.

¹²⁴ *Ibid.*

The national Back-to-School Drive began on October 17, 1918, and the local committees tried to track down children who did not return to school during the first few weeks of the fall. Forty-five of forty-eight states and Hawaii organized local committees and heeded advice for the Back-to-School Drive.¹²⁵ The CB reminded the local boards to be aware of attendance requirements and child labor laws.¹²⁶ The local committees' volunteers knew that education was a means to ensure that immigrant children learned English and American history and government; therefore, they went to students' homes to preach the significance of education. School was not only a tool of Americanization, but it was also an institution that prepared native born and immigrants to defend American beliefs in the future. The WCCND argued that it was "unpatriotic" for students to drop out of school.¹²⁷ Thousands of teenagers thought about economic obligation rather than their educational futures.

The CB and the WCCND believed that scholarships were necessary to decrease the number of students leaving school for financial reasons. The Bureau noted that education rather than work would better prepare these young Americans and help them "develop into more efficient workers and more useful citizens" in the near future.¹²⁸

¹²⁵ United States Children's Bureau, *Children's Year: A Brief Summary of Work Done and Suggestions for Follow-Up Work*, 8.

¹²⁶ United States Children's Bureau, *Suggestions to Local Committees for the Back-to-School Drive*, Publication 50 (Washington, D.C.: United States Government Printing Office, 1918), 4.

¹²⁷ "Memorandum: Back-to-School Drive Some "Whys" for the Drive," February 6, 1919, 1, Record Group 62: Records of the Council of National Defense, Box 904: Field Division, 15-B16 Child Welfare Memoranda," Folder: "C.W.M. #11 Back-to-School Drive, Some Whys for the Drive, February 6, 1919," The National Archives at College Park.

¹²⁸ United States Children's Bureau, *Scholarships for Children*, Publication 51 (Washington, D.C.: United States Government Printing Office, 1919), 3.

Unlike in the United Kingdom, the CB did not suggest creating scholarships from public funds; rather the scholarships should come from private sources.¹²⁹ The local Back-to-School drive committees had a scholarship team and the CB hoped that the local committees would provide a minimum scholarship of \$120 for at least one student in each of the 281,000 schools in the country.¹³⁰ Some states like Iowa and New Mexico drafted legislation to reduce child labor and increase the compulsory school attendance age.¹³¹ The main goal was to ensure that American children were protected and could afford to return to school.

Children staying in school became even more significant in late 1918. The Back-to-School campaign coincided with negotiations between the Allies and Germany for an armistice. On November 11, 1918, the armistice began and the American government quickly shifted gears to peace talks in 1919. The CB and the WCCND also anticipated the end of the First World War and reshaped its educational campaign. By February 11, 1919, most local committees launched the Stay-in-School campaign. The premise of the drive was “children back in school means soldiers back in jobs,” which was the slogan on the drive’s poster.¹³² The CB contacted over seven-hundred-and-fifty labor unions and asked union leaders to tell teenagers to focus on education.¹³³ In Phoenix, Arizona,

¹²⁹Ibid., 4.

¹³⁰ Ibid., 7.

¹³¹ United States Children’s Bureau, M. 392, February 28, 1919, 1, Record Group 62: Records of the Council of National Defense, Box 904: “Field Division, 15-B16 Child Welfare Memoranda,” Folder: “C.W.M. #12,” The National Archives at College Park.

¹³² United States Children’s Bureau, *Children’s Year: A Brief Summary of Work Done and Suggestions for Follow-Up Work*, 8.

fathers were enlisted to remind their sons of the importance of staying in school during the Father and Son Week.¹³⁴ In the Midwest, a judge emphasized the importance of education to parents of juvenile delinquents. He even requested government pamphlets to give to parents about school.¹³⁵ In New York, the committee studied why students dropped out of school by surveying 1,200 Manhattan children who had left school. The *New-York Tribune* reported that the reasons varied from job opportunities to a dislike for specific teachers.¹³⁶ One New York organization, The Jewish Big Sisters, sought to tackle school absenteeism. During the week, nine-year-old Becky Cohen cared for her toddler sister until the baby went to the nursery school at eleven and then Becky roamed the streets. Her mother, a widow, left for work to provide for the family, but could not ensure that her daughter attended school. The Jewish Big Sisters and other Big Sisters organizations ensured that girls like Becky made it to school each morning.¹³⁷ Socio-economic factors influenced children like Becky and their decisions about education. The CB and often the Red Cross granted scholarships to students with economic hardships.¹³⁸

¹³³ Letter to Ina J. Perkins, March 8, 1919, Record Group 102: Records of the Children's Bureau, 1908-1969, Box 76: "Central File, 1914-1920, 8-2-1-11," Folder: "8-2-1-11 Children's Year Publicity" The National Archives at College Park.

¹³⁴ "Special Reason Why Fathers Should Try to Win Their Sons," *The Arizona Republican*, February 9, 1919, 6.

¹³⁵ Mrs. Matthew Page Gaffney, enclosure to Hannah Mitchell, April 1, 1919, Record Group 102: Records of the Children's Bureau, 1908-1969, Box 76: "Central File, 1914-1920, 8-2-1-11," Folder: "8-2-1-11 Children's Year Publicity" The National Archives at College Park.

¹³⁶ "New Crusade Aims to Lure Children Back to School," *New-York Tribune*, February 2, 1919, 10.

¹³⁷ "New Plans Under Way for Jewish Big Sister Drive," *New-York Tribune*, February 2, 1919, 10.

¹³⁸ "New Crusade Aims to Lure Children Back to School," 10.

The CB believed that the Stay-in-School drive accomplished two goals: keeping students in school and opening jobs for returning veterans.

According to the CB, the educational drives prompted state and local officials to enforcement of existing attendance and child labor laws more effectively. Some state educational officials and committees sought to increase attendance in schools, but faced obstacles. For instance, Montana State Superintendent Mae Trumper was extremely interested in improving education in her state, but needed more schools. Viola Paradise, a member of the CB who surveyed maternal and infant health in eastern Montana, believed that the drive would require additional rural schools.¹³⁹ Many educational drive committees encountered illiteracy among immigrants and poor Americans; therefore, the committees' school drives stressed the importance of literacy. Some states, like Texas and Arkansas, wanted to wipe out illiteracy. The Texas officials wanted to achieve this goal by 1920. While this ambitious plan was not successful, the state officials increased public interest in education.¹⁴⁰ The Children's Year educational drives encountered these obstacles, but they did not reduce concerns in public compulsory education.¹⁴¹

The Children's Year ended on April 6, 1919, and the CB believed it possibly saved at least 100,000 infants' lives and created new standards for child health including

¹³⁹ Viola Paradise, letter to Eleanor Hunter, March 3, 1919, Record Group 102: Records of the Children's Bureau, 1908-1969, Box 76: "Central File, 1914-1920, 8-2-1-11," Folder: "8-2-1-11 Children's Year Publicity" The National Archives at College Park. For more information on Viola Paradise see: Harry W. Fritz, Mary Murphy, and Robert R. Swartout, eds. *Montana Legacy: Essays on History, People, and Place* (Helena: Montana Historical Society Press, 2002), 139-140; Rima Apple, *Perfect Motherhood*, 78.

¹⁴⁰ United States Children's Bureau, *Children's Year: A Brief Summary of Work Done and Suggestions for Follow-Up Work*, 10-11.

¹⁴¹ Donald Parkerson and Jo Ann Pakerson, *Transitions in American Education: Social History of Teaching* (New York: Rutledge, 2014), "The Resurgence of the NEA," paragraph 3.

physical examinations and treating malnourished preschoolers.¹⁴² The CB and WCCND work did not end when the campaign was over. According to the CB's closing news release, the year had been a "war measure and it is well to remember that as a war measure President Wilson said it was 'second only in importance' to measures needed to meet the requirements of combatants."¹⁴³ Before the Children's Year appropriation ended on July 1, 1919, and the WCCND dissolved, the team used left over funds to sponsor a child welfare conference series. The CB vowed that the efforts should not only be a wartime measure, but also "a peace measure."¹⁴⁴ The standards produced from the Conference on Child Welfare Standards laid the foundation for maternal and child welfare and health in the 1920s.

On May 5, 1919, groups of child welfare reformers from the United States, Canada, Great Britain, France, and Japan met in Washington, D.C. at the White House Conference on Standards of Child Welfare, the second series of the White House Conference on Children.¹⁴⁵ This conference used the momentum of the Children's Year

¹⁴² Julia Lathrop, "Seventh Annual Report of the Chief, Children's Bureau to the Secretary of Labor, Fiscal Year Ended June 30, 1919," 7.

¹⁴³ H. Anderson, Enclosure to Dr. Anna Rude, April 22, 1919, "For Release Sunday, April 6, 1919."

¹⁴⁴ Ibid.

¹⁴⁵ "Prepared by Mrs. Laura Clarke Gaffney for the Democratic National Committee," May 22, 1919, 1, Record Group 102: Records of the Children's Bureau, 1908-1969, Box 76: "Central File, 1914-1920, 8-2-1-11," Folder: "8-2-1-11 Children's Year Publicity" The National Archives at College Park. The overwhelming majority of the second White House Conference on Children sources are not available now. According to the scope and content of the White House Conference on Children and Youth Records, 1930-1970 states, "The official records of these and earlier conferences have not been located and may no longer exist." Even so, the Children's Bureau saved some material and a few publications are still accessible. "White House Conference on Children and Youth Records, 1930-1970 Scope and Content," Dwight D. Eisenhower Presidential Library, Abilene, Kansas, accessed February 2018, https://www.eisenhower.archives.gov/research/finding_aids/pdf/White_House_Conference_on_Children_and_Youth.pdf.

to address many issues that the CB and the WCCND identified. The American experts listened to their foreign counterparts about education and health. According to one report, the experts paid attention to Britain's Education Act of 1918. Julia Lathrop, the chief of the Children's Bureau, believed America needed an educational act, but the United States would have to pay particular attention to rural areas children.¹⁴⁶ These experts also met at regional conferences in nine major cities throughout the month of May and early June to discuss issues regarding obstetrics, infant, toddlers, school-age children, and youth health and well-being.¹⁴⁷

Experts explored the importance of maternal health and developed standards for obstetrics. In the last decade of the nineteenth century and the early twentieth century, Johns Hopkins University was a leader in medical education and obstetrics. J. Whitridge Williams, the first Professor of Obstetrics at Johns Hopkins University and the author of the seminal text, *Williams' Obstetrics*, wrote a position paper on care for mothers. He realized, however, that it was difficult to produce "universal standard requirements for obstetrics," because of regional differences and the size of the American population.¹⁴⁸ Williams campaigned for better obstetrics training, especially after the 1910 Flexner

¹⁴⁶ Laura Clarke Gaffney, "The Children's Bureau's Conference on Child Welfare Standards," May 20, 1919, 4, Record Group 102: Records of the Children's Bureau, 1908-1969, Box 76: "Central File, 1914-1920, 8-2-1-11," Folder: "8-2-1-11 Children's Year Publicity" The National Archives at College Park.

¹⁴⁷ "Prepared by Mrs. Laura Clarke Gaffney for the Democratic National Committee," May 22, 1919, 1. Experts met at regional conferences in New York, Boston, Cleveland, Knoxville, Chicago, Minneapolis, Denver, San Francisco, and Seattle. At these conferences, the experts discussed the standards agreed upon at the White House Conference.

¹⁴⁸ J. Whitridge Williams, "Maternity and Infancy: Standard Requirements for Obstetrical Care," in *Standards of Child Welfare: A Report of the Children's Bureau*, Publication 60, United States Children's Bureau, ed. (Washington, D.C. United States Government Printing Office, 1919), 145.

Report, and encouraged medical schools to improve obstetric training.¹⁴⁹ He declared that all mothers should have access to medical care at least once a month during the second half of pregnancy, a complete gynecological exam four-to-six weeks before the due date and four weeks after, regular check-ups for the baby for the first year, and a medical professional who used the “aseptic technique” not “meddlesome midwifery.”¹⁵⁰ The experts also wanted to treat mothers and prevent children from contracting venereal diseases such as syphilis. Charles Chapin, a physician, proponent of the germ theory, and leader in the Progressive public health movement, believed that midwives were simply “unnecessary” and that they could “gradually be eliminated.”¹⁵¹ In the early 1900s, Chapin published numerous articles concerning infectious disease prevention that promoted the germ theory of disease and public health organizations at the state level. Chapin worried that foreign midwives threatened ideas of scientific motherhood and that

¹⁴⁹ For more information on J. Whitridge Williams see: Charlotte G. Borst, *Catching Babies: The Professionalization of Child Birth, 1870-1920* (Cambridge: Harvard University Press, 1995); Andrea Tone, ed. *Controlling Reproduction: An American History* (Wilmington: Scholarly Resources, Inc., 2001), 66-74; P.M. Dunn, “John Whitridge Williams, MD (1866-1931) of Baltimore: Pioneer of Academic Obstetrics,” *Archives of Disease in Childhood, Fetal and Neonatal Edition*, vol. 92, no. 1 (January 2007): F74-F77.

¹⁵⁰ J. Whitridge Williams, “Maternity and Infancy: Standard Requirements for Obstetrical Care,” 145.

¹⁵¹ Charles Chapin, “The Control of Midwifery,” in *Standards of Child Welfare: A Report of the Children’s Bureau*, 163. Charles V. Chapin served as the superintendent of the Providence Board of Health from 1884 to 1932. During his nearly fifty-year career, he devoted himself to disease prevention and the new public health movement. In the late 1800s and early 1900s, he argued against filth theory in favor of germ theory. By the late 1920s, Chapin was a renowned figure in American public health. In 1927, he was the President of the American Public Health Association (APHA). During the following two years he received the National Academy of Sciences Public Welfare Medal and APHA’s first Sedgwick Memorial Medal, an honor named after William T. Sedgwick, a late nineteenth and early twentieth centuries public health stalwart. Like Sedgwick, Chapin studied epidemiology and championed public health. For more information on Charles V. Chapin see: James H. Cassedy, *Charles V. Chapin and the Public Health Movement* (Cambridge: Harvard University Press, 1962); George Rosen, *A History of Public Health, Revised Expanded Edition* (Baltimore: The Johns Hopkins University Press, 2015), 185, 193; Nancy Tomes, *The Gospel of Germs: Men, Women, and the Microbe in American Life* (Cambridge: Harvard University Press, 1999).

nurses needed to teach the mothers.¹⁵² A few doctors, specifically female or foreign doctors, defended midwives as valuable medical caregivers.¹⁵³ The Children's Year promoted better standards for health officials and health.

The Children's Year revealed that thousands of American youngsters were underweight and many had preventable or treatable childhood diseases. The national weighing and measuring drive only gathered data for young children, but public health officials and the CB were concerned about all American adolescents and the productive citizens they would become. Dr. William Emerson of Boston, Massachusetts, argued that weighing and measuring was essential to identify children who are at risk of being malnourished. To ensure that all children and parents had the opportunity to understand nutrition, Emerson recommended nutrition clinics and classes for school-age children. Health departments offered nutrition clinics for malnourished children, where the public health officials conducted physical, mental, and social exams on these children. Malnourished children were at risk for ailments such as respiratory illnesses. The health officials also gathered data on the children's homes or social lives. This included information ranging from physical activities to what the children ate. By obtaining this data, the physicians and nurses could offer a hypothesis suggesting why a particular child was malnourished. The public health officials used this knowledge to plan nutrition classes. Dr. Emerson noted that the best nutrition classes should have no more than

¹⁵² Charles Chapin, "The Control of Midwifery," 163.

¹⁵³ In America, physicians and midwives have had a complex relationship. Marie Jenkins Schwartz asserted that nineteenth century, physicians pushed healing women or midwives out of birthing rooms. Due to professional reasons, doctors often saw midwives as uneducated, who lacked scientific knowledge. Marie Jenkins Schwartz, *Birthing a Slave: Motherhood and Medicine in the Antebellum South* (Cambridge: Harvard University Press, 2006).

twenty children per class, which allowed the nutrition teacher the ability to weigh each child each week. The parents and the child were responsible for tracking their activity level and food consumption for at least two days a week to receive rewards, such as the blue star award for resting. The nutrition teacher gave the gold star to the child who gained the most weight in a week. This reward system gave many an incentive to take the nutrition class seriously. If a child lost weight, the nutrition teacher or doctor would meet with the school-age child to go over individual goals.¹⁵⁴ These nutrition classes helped nurses gain authority in their community.

During the Children's Year, the CB and WCCND suggested that states employ more public health nurses and create maternal and child hygiene divisions. Dr. Thomas D. Wood, the Chairman of the National Council of Education's Committee on Health Problems in Education, reminded the experts of the recent revelation that over sixteen million American children were malnourished or diseased. He proclaimed, "A stunning indictment of our democracy is involved in the fact that the tragedy of a world war was needed to reveal such a vital source of national peril and weakness."¹⁵⁵ The child health experts who met during May and June 1919 believed that the United States had to have standards to protect children's health. One of these ideals was a school nurse for every 1,000 to 3,000 pupils. Wood charged the school nurses to frequently examine classes, provide first aid, help conduct physical examinations and record keeping, teach students

¹⁵⁴ William R.P. Emerson, "The School Child: Nutrition Clinics," in *Standards of Child Welfare: A Report of the Children's Bureau*, Publication 60, United States Children's Bureau, ed. (Washington, D.C. United States Government Printing Office, 1919), 238-244.

¹⁵⁵ Thomas D. Wood, "Health Examinations and the School Nurse," in *Standards of Child Welfare: A Report of the Children's Bureau*, Publication 60, United States Children's Bureau, ed. (Washington, D.C. United States Government Printing Office, 1919), 248.

about nutrition and hygiene, mediate discussions with children's parents, and provide treatment advice including recommending physician care. The Children's Year and the conference meetings raised awareness that America needed more public health nurses, both those working for state and local health departments and those employed by school districts, as essential health personnel to prevent and treat disease among American children.

According to the child welfare experts, American mothers, infants, children, and children with special needs required protection. The national and state governments, public health organizations, volunteers, and society were accountable for the health of the child; therefore, the CB's conference delegates issued minimum standards to protect women and children. The standards were approved in an attempt to improve maternal, infant, preschoolers, school-age children, and teenagers' health and ranged from physical examinations to birth registrations.¹⁵⁶ These experts also issued an opinion on the "minimum standards for the protection of children in need of special care" that addressed housing, income, placing children in foster care, child welfare legislation, and juvenile delinquency.¹⁵⁷ The majority of the conference attendees also supported the Maternity Bill, the forerunner to the Promotion of the Welfare and Hygiene of Maternity and Infancy Act of 1921 or the Sheppard-Towner Act.¹⁵⁸ According to Ladd-Taylor, the

¹⁵⁶ United States Children's Bureau, *Standards of Child Welfare: A Report of the Children's Bureau*, Publication 60, 436-439.

¹⁵⁷ *Ibid.*, 440-444.

¹⁵⁸ "Children's Year: The Introduction to the Children's Era," June 3, 1919, 7, Record Group 102: Records of the Children's Bureau, 1908-1969, Box 76: "Central File, 1914-1920, 8-2-1-11," Folder: "8-2-1-11 Children's Year Publicity" The National Archives at College Park.

Sheppard-Towner Act “provided federal matching grants to the states for information and instruction on nutrition and hygiene, prenatal and child health clinics, and visiting nurses for pregnant women and new mothers.”¹⁵⁹ The Children’s Year and the culminating event, the 1919 White House Conference on Children, provided the groundwork for state maternal and infant hygiene departments. From April 1919 to April 1922, the two years between the end of the Children’s Year and the availability of Sheppard-Towner Act funds, nearly half of the states started maternal and child hygiene departments. For instance, Alabama organized the Bureau of Child Hygiene in 1919 and began treating mothers and children in 1920.¹⁶⁰ Similarly, the Connecticut legislature created the Bureau of Child Hygiene in 1919. According to the Commissioner of the Connecticut State Board of Health, John T. Black, child hygiene work began in the state in June 1918 as part of the CB’s and the Connecticut Women’s Committee of the State Council of Defense’s Children’s Year campaign. The effort of the groups prompted the state legislature to create a Division of Child Hygiene that began work on July 1, 1919, and a Division of Public Health Nursing because “child welfare work depends largely upon public health nursing.”¹⁶¹ The CB’s and the WCCND’s work created networks between public health workers and child welfare advocates that continued or began promoting child hygiene at the state level.

¹⁵⁹ Molly Ladd-Taylor, *Mother-Work*, 168-169.

¹⁶⁰ Alabama State Board of Health, “Bulletin of the Alabama State Board of Health: Child Hygiene in Alabama 1919 to 1923,” 25-28, Series: 028237, Box: “Department of Public Health State Publications 1896-1952,” Alabama Department of History and Archives.

¹⁶¹ John T. Black, *Thirty-Sixth Report of the Connecticut State Department of Health for Two Years Ending June 30, 1920* (Hartford: State of Connecticut Department of Health, 1920), 171.

Table 2.2 The Origins of State and Territory Child Hygiene Programs

Origin Year	State and Territory Child Hygiene Program
1910	LA
1914	NY
1915	KS, MA, NJ
1916	OH
1917	IL, IN, MT
1918	VA
1919	AL, AZ, CA, CO, CT, GA, HI, ID, MI, MO, NC, RI, SC, TX, WV, WI
1920	ME, MS
1921	DC, NE, NH, NM, OR
1922	MD, MN, NV, OK
1923	AR, DE, IA, ND, SD, TN, WA, WY
N/A	VT

As of 1925, Vermont did not have a specific organization devoted to child hygiene work. Taliaferro Clark and Selwyn D. Collins, *A Synopsis of the Child Hygiene Laws of the Several States Including School Medical Inspection Laws* (Washington, D.C.: United States Government Printing Office, 1925),1-2.

Table 2.3 The Number of States or Territories That Created a Child Hygiene Program during a Given Year.

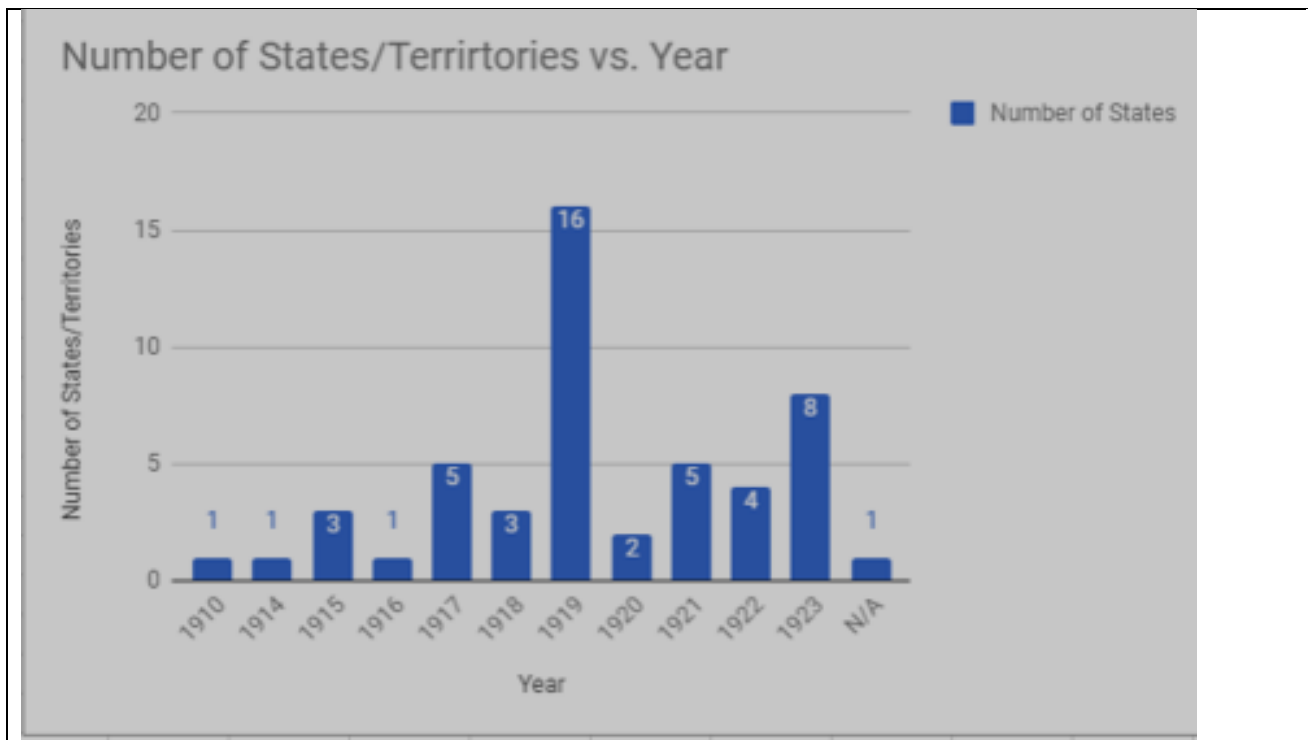


Table 1.3 (continued)

As of 1925, Vermont did not have a specific organization devoted to child hygiene work. Taliaferro Clark and Selwyn D. Collins, *A Synopsis of the Child Hygiene Laws of the Several States Including School Medical Inspection Laws* (Washington, D.C.: United States Government Printing Office, 1925), 1-2.

The Children's Year and the White House Conference revealed the significance of having maternal and child hygiene departments to educate and care for mothers and children. Only after the Children's Year and the White House Conference, did the Children's Bureau gain leverage in Congress to push through a maternity bill. The Sheppard-Towner Act of 1921 provided funds to help expand these state agencies that were in their infancy. However, the law was not the catalyst for state child hygiene departments throughout America. Historian Julia Grant explained that the CB used Children's Year data to promote the Sheppard-Towner Act; Grant's observation is salient because the Year did produce statistics on American children.¹⁶² Yet, the Children's Year provided more than just data that allowed the CB to implement the Sheppard-Towner Act quickly. The Children's Year helped the CB develop stronger relationships with state boards of health that became convenient as the CB continued the push for a national maternal and child hygiene agenda in the early 1920s.

¹⁶² Julia Grant, *Raising Baby by the Book*, 81-82.

CHAPTER III

THE SISTER STATES' COMMUNITY HEALTH PROGRAMS: THE SHEPPARD-TOWNER ACT IN MISSISSIPPI AND ALABAMA, 1921-1929

On December 19, 1922, many Mississippi women and mothers were preparing for the holiday season. Some of these women flipped through the Tuesday morning *Clarion-Ledger*, the largest newspaper in the state, searching for advertisements about the visiting Santa Claus at Kennington's Store on Congress Street in downtown Jackson, Mississippi or looking for the right present such as a Victrola or books.¹⁶³ N.H. Thomas Grocery reminded readers that they had "Everything for the Fruit Cake."¹⁶⁴ These women may have noticed an article targeted at Mississippi society women entitled "Mothers and Children." The article explained the importance of the Sheppard-Towner Act or the Promotion of the Welfare and Hygiene of Maternity and Infancy Act of 1921 in the state of Mississippi.¹⁶⁵ The Sheppard-Towner Act funds allowed Mississippi public health

¹⁶³ *The Clarion-Ledger*, December 19, 1922, 4, 11-12.

¹⁶⁴ *Ibid.*, 11.

¹⁶⁵ For more information on the Sheppard-Towner Act consult: Molly Ladd-Taylor, "We Mothers Are So Glad the Day Has Come," in *Mother-Work: Women, Child Welfare, and the State, 1890-1930* (Urbana: The University of Illinois Press, 1994), 167-196; Molly Ladd-Taylor, *Raising a Baby The Government Way: Mothers' Letters to the Children's Bureau, 1915-1932* (New Brunswick: Rutgers University Press, 1986); Joan Elizabeth Mulligan, "Three Federal Interventions on Behalf of Childbearing Women: The Sheppard-Towner Act, Emergency Maternity and Infant Care, and the Maternal and Child Health and Mental Retardation Planning Amendments of 1963," (PhD diss., University of Michigan, 1976), 25-51; Robyn Muncy, *Creating a Female Dominion in American Reform, 1890-1935* (New York: Oxford University Press, 1991), 103-150; Kriste Lindenmeyer, "Saving Mothers and Babies: Designing and Implement a National Maternity and Infancy Act, 1918-1930," in *"A Right to Childhood," The U.S. Children's Bureau and Child Welfare, 1912-1946* (Urbana: The University of Illinois Press, 1997), 76-107; Virginia Sapiro, "The Gender Basis of American Social Policy," in *Women, the State, and Welfare*, ed. Linda Gordon

officials to expand public health nursing and reach women and children previously neglected by the state's early public health system. Public health personnel taught women how to prepare to be mothers and how to provide nutritious meals for their children.¹⁶⁶

According to the article, the Sheppard-Towner Act was “the object of a great deal of interest by the club women of Mississippi.”¹⁶⁷ Many organizations worked together with public health officials to reduce infant and maternal mortality during the 1920s. Although Mississippi State Board of Health (MSBH) already operated a maternal and child hygiene division, the Sheppard-Towner Act enabled the state to expand community child hygiene projects. One aspect of child health work included the MSBH collaborating with the nutrition division of the child welfare department to ensure that pregnant

(Madison: The University of Wisconsin Press, 1990), 36-54; Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Cambridge: The Belknap Press, 1992), 494-522; Alexandra Minna Stern, “Making Better Babies: Public Health and Race Betterment in Indiana, 1920-1935,” *American Journal of Public Health* 92, no. 5 (May 2002): 742-752; Alexandra M. Stern and Howard Markel, eds., *Formative Years: Children's Health in the United States, 1880-2000* (Ann Arbor: The University of Michigan Press, 2004), 9-10, 50, 108, 134-135, 142-143; Richard Mackel, *Save the Babies: American Public Health Reform and the Prevention of Infant Mortality, 1850-1929* (Ann Arbor: University of Michigan Press, 1990), 200-219; J. Stanley Lemons, “The Sheppard-Towner Act: Progressivism in the 1920s,” *Journal of American History* 55, no. 4 (March 1969): 776-786.

¹⁶⁶ “Mothers and Children,” *The Clarion-Ledger*, December 19, 1922, 4. For more information on Southern clubwomen and health work consult the following: Anastasia Sims, *The Power of Femininity in the New South and Women Organizations and Politics in North Carolina, 1880-1930* (Columbia: University of South Carolina Press, 1997); Anne M. Knupfer and Christine Woyshner, eds., *Educational Work of Women's Organizations, 1890-1960* (New York: Palgrave Macmillan, 2008), 31, 111, 217, 228; Gerda Lerner, “Early Community Work of Black Women,” *The Journal of Negro History* 59, no. 2 (1974): 158-167; Tera Hunter, *To 'Joy My Freedom: Southern Black Women's Lives and Labors After the Civil War* (Cambridge: Harvard University Press, 1997), 137, 209, 213-214; Martha Swain, “Mississippi White Women's Clubs in the Quest for Women's Rights in the Twentieth Century,” in *Mississippi Women: Their Stories, Their Lives—Volume 2*, eds., Elizabeth Anne Payne, Martha H. Swain, and Marjorie Julian Spruill (Athens: University of Georgia Press, 2010), 269-286; Mary Martha Thomas, “Black Women During the Progressive Era, 1890-1920,” in *Stepping Out of the Shadows, Alabama Women, 1819-1990* (Tuscaloosa: University of Alabama Press, 1995), 75-95.

¹⁶⁷ “Mothers and Children,” 4.

women, infants, and children had an adequate diet. Eva Lambert, a dietitian and leader of the nutrition division, emphasized the importance of Mississippians working together to accomplish the goal of the Sheppard-Towner Act. To collaborate with the maternity and infant health efforts, clubs like the Parent-Teacher Association worked with public health workers to emphasize the importance of clean milk, proper feeding, and weighing children regularly.¹⁶⁸ In Mississippi and other southern states, this often meant that white public health nurses and club women worked to educate white mothers-to-be and the same nurses communicated with African American club women and midwives, who worked as intermediaries for the public health officials to spread information for the African American community.¹⁶⁹ Mississippi and Alabama public health departments accepted national Sheppard-Towner standards and adhered to local customs of segregation by separately advising poor white and African American women.

This chapter follows the work of the Children's Bureau (CB) to secure the continuation of a national maternal and infant healthcare program after the Children's Year and the 1919 White House Conference on Standards of Child Welfare. In the late 1910s and early 1920s, the CB lobbied Congress for a national maternity and infant healthcare bill that would provide funding and standards for healthcare for American mothers and infants. By late 1921, the Bureau secured appropriations when Congress passed the Sheppard-Towner Act, a law that allowed states to develop their rather new

¹⁶⁸ Ibid.

¹⁶⁹ Susan L. Smith, "White Nurses, Black Midwives, and Public Health in Mississippi, 1920-1950," in *Women and Health in America: Historical Readings, Second Edition*, ed. Judith Walzer Leavitt (Madison: The University of Wisconsin Press, 1999), 444-445.

child hygiene departments or to create child health departments. As noted in Chapter Two, most states developed maternal and child health programs before the enactment of the Sheppard-Towner Act, but the act allowed states to devote more effort to the cause.

In 2010, historians Elizabeth Anne Payne and Martha Swain noted that they could not “secure an article on child-birth, midwifery, and public health” for their edited volume, *Mississippi Women: Their Histories, Their Lives*. The two scholars called for “further research and writing on the subject.”¹⁷⁰ Over the past decade, scholars have examined the importance of midwives in Mississippi and explored the importance of public health nursing in the state. Yet, Mississippi and other southern states’ participation in the Sheppard-Towner Program remains understudied. This chapter contends that the Sheppard-Towner Program, the CB’s national maternal and newborn hygiene program, allowed Deep South states like Alabama and Mississippi to organize a working maternal and child community health model in each respective state. The Deep South maternal and child healthcare systems cared for all mothers and children in that geographic community not because the Sheppard-Towner Act mandated it, but because the system incorporated aspects of the Deep South’s economy, public health infrastructure, culture, and racial politics. The Alabama and Mississippi Sheppard-Towner programs continued paternalistic medicine and attempted to secure the future of southern society, culture, and economy by protecting its mothers and newborns.¹⁷¹ Although the Mississippi and

¹⁷⁰ Elizabeth Anne Payne, Martha H. Swain, and Marjorie Julian Spruill, *Mississippi Women, Volume 2*, 149.

¹⁷¹ This argument is influenced by Keith Wailoo and his discussion of how a healthcare system reflects an area’s political economy, institutions, and culture. Keith Wailoo, *Dying in the City of the Blues: Sickle Cell Anemia and the Politics of Race and Health* (Chapel Hill: The University of North Carolina Press, 2001), 29,33, 84-85.

Alabama Sheppard-Towner programs had slight differences but looked very similar because the states shared a common economy and culture.

During World War I, the Children's Bureau actively tried to reduce infant mortality and improve children's health. One program, the Children's Year (April 1918-April 1919), focused on weighing infants and preschoolers in order to diagnose malnutrition. After the war, child welfare advocates met at the second White House Conference on Children to discuss the state of children in America. According to historian Molly Ladd-Taylor, this 1919 White House Conference on the Minimum Standards for Child Welfare focused on three issues: "child labor and education, maternal and child health, and children in need of special care."¹⁷² Leaders from the CB, like Chief Julia Lathrop, and other progressive women continued to lobby for the protection of American mothers and children.¹⁷³

In the backdrop of World War I, Congress launched a campaign to provide better maternal and infant care for mothers. In hopes of securing maternal and child welfare legislation, Montana Republican Jeannette Rankin, the first female Representative, and Arkansas's Democratic Senator, Joseph Robinson proposed similar bills in each house on July 1, 1918. Historian Kriste Lindenmeyer noted that Rankin's "Bill to Encourage Instruction in the Hygiene of Maternity and Infancy" was "more successful" because the House Committee on Labor held two hearings in January 1919 to determine the need for

¹⁷² Molly Ladd-Taylor, *Mother-Work*, 90.

¹⁷³ For more information on progressivism and the Sheppard-Towner Act see: J. Stanley Lemons, "The Sheppard-Towner Act: Progressivism in the 1920s," 776-786.

a maternal and infant health plan.¹⁷⁴ Although Rankin's and Robinson's bills did not pass in 1919, members of Congress did not forget the significance of maternal and infant hygiene. No longer a representative, Rankin still supported a bill that would help women and children throughout the country. Another maternity and infant bill was introduced and tabled again in 1920. These bills never made it to floor due to time constraints of the session.¹⁷⁵

By 1921, Horace Towner, a Republican Representative from Texas, initiated a bill that would readdress maternal and infant health care. On April 11, 1921, Towner presented the bill and the House referred the bill to the Committee on Interstate and Foreign Commerce. That July, the committee held a hearing on the "protection of maternity," which was more relevant than previous years. The committee chairman Samuel E. Winslow, a Republican Representative of Massachusetts, claimed that "I think it is due to the committee to have this said--- with a frank flat statement that this bill coming up to-day is really in logical order for the first time."¹⁷⁶ During the last Congressional session, a similar bill had made its way through the Senate, but the bill did not make it through the House. Towner noted that the House committee wanted to alter Senator Morris Sheppard's 1920 maternity bill and by 1921, Sheppard and Towner

¹⁷⁴ Kriste Lindenmeyer, "A Right to Childhood," 76-78.

¹⁷⁵ For more information on maternity and infant health bills introduced prior to the Sheppard-Towner Act see: Joan Elizabeth Mulligan, "Three Federal Interventions on Behalf of Childbearing Women: The Sheppard-Towner Act, Emergency Maternity and Infant Care, and the Maternal and Child Health and Mental Retardation Planning Amendments of 1963," 25-39.

¹⁷⁶ United States Congress House of Representatives, Committee on Interstate and Foreign Commerce, *Public Protection of Maternity and Infancy: Hearings Before the Committee on Interstate and Foreign Commerce of the House of Representatives*, 67th Congress, 1st sess., 1921, 5.

reintroduced a maternity and infancy protection bill that was “in exactly the form which you reported the bill; in other words, incorporating all the amendments that were agreed to by this committee during the last Congress.”¹⁷⁷ Sheppard and Towner wanted to guarantee that the bill passed after three attempts to protect the women and children.

Towner argued that the “National Government ought to do something” in conjunction with various welfare organizations to protect and provide healthcare for American women and children.¹⁷⁸ Many major welfare advocates supported the bill and testified on the benefits of a national maternal plan in July 1921. Dr. Josephine Baker, the Director of the Child Hygiene Division for the New York City Board of Health and later a consultant for the CB, and Dr. Ellen C. Potter, the Director of the Division of Child Hygiene for the Pennsylvania State Department of Health, explained that maternal and child welfare issues were not localized to New York City or Pennsylvania, but were a national problem.¹⁷⁹ They argued that the United States government would provide the blueprint for a maternal and infant health program that focused on community health and educating the public about motherhood and infant health.¹⁸⁰ Yet, Baker explained that states should administer the programs, while the federal government should approve states’ plan to guarantee the local programs met national standards.¹⁸¹ Many state departments of health had incomplete data on maternal and infant mortality rates and

¹⁷⁷ Ibid., 7.

¹⁷⁸ Ibid., 7-8.

¹⁷⁹ Ibid., 13-27,42-47.

¹⁸⁰ Ibid., 9.

¹⁸¹ Ibid., 15.

worked with mothers to educate on better nutrition and nurturing tactics, while others did not have division specifically provide care for mothers and children. The CB had estimates and determined that United States needed to do a better job protecting women and children from preventable deaths. At the hearing, Dr. Baker stressed that a maternal and infant health program was necessary because the United States' maternal mortality rates ranked below seventeen other nations.¹⁸² When comparing the United States' maternal mortality rates to Norway, Sweden, the Netherlands, and Italy, the United States had more than double the maternal mortality rates at six-and-a-half per 1000 births.¹⁸³ If the bill passed, the federal government would take a more active role in maternal and child health. Either the United States Public Health Service (USPHS) or the CB would do more than gathering statistical data and completing studies. The bill stipulated that the government would provide appropriations for state governments to educate the general population on maternal and infant health care and to provide care through community public health agencies.

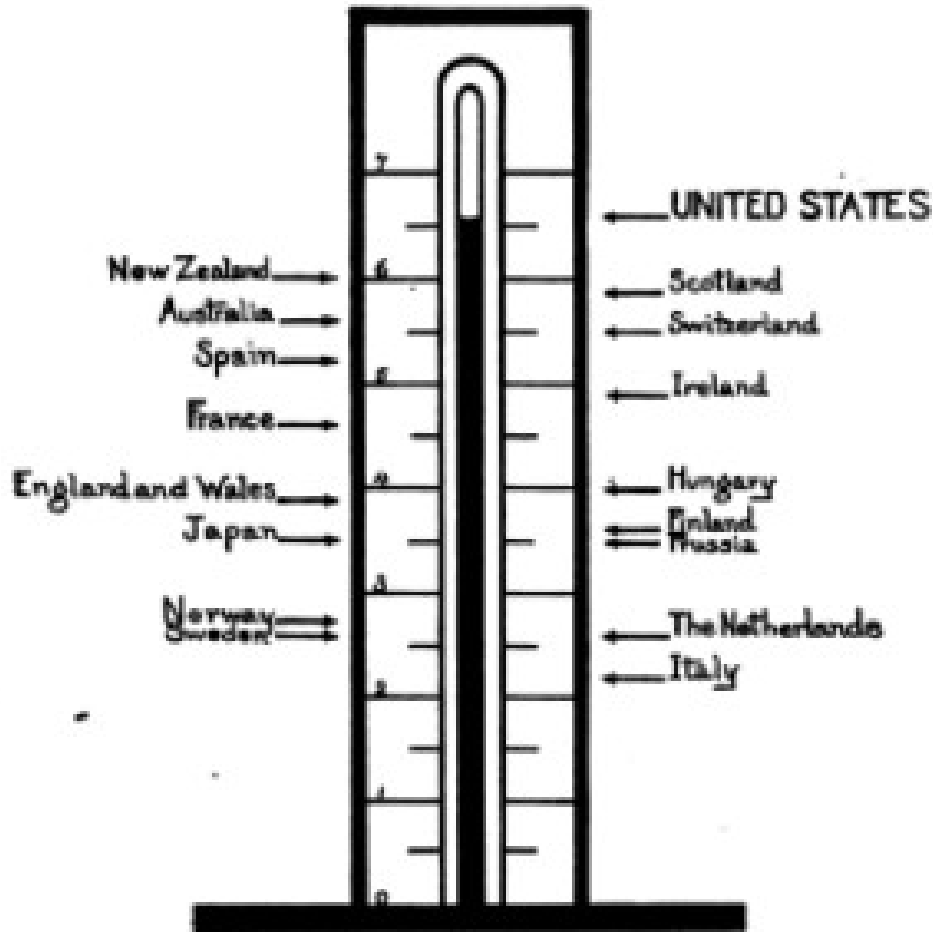
¹⁸² Ibid.

¹⁸³ Ibid., 16. Norway, Sweden, the Netherlands, and Italy had maternal mortality rates below three deaths per 1000 births in 1917.

MATERNAL MORTALITY RATES

per 1000 births

Latest available figures up to 1917



The United States lost over 21,000 women in 1918 from childbirth. We have a higher maternal death rate than any other of the principal countries.—Children's Bureau, U. S. Department of Labor.

Figure 3.1 Dr. Josephine Baker and the Children's Bureau used this chart to explain to the how American maternal care lagged behind other developed countries. The CB often used data to back support for the Sheppard-Towner Act.

United States Congress House of Representatives, Committee on Interstate and Foreign Commerce, Public Protection of Maternity and Infancy: Hearings Before the Committee on Interstate and Foreign Commerce of the House of Representatives, 67th Congress, 1st sess., 1921, 16.

In 1920, the American Medical Association (AMA), the leading medical society, launched its unwavering campaign against a national maternity and infant health bill as an attempt to preserve the professionalism of white male physicians, to control specialized medical knowledge, and out of fear that a national maternal and infant hygiene program would lead to socialized medicine that would undermine their profession and profits.¹⁸⁴ By 1921 most AMA members did not support the Promotion of the Welfare and Hygiene of Maternity and Infancy Act of 1921, but the bill still garnered political support from other medical and public health associations, such as the American Child Health Association.¹⁸⁵ By November 1921, the bill's sponsors gained enough support to push the bill through both houses after campaigning for over three years to provide better maternal and infant care for American mothers and children. Congress voted on a bill that promised over one million dollars for maternal and infant hygiene for the fiscal year ending on June 30, 1922. On November 23, 1921, President Warren Harding signed the bill into law and the CB assumed control over these funds. The CB would ensure that states received money to create or extend maternal and child health

¹⁸⁴ Not all members of the AMA opposed the Sheppard-Towner Bill. Some female CB doctors remained member of the AMA and supported the national program. Kriste Lindenmeyer, "A Right to Childhood," 85-87, 89; Robyn Muncy, *Creating a Female Dominion in American Reform*, 140-141. For more information on the AMA's opposition of the Sheppard-Towner Act see: Kriste Lindenmeyer, "A Right to Childhood," 85-89; 103-108; Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982), 260-261; Robyn Muncy, *Creating a Female Dominion in American Reform*, 124, 125, 128, 132-140, 142, 147, 148, 150; Molly Ladd-Taylor, *Mother-Work*, 169, 171-173, 174, 184-190; Joan Elizabeth Mulligan, "The Federal Interventions on Behalf of Childbearing Women: The Sheppard-Towner Act, Emergency Maternity and Infant Care, and The Maternal and Child Health and Mental Retardation Planning Amendments of 1963," (PhD diss., University of Michigan, 1976), 39-43.

¹⁸⁵ Molly Ladd-Taylor, *Mother-Work*, 170.

programs, but funding did not become available until April 1922.¹⁸⁶ Forty-two states quickly accepted appropriations under the Sheppard-Towner Act. The states with child hygiene departments took advantage of the funds more efficiently than those that had to organize departments and meet national standards. From 1922 to 1923, twelve states created maternal and child health programs.¹⁸⁷ The forty-two states that accepted funds used the appropriations to benefit their specific community's needs. In Alabama and Mississippi, the departments used the funding to address problems surrounding midwifery and to decrease maternal and infant mortality. In the Midwest, states including Indiana incorporated Sheppard-Towner funds into eugenic projects to create better native-born white newborns.¹⁸⁸ States operated their Sheppard-Towner programs in a way that fit into the existing political, societal, and culture structure. In the Deep South, state boards of health had to consider the sharecropping system and segregation when implementing the maternal and infant health program.¹⁸⁹

¹⁸⁶ Children's Bureau, *Promotion of the Welfare and Hygiene of Maternity and Infancy: Text of Act of November 23, 1921 and Maximum Amounts Available to the States, Publication 95*, (Washington, D.C.: United States Government Printing Office, 1921), 3. One million dollars in 1922 is equivalent to nearly \$14.5 million dollars in 2017 currency. For more information, see the Consumer Price Index Inflation: <https://data.bls.gov/cgi-bin/cpicalc.pl> (accessed July 2017); Grace Abbott, "Federal Aid for the Protection of Maternity and Infancy," *American Journal of Public Health* 12, no. 9 (September 1922): 737-742. For the fiscal year ending June 30, 1922, the government only offered \$715,000 directly to states and territories.

¹⁸⁷ Taliaferro Clark and Selwyn D. Collins, *A Synopsis of the Child Hygiene Laws of the Several States Including School Medical Inspection Laws* (Washington, D.C.: United States Government Printing Office, 1925), 1-2.

¹⁸⁸ Alexandra M. Stern, "Making Better Babies: Public Health and Race Betterment, 1920-1935," *American Journal of Public Health* 92, no. 5 (May 2002): 742-752; Alexandra M. Stern and Howard Markel, eds., *Formative Years*, 134-135, 142-143.

¹⁸⁹ Keith Wailoo, *Dying in the City of the Blues*, 29.

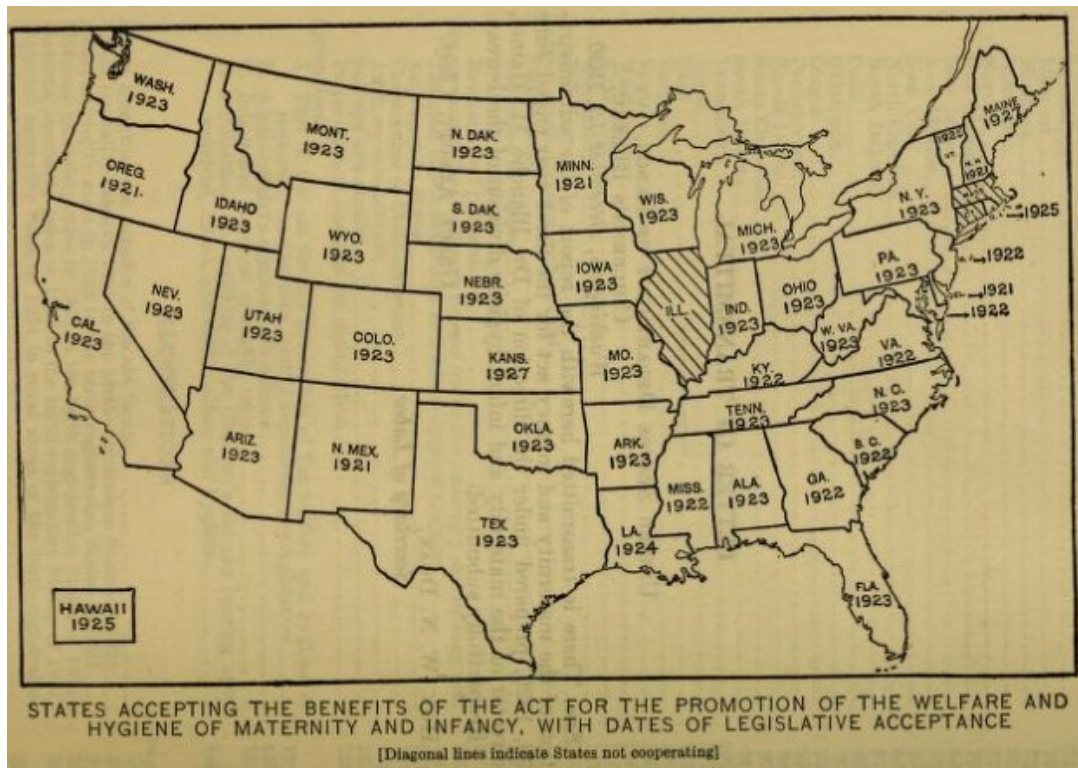


Figure 3.2 Year that states or territories initially accepted Sheppard-Towner funds. Three states, Illinois, Connecticut, and Massachusetts never accepted funds. Massachusetts did not receive funds because many physicians feared control of their profession and other groups like the Sentinels of the Republic argued that the national maternal and infant health program would interfere with state and personal rights.

United States Children's Bureau. The Promotion of the Welfare and Hygiene of Maternity and Infancy: The Administration of the Act of Congress of November 23, 1921, For Fiscal Year Ended June 30, 1929 (Washington: United States Printing Office, 1931), vi; Barbara Gutmann Rosenkrantz, Public Health and the State: Changing Views in Massachusetts, 1842-1936 (Cambridge: Harvard University Press, 1972), 154-155.

At the same time Congress debated the importance of a maternal and infant public health program, public health workers debated the meaning of their profession. In January 1920, Charles-Edward Amory Winslow, a bacteriologist, seminal figure in the field of public health, and the vice-president of the American Association for the Advancement of Science, questioned the state of public health. He explained that the public still saw health officials as “people to whom one complains of unpleasant accumulations of rubbish in the back yard of a neighbor” or sanitation.¹⁹⁰ Winslow believed the public health movement of the twentieth century was much more than sanitation, which he labeled the first stage.¹⁹¹ Winslow summarized his definition of public health:

Public health is the science and the art of preventing disease, prolonging life, and promoting physical health and efficiency through organized *community* efforts for the sanitation of the environment, the control of the community infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing service for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health.¹⁹²

His definition explained that community health had to address everyone in a specific community. Public health workers have long debated the meaning of community. Scholars Kathleen MacQueen, Eleanor McLellan, David S. Metzger, Susan Kegeles, Ronald P. Strauss, Roseanne Scotti, Lynn Blanchard, and Robert T. Trotter, II's identified five core elements of a community in public health are used to define

¹⁹⁰ C.-E.A. Winslow, “The Untilled Fields of Public Health,” *Science* (January 9, 1920): 24.

¹⁹¹ Ibid.

¹⁹² Ibid., 30.

community. Community describes a group of people, who live in the same geographic area (locus), share similar perspectives (sharing), work together for common goals (joint action), social ties, and diversity.¹⁹³ When addressing healthcare in the Deep South, public health officials needed to treat all citizens regardless of color and gender to protect the entire community. Community maternal and infant hygiene programs were an important component of internal security for Alabama and Mississippi. Historian Philip Frana explained the concept of the modern public health movement by defining two Greek concepts: *synoikismos* and *agape*. He noted that *synoikismos* meant that the people created a polis and *agape* signified a community “unselfish caring and seeking for the greater good,” which required “mutual giving and taking.”¹⁹⁴ Winslow had explained community health did not focus solely on rich or poor, but all.¹⁹⁵ In Mississippi and Alabama, the Sheppard-Towner programs operated as community health programs that considered all mothers’ and infants’ health, for the good of the both states. In reality, these community programs did consider all mothers’ and infants’ health, but not equally. Black and white mothers often did not have access to the same care and sometimes not even the same public health officials.

¹⁹³ Kathleen MacQueen, et al. identified five core elements of a community in public health: “locus, sharing joint action, social ties, and diversity.” Kathleen M. MacQueen, et. al., “What is Community? An Evidence-Based Definition of Participatory Public Health,” *American Journal of Public Health* 91, no. 12 (December 2001): 1929-1938. Also see: Richard A. Goodman, Rebecca Bunnell, and Samuel F. Posner, “What is ‘Community Health’? Examining the Meaning of the Evolving Field in Public Health,” *Preventive Medicine* 67, Supplement 1 (October 2014): S58-S61.

¹⁹⁴ Philip L. Frana, “Coordinating the Experts and the Masses: The Professions of Health and the Creation of American Community Health, 1915-1940, (PhD diss., Iowa State University, 1999), 3-4.

¹⁹⁵ Winslow, “The Untilled Field of Public Health,” 28.

By the 1920s, federal government and public health officials viewed public health as a part of national security. Congress, public health officials, and CB members viewed the Sheppard-Towner Act as a nationwide program to reduce America's high maternal and infant mortality rates.¹⁹⁶ However, like many of the public health campaigns such as tuberculosis in the 1910s and 1920s, the Sheppard-Towner program had elements that made it both local and national in scope. The community played a large role in maternal and infant hygiene projects during the 1920s and local communities addressed anxieties about race, culture, and labor systems. In Alabama, Mississippi, and other states, the state boards of health utilized funding from the Sheppard-Towner Act and cooperated with the federal CB to create both national and localized maternal and infant health care programs. Alabama and Mississippi governments hired public health nurses to teach southern women scientific motherhood. A handful of public health nurses worked in close connection to their communities by reaching out to club women and going to the plantations to teach women and to vaccinate children. In the South, the public health agencies needed cooperation with plantation owners to vaccinate and educate their sharecroppers and tenant farmers. Reaching immigrant mothers and addressing factory working conditions remained an issue for urban and mostly northern public health officials; in the South, public health officials operated Sheppard-Towner programs within a Jim Crow society, while promoting community hygiene that included all mothers and infants.

¹⁹⁶ Alan I. Marcus, "Disease Prevention in America: From A Local to a National Outlook, 1880-1910," *Bulletin of the History of Medicine* 53 (Summer 1979). By the 1910s, public health was a national concern.

The history of the Mississippi maternal and child hygiene program began before the passage of the Sheppard-Towner Act. On April 14, 1921, members of the Executive Committee of the Mississippi State Board of Health (MSBH) met in the old Capitol Building in downtown Jackson to discuss the “midwifery situation.” The members discussed a plan and regulations to improve midwifery in the state. The MSBH Bureau of Child Welfare defined a midwife as “any ~~woman~~ person (with the exception of licensed physicians) who makes a business of attending women during child-birth.”¹⁹⁷ The new plan required these people, more specially women, to register with the state and maintain a permit. She had to have good character, be clean, and maintain the proper instruments and drugs needed for maternity care. For instance, a midwife had to maintain a kit that included a sterile gown and cap, Lysol, Synol soap, boric acid powder, and one percent silver nitrate solution for the newborns’ eyes. The midwife would also have tools such as a clinical thermometer, nail cleaner, and “blunt scissors for cutting cord.” She could only use equipment selected by the MSBH and maintained in midwife’s bag at all times. Each time she used her equipment, she had to sterilize the tools in boiling water for at least twenty minutes. The MSBH implemented these regulations to reduce maternal and infant mortality. To maintain these standards, the Board placed the Director of the Bureau of Child Welfare, Felix J. Underwood, in charge of supervising and educating Mississippi midwives.¹⁹⁸ By July, the Board studied the current state of midwifery in the state and

¹⁹⁷ Mississippi State Board of Health Executive Committee, “Minutes of Executive Committee Meeting,” April 14, 1921, Series: 2036, Box: 8416, Folder: “Midwifery Procedures 1921, 1948, n.d.,” Mississippi Department of Archives and History.

¹⁹⁸ Ibid. Originally, the Board stated that a midwife would be a woman, but struck through woman. Although the regulations allowed any person to practice midwifery, it Mississippi females strongly dominated the field.

determined that 4209 midwives delivered in the state and later “rounded up” an additional 2001 practicing midwives, for a total of 6210 midwives statewide. In the 1920s, the MSBH relied on Mary D. Osborne, the Director of the Bureau of the Public Health Nursing and other public health nurses met with midwife clubs throughout the state. The public health nurses taught the midwives new techniques and oversaw the midwives’ work.¹⁹⁹ Historian Susan L. Smith argued that white nurses and mostly African-American midwives “worked together to implement the modern public health care system in Mississippi and other southern states.”²⁰⁰ While nurses and midwives cooperated in the 1920s, the system remained paternalistic in nature.²⁰¹

The MSBH relationship with public health nursing was in its infancy in 1921. Nursing scholars Margaret Morton, Edna Roberts, and Kaye Bender explained that the first public health nurses worked for the American Red Cross or the National Tuberculosis Association, not for the State Board. Yet in the early 1920s, two groups wished to improve and regulate public health nursing in the state. The American Red Cross (ARC) wanted to “form a cooperative relation with the Board and place a state nurse in the Office of the Board of Health who would head up public health nursing activities” in late February 1920.²⁰² The first Director of the Bureau of Public Health

¹⁹⁹Mississippi State Board of Health, “Study of Midwife Activities in Mississippi- July 1, 1921-June 30, 1929,” Series: 2036, Box: 8416, Folder: “Midwife Populations 1921-1929;1975,” Mississippi Department of Archives and History.

²⁰⁰ Susan L. Smith, “White Nurses, Black Midwives, and Public Health in Mississippi, 1920-1950,” 444-445.

²⁰¹ Ibid.

²⁰² Margaret Morton, Edna Roberts, and Kaye Bender, *Celebrating Public Health Nursing: Caring for Mississippi’s Communities with Courage and Compassion, 1920-1993* (Jackson: Mississippi State Department of Health, 1993), 8-9.

Nursing only served briefly, and soon Mary D. Osborne began her tenure as the second director in April 1921.²⁰³ She was originally from Ohio, where she received her early nursing education at the Akron City Hospital in 1902 before relocating to New York City to pursue maternal and infant hygiene nursing. Osborne was involved with the American Red Cross in New York, which helped secure her position as Director of Public Health Nursing in Mississippi.²⁰⁴ The second organization, the United States Public Health Service (USPHS), sent Chief Nurse Laurie Jean Reid to study the conditions of maternal and infant hygiene and to work with the MSBH.²⁰⁵ The cooperation with the ARC and the USPHS gave the MSBH Bureau of Child Welfare and Bureau of Public Health Nursing the ability to create regulations for the public health nurses, who worked for the state or for local organizations.

When the Sheppard-Towner Act passed in late 1921, the MSBH already had the bare infrastructure of what would become the Division of Maternal and Child Health, yet the Board needed more county public health departments and personnel, particularly nurses. Public health officials cooperated with women's clubs and schools to teach women and young children the importance of hygiene. They specifically taught mothers better scientific practices including feeding methods. The MSBH began to promote scientific motherhood movement in the early 1920s.

²⁰³ Ibid., 9.

²⁰⁴ "Mary D. Osborne (1875-1946) 1996 Inductee," American Nurses Association, accessed August 2017, <http://www.nursingworld.org/MaryDOsborne>.

²⁰⁵ Margaret Morton, Edna Roberts, and Kaye Bender, *Celebrating Public Health Nursing*, 8-9.

Since the MSBH already had an operating Bureau of Child Welfare and Bureau of Public Health Nursing by 1922, Mississippi quickly met the standards for the program and accepted Sheppard-Towner funds by early 1922. On January 4, 1922, Democratic Governor Lee Russell addressed the Mississippi Legislature in his Biennial Message, where he explained the significance of the Sheppard-Towner Act. If the state accepted the terms, the Board would receive \$10,000 and an additional \$17,076.58 that had to be matched by Mississippi. Russell asked that the legislature give “careful consideration” to accepting the act because it was a “generous offer” to improve maternal care.²⁰⁶ By late March, the State House passed H.B. No. 296, which made appropriations for the MSBH including funds for the Sheppard-Towner Act for 1922.²⁰⁷ With approval of the Sheppard-Towner Act, Mississippi could expand its maternal and child welfare programs and reduce mortality rates.

The MSBH had data about the current maternal and child health situation because of a recent USPHS study. Laura Jean Reid, Chief Nurse in the USPHS, went to Mississippi to gather information on high maternal and infant mortality rates in the state.²⁰⁸ She explained that in Mississippi nine out of every hundred infants died in 1920.²⁰⁹ The infant mortality rate for African Americans was higher. When creating a plan for Mississippi, Reid stated that “We must keep in mind the following facts—That

²⁰⁶ “Governor Delivers Biennial Message of Rigid Economy,” *The Clarion-Ledger*, January 5, 1922, 2.

²⁰⁷ “H.B. No. 296,” *The Winona Times*, April 14, 1922, 5.

²⁰⁸ Margaret Morton, Edna Roberts, and Kaye Bender, *Celebrating Public Health Nursing*, 8-9.

²⁰⁹ Laurel Jean Reid, “Maternity and Infant Hygiene is Discussed,” *Jackson Daily News*, April 21, 1922, 4.

56 per cent of the population is colored. That the State is largely rural...”²¹⁰ Reid noted concerns about the approximately 4200 practicing midwives of the original July 1921 survey. According to her, over 4000 were African American and the majority were uneducated. She described most Mississippi midwives as “illiterate, ignorant negro women, without the knowledge of the first principles of ordinary soap and water cleanliness.”²¹¹ They did not have the appropriate training necessary. Yet, the midwives were necessary because the 1700 Mississippi doctors could not manage all maternity cases. Reid argued that public health workers must educate midwives and women about maternal and infant hygiene because many Mississippi and southern women lack a basic knowledge and education on “child-bearing.”²¹² As a white nurse, she believed that public health officials, especially nurses, needed to educate and supervise these midwives. Thousands of Mississippi women would encounter public health nurses or newly educated midwives during the decade, who taught the mothers scientific maternal knowledge ranging from information about preventing infections in newborns to the importance of birth registration.

By July 1922, officials from the MSBH, including Dr. W.S. Leathers, the MSBH Executive Officer, Felix J. Underwood, the Director of Child Welfare, and Mary D. Osborne, the Director of the Bureau of Public Health Nursing convened to set the goals

²¹⁰ Ibid.

²¹¹ Ibid., 3-4. For more discussion on physicians’ views on midwives see: Kelena Reid Maxwell, “Birth Behind the Veil: African American Midwives and Mothers in the Rural South, 1921-1962,” (Rutgers University: PhD diss., 2009).

²¹² Ibid.; Laura Jean Reid, “The Plan of the Mississippi State Board of Health for the Supervision of Midwives,” 3, Series:2012 Box: 8752 Folder: “Midwifery,” Mississippi State Department of Archives and History.

of the new public health nursing force in the state. Jane Van De Vrede, the Director of Nursing for the Southern Division, American Red Cross also attended the meeting to help define the role of a public health nurse in Mississippi. These administrators determined that the Bureau of Public Health Nursing would determine the guidelines for public health nursing in the state.²¹³ At the same time, Red Cross public health nurses cooperated with MSBH. In Yazoo County, Mrs. Leila Morgan, the county Red Cross Nurse spoke with Director Osborne about activities in the county. In July, Morgan said, “I gave instructions to pre-natal cases, the care of infants and pre-school age children.” Her statistics reveal a typical month of patient care: fifty-seven infant welfare visits, twenty-eight babies weighted, and fifteen lessons presented to mothers on infant care.²¹⁴ Morgan guided midwives in Yazoo County and followed the new laws regarding midwifery. She reported that she “inspected the outfits of three midwives, and stressed the importance of following the law...”²¹⁵ Morgan’s work was an example of early child hygiene programs that some counties were officially beginning in the spring and summer of 1922. For instance, in Carroll County, Mississippi, the Board of Supervisors appropriated \$1500 to establish child welfare work according to the MSBH’s plan in May 1922.²¹⁶ MSBH sent public health officials to the county to begin collaborative child health work. In August,

²¹³ Mississippi State Board of Health, Bureau of Public Health Nursing, “Special Report” (Handwritten title), Series: 1863, Box: 8418, Folder: “Role of the Public Health Nurse, 1922-1973,” Mississippi State Department of Archives and History.

²¹⁴ “July Was Active Month for Nurse: Mrs. Morgan Makes Her Monthly Report of Work Accomplished,” *The Yazoo City Herald*, August 11, 1922, 6.

²¹⁵ Ibid.

²¹⁶ “Minutes Board of Supervisors, Carroll County,” May 1922, 192, Series: 1863, Box: 8405, Folder: “Carroll-1922-1953,” Mississippi Department of Archives and History, Jackson, Mississippi.

the state Child Welfare Unit held clinics in both Vaiden and Carrollton, where public health personnel coordinated with the local physician and educated the populace.²¹⁷ Tallahatchie County also organized public health work and employed two physicians and a nurse. This county department addressed various aspects of public health, but its first efforts were on improving childhood “defects” ranging from communicable diseases to physical disabilities.²¹⁸ With the help of Sheppard-Towner funds, the new county units and existing Red Cross programs were reaching more people in rural areas and towns.

Public health officials worked with schools and local organizations to educate the public on maternal and child welfare. Yazoo County Red Cross Nurse Leila Morgan reported her February 1923 projects via *The Yazoo City Herald*. Morgan explained that “bad weather kept me from going into the country during the first part of the month,” but she had plenty to do in Yazoo City. She conducted thirty-three infant welfare and thirty-five preschool visits. In addition, she weighed over four hundred students and determined that approximately one hundred and thirty-three were underweight. To stress the importance of public health to parents and children alike she attended Parent Teacher Associations and hosted several health talks.²¹⁹ Nurses like Morgan attempted to inform the community by attending various local functions.

²¹⁷ Felix J. Underwood to Mrs. Neil, August 21, 1922, Series: 1863, Box: 8405, Folder: “Carroll-1922-1953.”

²¹⁸ “Health Unit Arrives and Begins Work In Tallahatchie County,” *The Mississippi Sun*, November 9, 1922.

²¹⁹ “Red Cross Nurse Makes Her Report: Bad Weather Forced Her to Spend Most of Her Time in the City,” *The Yazoo City Herald*, March 16, 1923, 1.

In Harrison County, the MSBH Bureau of Child Welfare “assigned a nurse to duty” on October 1, 1923. The county provided \$1000 for the work and the state allocated \$1000 from Sheppard-Towner funds. The county paid the nurse \$1200 and she had eight hundred dollars for travel expenses.²²⁰ According to the Bureau of Child Welfare, the Harrison County nurse devoted half of her time to maternity and infant hygiene. In this capacity, she was to supervise and train midwives and operate a health center. The State Board urged her to hold office hours at the health center at least one day a week “for consultations with midwives, pre-natal cases, parents with infants, pre-school and school children, teachers, patrons of the school and others interested in health activities.”²²¹ Nurses also held demonstrations for midwives and instructed pregnant women on topics ranging from infant care or feeding to “how to prepare for a birth in the home.”²²² When teaching midwives, she encouraged them “to be teachers of health in their own community.”²²³ The midwives were vital to teaching African Americans and poor whites about current public health standards. Public health physicians and nurses influenced the population’s views on public health.

Public health nurses and midwives instructed African American women on public hygiene. Mary Grayson, an African American Home Demonstration Agent in Tallahatchie County, worked with local health professionals including Josie Strum, a

²²⁰ Felix J. Underwood, “Bureau of Child Welfare: Budget for Harrison County,” October 1, 1923, Series: 1863, Box: 8405, Folder: “Harrison: 1923, 1947,” Mississippi Department of Archives and History.

²²¹ “Bureau of Child Welfare: Plan of Work for County Nursing Service” October 1, 1923, 1, Series: 1863, Box: 8405, Folder: “Harrison: 1923, 1947.”

²²² *Ibid.*, 1-2.

²²³ *Ibid.*, 2.

white public health nurse, to host home demonstration meetings in the communities of Philipp, Webb, Sumner, Glendora, and Cascilla. Nurse Strum and Dr. C.F. Freeland, a local physician, instructed black club women in “sanitation and health.”²²⁴ Strum may have discussed maternal and child hygiene at these meetings because this was the focus of her county public health work. Grayson thanked Strum and Freeland for cooperating and for “giving such needed health lectures and instructions to my people, and I am assured that my people will be greatly benefitted.”²²⁵ Grayson wanted these African American women to have access to educational material on hygiene and believed that the women would follow the suggestions.²²⁶ Black home demonstration agents used opportunities like National Negro Health Week to encourage public health workers to educate the African American public about community health work.²²⁷ Public health workers used public lectures like these to teach mothers about proper nutrition for their newborns and basic hygiene.

²²⁴ “Of Interest to the Colored Readers: Health Meetings,” *The Mississippi Sun*, April 10, 1924, 8.

²²⁵ Ibid.

²²⁶ Ibid.

²²⁷ Susan Smith, *Sick and Tired of Being Sick and Tired: Black Women’s Health Activism in America, 1890-1950* (Philadelphia: University of Pennsylvania Press, 1995), 51-57.



Figure 3.3 A Mississippi public health nurse teaching black midwives. This is one example of what a midwifery class would look like during the 1920s and 1930s.

“Midwife Class,” Series 2170: Mississippi State Department of Health Photograph Album, ca. 1930s, Mississippi State Department of Archives and History, Jackson, Mississippi.

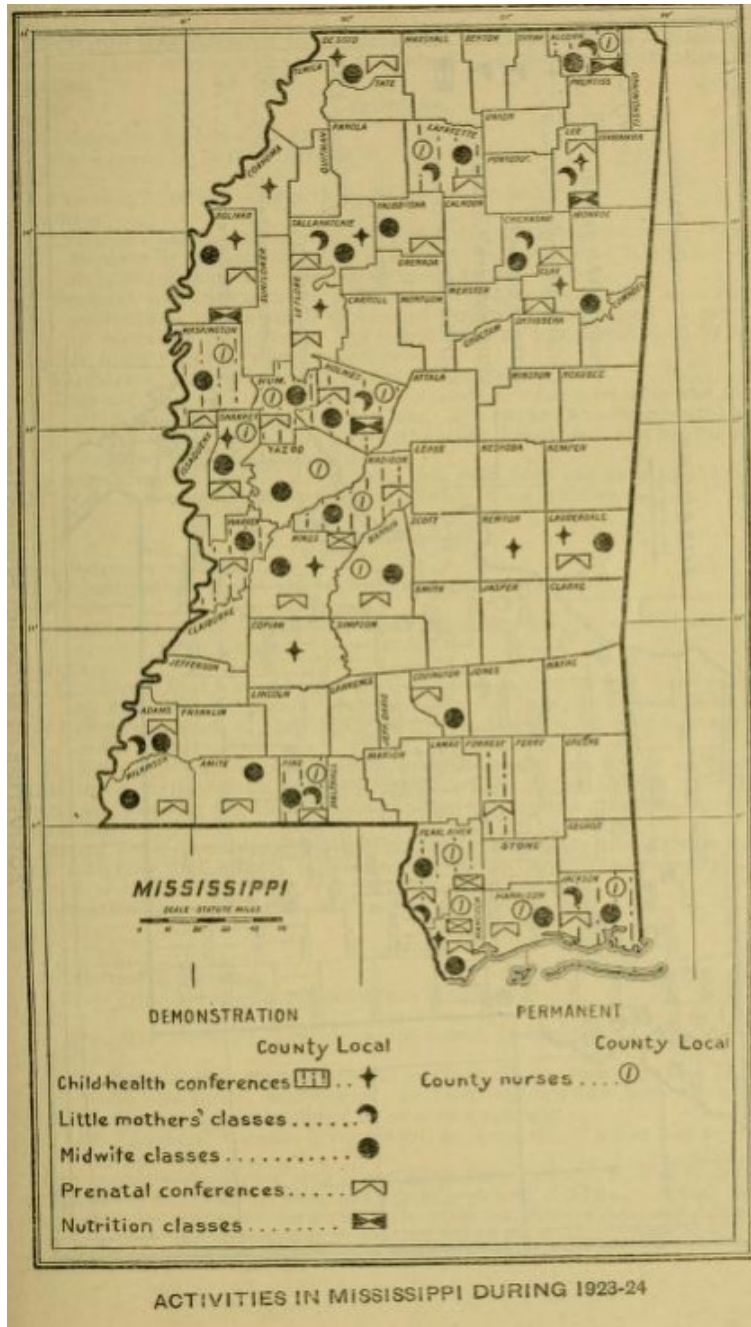


Figure 3.4 This Mississippi map shows public health activities at the county level in 1924. The legion specifically highlights demonstrations related to maternal and child hygiene.

United States Children's Bureau. The Promotion of the Welfare and Hygiene of Maternity and Infancy: The Administration of the Act of Congress of November 23, 1921, For Fiscal Year Ended June 30, 1924 (Washington: United States Printing Office, 1925), 31.

Public health officials addressed their intended audience in a variety of ways from publishing reports in newspapers to speaking at local conferences and clinics. In 1924, Felix J. Underwood, now the Director of the MSBH, released weekly health suggestions to local newspapers. One week, he warned against diphtheria fatalities among young children and emphasized the importance of pre-school health. Underwood reminded parents that they should bring their pre-school children to clinics, so public health officials could identify and treat developing defects. In addition, the public health officers offered preventive medicine such as vaccines to prevent childhood illness.²²⁸

Underwood's column circulated throughout the state papers and was the most frequent public health publication that Mississippians likely encountered. Many county health departments also communicated with the public through local newspapers. In Tallahatchie County, *The Mississippi Sun* announced a birth registration campaign, "REGISTER YOUR BABY." The article informed new parents that Dr. J. E. Powell, the Tallahatchie County Registrar of Vital Statistics and a public health advocate, could help parents register the birth of their child with MSBH. In return, parents would receive a "beautiful birth certificate" and a folder entitled "Save the Baby." The folder included "splendid information on the care of infants," which likely included feeding instructions and hygiene advice.²²⁹ Throughout the 1920s, the MSBH and county departments of health used newspapers to communicate with the public. They announced forthcoming

²²⁸ "Weekly Health Suggestions," 1924, 3, Series: 1014, Box: 15271, Folder: "Weekly Health Suggestions by Felix J. Underwood, M.D., State Health Officer Mississippi, 1924," Mississippi Department of Archives and History.

²²⁹ "REGISTER YOUR BABY," *The Mississippi Sun*, February 21, 1924, 4.

events, offered advice, and reported vital statistics to raise public awareness about healthcare.

In Leflore County, *The Greenwood Commonwealth* ran three front-page articles about a three-day October 1924 children's health clinic hosted by the MSBH and the Greenwood Parent-Teachers Association. Doctors and the Red Cross nurse spent two days examining children in the county and the last day, the team examined the children of Greenwood.²³⁰ The clinic was available to white and African American children as required by the Sheppard-Towner Act. Mississippi public health officials wanted to ensure the entire community was healthy. One possible reason was for the economic future of Mississippi. Historian Keith Wailoo asserted that the local political economy shaped a community healthcare system and who had access to care.²³¹ The Mississippi Delta's labor system revolved around black labor to sharecrop or tenant farm the large cotton plantations. Scholar James Cobb explained that although Delta planters has a difficult time keeping their labor supply, the planters still "exercised firm control of both the economy and the society of Yazoo Mississippi Delta at the close of the 1920s."²³² Even so, reliance on black labor gave African American tenants some leverage.²³³

²³⁰ "Call Conference Child Health: Conference for Leflore County Will be Held at Greenwood on October 1,2,3." *The Greenwood Commonwealth*, September 20, 1924, 1; "Child Health Clinic Being Held: Children From Towns and County Outside of Greenwood Being Examined Today," *The Greenwood Commonwealth*, October 1, 1924, 1; "Health Clinic is on Last Day: Examinations of Children Living in Greenwood is Program for Clinic During Final Day," *The Greenwood Commonwealth*, October 3, 1924, 1.

²³¹ Keith Wailoo, *Dying in the City of the Blues*, 28-29.

²³² James C. Cobb, *The Most Southern Place on Earth: The Mississippi Delta and the Roots of Regional Identity* (Oxford: Oxford University Press, 1992), 124.

²³³ James C. Giesen, *Boll Weevil Blues: Cotton, Myth, and Power in the American South* (Chicago: The University of Chicago Press, 2011), 93.

Healthcare for African American sharecroppers was a middle ground.²³⁴ Since the plantation system began in Mississippi in the first half of the nineteenth century, plantation owners provided medical care for slaves as part of paternalism and to protect their economic investments. At the same time, plantation owners often allowed slaves to treat minor wounds.²³⁵ After the Civil War, plantation owners allowed black midwives to deliver sharecroppers' newborns, but the owners also supported public health workers educating black mothers at clinics and vaccinating children. The twentieth century plantation owners sought to control public health efforts and to preserve white supremacy and their current and future labor force, mothers and children.²³⁶ Public health workers fit into this system and operated in the Delta's segregated society. For instance, the Leflore County health clinic was located at the Greenwood Confederate Memorial Building, which was a large meeting place.²³⁷ The building and other Confederate memorials served as symbols of white supremacy.²³⁸ It is likely that some African Americans felt uncomfortable taking their children to this location. These maternal and infant health programs were part of the community health movement that offered care to all in the

²³⁴ Keith Wailoo explained that medicine institutions "reflected the mores, laws, and the political economy of their region." He also contended that in Memphis African American healthcare was a compromise between African Americans and white businessmen. In the Delta, the compromise was between the black sharecropper and the plantation owners. Wailoo, *Dying in the City of the Blues*, 29, 84-85.

²³⁵ Todd Savitt, *Race and Medicine in the Nineteenth- and Early-Twentieth-Century America* (Kent: The Kent State University Press, 2007) Loc. 1530-1610, Kindle.

²³⁶ Keith Wailoo, *Dying in the City of the Blues*, 29.

²³⁷ "Child Health Clinic Being Held: Children From Towns and County Outside of Greenwood Being Examined Today," *The Greenwood Commonwealth*, October 1, 1924, 1.

²³⁸ David Goldfield, *Still Fighting the Civil War: American South and Southern History, Updated Edition* (Baton Rouge: Louisiana State University Press, 2002), 321-322.

community, but still operated in Jim Crow Mississippi. The Mississippi Sheppard-Towner program adhered to the system of segregation enshrined in law and custom.²³⁹

Midwives delivering poor white and black newborns was customary in 1920s Mississippi, but new standards forced practicing midwives to follow more stringent regulations. By 1925, Mississippi's Sheppard-Towner program had operated for three years and had set standards and goals the MSBH attempted to achieve. Directors Underwood and Osborne wanted to improve public health nursing and midwifery to decrease Mississippi mortality rates and have a healthier population. Dr. Underwood worried about teaching midwives and giving them the knowledge to prevent death or blindness in infants. Like many other white physicians, Underwood thought that midwives were undereducated and a threat to medical professionalism. Many doctors saw midwives as un-American because they were either African American or immigrants.²⁴⁰ In February 1925, Dr. Felix Underwood, addressed a group of public health officials and physicians at the Southern Medical Association:

What could be more pitiable picture than that of a prospective mother housed in an unsanitary home and attended in the most critical period by an accoucher, filthy, and ignorant, and not far removed from the jungles of Africa, laden with its atmosphere of weird superstition and voodooism?²⁴¹

²³⁹ Keith Wailoo notes that Southern healthcare systems incorporated racial segregation during the era of Jim Crow medicine. Keith Wailoo, *Dying in the City of the Blues*, 33.

²⁴⁰ Obstetricians wanted to exclude midwives from the delivery process because they were undereducated and to ensure that physicians would become the leading expert in maternal and infant care. In Chapter 7: "The Absence of Midwives from America," G.J. Barker-Benfield discusses the doctor-led movement in the late nineteenth and early twentieth centuries to regulate midwives. G.J. Barker-Benfield, *The Horrors of the Half-Known Life: Male Attitudes toward Women and Sexuality in Nineteenth-Century America*, 2nd Edition (New York: Routledge, 2014), 61-63; 57-66. For information on the decline of American midwifery see: Judy Barrett Litoff, *American Midwives, 1860 to the Present* (Westport: Greenwood Press, 1978).

²⁴¹ F.J. Underwood, "The Development of Midwifery in Mississippi," 1925, Series: 2036, Box: 8416, Folder: "History of Midwives in Miss. 1920s, 1950s," Mississippi Department of Archives and History.

Underwood viewed black midwives as devoid of character and cleanliness and saw white public health workers as saviors for the ignorant midwives. He told the group that ninety-seven percent of the midwives were African American “without any idea of what constitutes physical cleanliness.” He argued, “No systematic effort was made to improve these conditions until a few of the more progressive and humanitarian health officers and physicians gave freely of their time and energy...”²⁴² Underwood’s speech followed the southern public health officials’ argument that black midwives lacked scientific medical knowledge and needed to be regulated by state public health officials.²⁴³

During the 1920s, white public health nurses began supervising the midwives. These nurses would supervise and train midwives and expand notions of white supremacy through public health. The nurses examined the midwives’ health, instructed them in postpartum care and hygiene, and administered Wassermann or syphilis blood tests to the midwives. At the time, public health officials and the white public identified syphilis as an African-American disease because many whites presumed that African Americans lacked morals.²⁴⁴ In addition to being screened for syphilis, the midwives had to take typhoid and smallpox vaccines. County health nurses also met with midwife clubs regularly to present educational lessons on topics such as the lying-in period.²⁴⁵ The MSBH expected midwives to be clean and follow protocol, even if that meant calling for

²⁴² Ibid.

²⁴³ Susan Smith, “White Nurses, Black Midwives, and Public Health in Mississippi, 1920-1950,” 444-445.

²⁴⁴ Susan Reverby, *Examining Tuskegee*, xi-xiii; John Parascandola, *Sex, Sin, and Science* (Westport: Praeger, 2008), 38-39.

²⁴⁵ F.J. Underwood, “The Development of Midwifery in Mississippi.”

a physician when abnormal cases arose.²⁴⁶ MSBH worked for nearly half a decade trying to standardize midwifery and by the mid-1920s, Underwood monitored the progress of midwifery by sending questionnaires to physicians and public health officers. Over seventy percent of physicians, who replied to a July 1925 survey, said they saw an improvement “in personal cleanliness of the midwives” and “in calling of a physician to abnormal cases.”²⁴⁷ They viewed the maternal and infant work as successful and some doctors offered advice for improving the field further. One suggested sending more literature on maternal and child health to midwives. During the 1920s, the MSBH published a manual for midwives with specific instructions for birthing methods. A few doctors suggested better enforcement of standards and requiring those midwives who disobeyed to stop practicing.²⁴⁸ Historian Kelena Maxwell argued that the midwives valued the manual and the educational lectures because the scientific education allowed the midwives to better serve the black community.²⁴⁹ Although some counties were seeing changes in maternal and infant care, others still lacked county health workers.

Some counties received help from philanthropic and benevolent organizations like the Rockefeller Foundation to establish health departments, so that they could focus on public health issues like communicable disease control and maternal hygiene.²⁵⁰ The

²⁴⁶ Ibid.

²⁴⁷ Ibid.

²⁴⁸ Ibid. *Manual for Midwives* (Jackson: Mississippi State Board of Health, 1922). For more information on Midwives and the *Manual for Midwives* see: “Mary D. Osborne (1875-1946) 1996 Inductee.”

²⁴⁹ Kelena Maxwell, “Birth Behind the Veil,” 22,93-94.

²⁵⁰ For more information see: John Etting, *“The Germ of Laziness”: Rockefeller Philanthropy and Public Health in the New South* (Cambridge: Harvard University Press, 1981). Also, view The Rockefeller Foundation’s yearly review of public health and medical education from the 1920s. The Commonwealth Fund offered funds specifically for maternal and infant care after the Sheppard-Towner Act ended.

MSBH wanted all eighty-two counties to have a central county health department, yet even with available assistance from the government and other organizations, many counties did not yet achieve this goal in the 1920s. For counties without health units, the MSBH created a mobile film library that toured the state to educate Mississippians. MSBH workers offered lectures on public health issues with picture films. In addition, the mobile library staff worked with schools and groups like Rotary Clubs. The population of these counties gained information from the lectures and from literature available at the meetings.²⁵¹ To attract an audience, MSBH promised “wholesome comic pictures” to entertain the children and picture films with lectures on how a person could help “protect the health of yourself and your family and promote good health in your community.”²⁵² In the local Choctaw County newspaper, a bold large advertisement and article ran a headline, “Free Picture Show! And Public Health Lecture.”²⁵³ The film unit moved from community to community with specific times for specific members of a certain geographic community. In Ackerman, MSBH officials presented the lecture at the Ackerman Colored School on August 10, 1925 at 8 p.m. Later that week, the mobile unit returned to Ackerman for an August 13, 1925 showing. The paper stated that “everyone is cordially invited,” but the article suggested that African Americans and whites should

Mississippi State Department of Health, “Public Health Nursing 1920-1940,” http://msdh.ms.gov/msdhsite/_static/19,10786,378.html (August 2017).

²⁵¹ “Public Health Work Aided by Film Library,” *The Greenwood Commonwealth*, June 22, 1925, 3.

²⁵² “Free Picture Show! And Public Health Lecture By Representatives of the Mississippi State Board of Health,” *The Choctaw Plaindealer*, August 7, 1925, 2.

²⁵³ Ibid.

view the film separately.²⁵⁴ It does not note that African Americans could not come to other viewings, but segregation was customary.²⁵⁵ White Mississippi public health workers taught and served each of these races. Other counties had part-time county health departments but lacked all vital workers.²⁵⁶ The mobile unit benefitted these counties too because the lectures taught hygiene information where counties lacked public health physicians and nurses.

The mobile unit helped teach Mississippians about communicable disease and cleanliness, but the state needed more public health workers to examine and care for Mississippi's mothers and children. MSBH leadership including Underwood and Osborne continued to advocate for more nurses throughout the state. In October 1925, Underwood suggested to Dr. R.R. Kirkpatrick, Director of Coahoma County Health Department, that Coahoma County needed to hire a new nurse through the MSHB's Bureau of Public Health Nursing.²⁵⁷ By hiring a nurse through the Bureau of Public Health Nursing, the nurse would be familiar with public health nursing standards, file monthly nursing reports, have character, and cooperate with county physicians.²⁵⁸ By the following year, Ella Sayle served as the county public health nurse and was already assisting Dr. Kirkpatrick in teaching black midwives about proper equipment and receiving a

²⁵⁴ Ibid.

²⁵⁵ Ibid.

²⁵⁶ Public Health Work Aided by Film Library," 3.

²⁵⁷ Felix J. Underwood to Dr. R.R. Kirkpatrick, October 7, 1925, Series: 1863 Box: 8405 Folder: "County Files: Coahoma 1925" Mississippi Department of Archives and History.

²⁵⁸ Ibid.

midwifery permit.²⁵⁹ Yazoo County Health Department also added a new public health nurse, Allie Murphy. She was a graduate nurse with more training than most Mississippi nurses and had worked in maternal and infant healthcare for several years. The department hired Murphy specifically to teach midwives and focus on maternal and infant hygiene.²⁶⁰ By mid-decade, Mississippi had thirty-five public health nurses, who worked for counties or communities.²⁶¹ This allowed the nurses to have more clinics and treat more women, infants, and children.

From May Day, or Child Health Day, 1926 to late August 1926, public health officials hosted over forty-eight children's health conferences and evaluated approximately twenty-four hundred children. State Health Officer Underwood exclaimed, "The Bureau of Child Hygiene and Public Health Nursing of the State Board of Health and the Parent-Teacher Associations" provided "the golden opportunity to the children."²⁶² At the conferences, public health doctors examined children and offered treatment for physical and developmental ailments. In addition, other public health workers like nurses discussed breastfeeding and nutrition with mothers. Underwood

²⁵⁹"Colored Mid-Wives Met in Clarksdale Yesterday Afternoon," *The Clarksdale Press Register*, November 4, 1926. The first record located that mentions Ella Sayle was a June 1926 announcement of her May salary and expenses of \$162.50 in the paper. "Proceedings of the Board Of Supervisors Of Coahoma County," *The Clarksdale Press Register*, June 23, 1926.

²⁶⁰ "Add New Nurse to Health Office: Maternity and Infant Welfare Specialist Now On Job In Yazoo County," *The Yazoo Herald*, May 22, 1925, 1. Murphy had previously worked in Yazoo County.

²⁶¹ "Weekly Health Suggestions: Figures Establish Value of Public Health Nurse," 1925, Series: 1014, Box: 15271, Folder: "Weekly Health Suggestions by Felix J. Underwood, M.D., State Health Officer Mississippi, 1925," Mississippi Department of Archives and History.

²⁶² "Weekly Health Suggestions: Child Health Conferences," 1926, Series: 1014, Box: 15271, Folder: "Weekly Health Suggestions by Felix J. Underwood, M.D., State Health Officer Mississippi, 1926," Mississippi Department of Archives and History. Also available in *The Newton Record*, August 26, 1926.

claimed that mothers were “eager to follow advice on the care and feeding of their little ones.” The mothers also wanted to follow the “advice and instructions” of public health nurses.²⁶³ These nurses visited pregnant women and new mothers and recommended better nutrition. The MSBH officials understood that people from “different races and customs” viewed breastfeeding differently. The nurses’ job was to advocate breastfeeding among all Mississippi mothers. Public health nurses launched an “intensive educational campaign” for breastfeeding and they marketed the mother’s milk as more nutritious. This breastfeeding crusade was one of the few and geographically spread out American breastfeeding campaigns during the 1920s.²⁶⁴ Scholar Jacqueline Wolf contends that “by the 1920s and 1930s most women never even attempted breastfeeding, or they abandoned the practice after a few days or weeks.”²⁶⁵ The Mississippi breastfeeding campaign in the mid-1920s suggests that some Mississippi mothers were following the national trend and purchasing artificial milk formulas or feeding infants cow’s milk. The *Stone County Enterprise* ran an article about a recent Metropolitan Life pamphlet that suggested ninety percent of American newborns were drinking cow’s milk. The author stated, “Cow’s milk is good for older persons, but God never intended it for human babies. Cow’s milk is for cow babies, just as a mother’s milk is for human babies.” Later, statistics suggested that ten bottle-fed infants died to one breastfed infant.²⁶⁶ Like the concern journalist, the

²⁶³ Ibid.

²⁶⁴ Jacqueline H. Wolf, *Don’t Kill Your Baby: Public Health and the Decline of Breastfeeding om the Nineteenth and Twentieth Centuries* (Columbus: The Ohio State University Press, 2001), 187.

²⁶⁵ Ibid., 41.

²⁶⁶ “The Long Haul and Short Haul,” *Stone County Enterprise*, March 18, 1928, 3.

MSBH urged mothers to return to breastfeeding. To reach “certain classes of mothers,” the State Board hosted an infant hygiene conferences, where public health officials recommended breastfeeding and offered techniques to prevent illness such as colic.²⁶⁷ One place to reach many Mississippi mothers and children was on plantations, where they lived and worked as employees, tenants, or sharecroppers.

The organization of public health in Mississippi gave plantation owners another opportunity to strongly advise tenants or sharecroppers. According to *The Greenwood Commonwealth*, “all the health forces are cooperating with the schools, homes and plantations...” The County Health Unit entered plantations to provide vaccinations and other care toward disease in the spring and summer of 1926. The unnamed author clarified that the plantation owners of Leflore County were “having all their tenants vaccinated.”²⁶⁸ This included black children and mothers on the plantations. Near Money, Mississippi, the owner of the Race Track plantation required all three hundred and fifty residents to take vaccinations. Other plantation owners, such as the Lucas family of Leflore County, planned to get “all their tenants shot.”²⁶⁹ Plantation owners saw vaccinations and the public health movement as a means to guarantee a healthy community and labor force. With planters’ permission, the public health workers gained access to plantation communities and reinforced health care customs. In regards to maternal and child welfare, white public health nurses changed the way midwives and

²⁶⁷ “Weekly Health Suggestions: Breast Feeding,” 1926, Series: 1014, Box: 15271, Folder: “Weekly Health Suggestions by Felix J. Underwood, M.D., State Health Officer Mississippi, 1926,” Mississippi Department of Archives and History.

²⁶⁸ “Unit Gets Lots Cooperation,” *The Greenwood Commonwealth*, April 7, 1927, 1.

²⁶⁹ Ibid.

maternal care operated on plantations by providing more supervision and demonstrations on maternal and infant hygiene. This public health work set the precedent for maternal and infant hygiene on plantations for the next few decades.

In the later years of the Sheppard-Towner program, Mississippi public health officials explained how important children were to the state. Dr. Underwood argued that children were the “most valuable possession” of the state.²⁷⁰ The MSBH continued to emphasize methods to improve nutrition and hygiene. Mothers needed to establish “regular feeding habits” for children that did not include sweets or snacks in between meals. In addition, they should drink milk over adult beverages like coffee or tea. The public health nurses and physicians wanted parents to teach their children hygiene that included cleanliness habits.²⁷¹ The Board argued that children and mothers needed sunlight and rest. They advised mothers and children to get brief exposure to sunlight twice daily and produced literature on sunbathing to improve maternal and infant health.²⁷² Literature and conferences were intended to educate mothers and to improve overall maternal and child hygiene. Mothers could get literature on maternity care, infant and child hygiene from public health nurses or physicians, who held conferences, classes, and clinics. However, illiteracy was still high among African American and poor white Mississippians.

²⁷⁰ “Weekly Health Suggestions: The Children—Our Priceless Possession,” 1928, 51, Series: 1014, Box: 15271, Folder: “Weekly Health Suggestions by Felix J. Underwood, M.D., State Health Officer Mississippi, 1928,” Mississippi Department of Archives and History.

²⁷¹ “Weekly Health Suggestions: Feeding the Children, 1928, 38, Series: 1014, Box: 15271, Folder: “Weekly Health Suggestions by Felix J. Underwood, M.D., State Health Officer Mississippi, 1928,” Mississippi Department of Archives and History.

²⁷² Ibid.

In early 1929, Nettie Oris Turner, a Leflore County public health nurse, set up classes at local schools for adolescent girls to learn about “Health Hygiene.”²⁷³ These young women would be Mississippi’s future mothers, who would need to provide care for their family. Approximately one hundred Minter City, Schlater, and Money high school girls attended lectures on health to work towards receiving a health certificate. The girls learned about Home Hygiene and how to care for the sick and took exams on the subjects. Of the 102 girls who started the course, 82 completed the two-month program. Another Leflore County nurse, Correlia Scruggs focused on vaccinating children on local plantations against diphtheria and typhoid. According to the *Greenwood Commonwealth*, tenants of the Lucas Plantation “were eager to have the shots given to them as a preventative measure” because an African American child had recently died on the plantation.²⁷⁴ On one Saturday, Scruggs visited three plantations and vaccinated approximately “281 Negro children” and planned to follow-up to administer additional toxin-antitoxins.²⁷⁵ The Promotion of the Welfare and Hygiene of Maternity and Infancy Act not only helped mothers and infants, but because more public health workers were able to devote time to vaccinating against typhoid fever and diphtheria and determining health issues including malnourishment and pellagra in children. Mississippi used much of its Sheppard-Towner funds for child health clinics and conferences, which also benefitted toddlers and older children. These conferences allowed public health officials

²⁷³ “Health Nurse Has New Class,” *The Greenwood Commonwealth*, Mon, Feb 25, 1929, 1.

²⁷⁴ “Nurse Gave Shots to 281 Negro Children,” *The Greenwood Commonwealth*, September 7, 1929, 6.

²⁷⁵ Ibid.

to treat or prevent disease before adulthood. Whether public health nurses taught young women about health hygiene or hosted clinics, the public health nurses played one of the most significant roles in the maternal and infant healthcare system.

The efforts from Sheppard-Towner activities helped the MSBH to bolster its activities from the early 1920s. MSBH's policy led to better-educated midwives and the state forced those who did not meet standards out of practice. When the Sheppard-Towner Act passed, Mississippi had approximately 6200 midwives, but by the end of the program the MSBH had reduced that number to around 3000.²⁷⁶ Doctors and nurses were taking more responsibility over maternal and infant hygiene as part of professional control. Mississippi saw a vast improvement in its maternal and infant mortality rates during Sheppard-Towner years. During the Sheppard-Towner years, Mississippi hosted 1500 maternal and child health talks, more than any other state and provided literature to the parents of any infant, whose birth was registered.²⁷⁷ In 1929, the Mississippi infant mortality rate sat at 72.1 per 1,000, while nationally 67.6 mothers died per 1,000 live births. White infants in Mississippi had a greater chance of survival than the national average, but African American infant mortality rates were much higher at 84.9.²⁷⁸ Although the infant mortality rates were higher than the national average, Mississippi's maternal health standards were becoming more scientific. The Bureau of Child Hygiene

²⁷⁶ Mississippi State Board of Health, "Study of Midwife Activities in Mississippi- July 1, 1921-June 30, 1929."

²⁷⁷ Children's Bureau. *The Promotion of the Welfare and Hygiene of Maternity and Infancy: The Administration of the Act of Congress of November 23, 1921, For Fiscal Year Ended June 30, 1929* (Washington: United States Printing Office, 1931), 21-22.

²⁷⁸ United States Bureau of the Census, *Birth, Stillbirth, and Infant Mortality Statistics 1933* (Washington, D.C.: United States Government Printing Office, 1936), 25.

and Public Health Nursing personnel emphasized the importance of nutrition, vaccinations, cleanliness and scientific motherhood ideology. In the late 1920s, midwives still delivered most African American babies, but with the aid of Sheppard-Towner funds, public health nurses helped to introduce new methods for maternal and infant care. Cleanliness remained a number one goal to prevent disease and infection among mothers and newborns. Mississippi's Sheppard-Towner program is an example of how states used the funds to enhance their public health nursing programs and encourage maternal and infant hygiene. Other Deep South states such as Alabama also applied for Sheppard-Towner money to help establish maternal and child hygiene programs in more counties.

When Congress enacted the Sheppard-Towner Act in late 1921, Alabama quickly responded to the opportunity to receive federal funding for maternal and infant health care. Governor Thomas Killby accepted the terms for Sheppard-Towner money and named the Alabama State Board of Health (ASBH) as the governing agency for the maternal and infant hygiene program.²⁷⁹ The ASBH placed the Sheppard-Towner program under the Bureau of Child Hygiene that had been established in 1919 and started operating in 1920. In early 1922, an experimental maternal and infant health program started in Talladega County.²⁸⁰ The county was a rural county with approximately 41,000

²⁷⁹ Alabama State Board of Health, "Bulletin of the Alabama State Board of Health: Child Hygiene in Alabama 1919 to 1923," 25-28, Series: 028237, Box: "Department of Public Health State Publications 1896-1952," Alabama Department of History and Archives.

²⁸⁰ Ibid.

people, of which over thirty-seven and a half percent were African American.²⁸¹ According to the ASBH Bureau of Child Hygiene, Talladega County already had an established county health department with a public health nurse, so this particular rural county had the infrastructure needed to assess how to implement the Sheppard-Towner program in Alabama. The local newspaper, *Our Mountain Home*, proclaimed that Talladega County was the “first county in U.S. to take advantage of Shepherd-Towner [sic] Act.”²⁸² Funds for the Sheppard-Towner Act were not officially available to states until March 22, 1922; ASBH was really using Talladega County as a model for implementing the state’s Sheppard-Towner program when Alabama received its first appropriation. From the very beginning the program in the county followed a community hygiene or health model. The temporary nurse for maternity and infant hygiene and an employee of the ASBH, Elizabeth McKenzie, was a local woman and knew the community she would serve. In February, she contacted Talladega physicians to determine the needs for expectant mothers in the county.²⁸³ During the early months of 1922, McKenzie visited mothers and met with organizations throughout the county. McKenzie attended the Business Women’s Easter Banquet where she used the opportunity to share with these white and middle-to-upper-class women information about the maternal and infant health care work in the county.²⁸⁴ The papers do not

²⁸¹ United States Bureau of the Census, *Fourteenth Census of the United States Taken in the Year 1920, Volume III: Population 1920 Composition and Characteristics of the Population by States* (Washington, D.C.: United States Government Printing Office, 1922), 71.

²⁸² “Another Forward Step by County Health Department,” *Our Mountain Home*, February 22, 1922, 1.

²⁸³ Ibid.

²⁸⁴ “Business Women’s Club Holds Easter Banquet,” *Our Mountain Home*, April 19, 1922, 2.

indicate how McKenzie helped African American mothers and babies, but it was common for the health department to offer service to the county's black population. The Bureau of Child Hygiene claimed that the experimental program was a "considerable success," and the physicians and "rural people" approved of the program.²⁸⁵



Figure 3.5 Public health officials hosted infant and pre-school hygiene clinics in River Falls, Covington County, Alabama circa 1919 to 1923. Mothers attended these clinics to learn more about their child's health and to have their children examined.

Alabama State Board of Health, "Bulletin of the Alabama State Board of Health: Child Hygiene in Alabama 1919 to 1923," 8, 24, Series: 028237, Box: "Department of Public Health State Publications 1896-1952," Alabama Department of History and Archives.

²⁸⁵ Alabama State Board of Health, "Child Hygiene in Alabama 1919 to 1923," 25-26, Series: 028237 Box: "Department of Public Health: State Publications, 1896-1952," Alabama Department of Archives and History, Montgomery, Alabama.

After three months of investigating in Talladega County, the state's program officially began in April 1922, when a training base for new maternal and infant hygiene personnel opened in Jefferson County, the home of Alabama's largest city, Birmingham. Jefferson County provided an opportunity for nurses to observe maternal and infant health conditions in the city and for the health officials to learn more about maternal and infant healthcare. The training station allowed nurses to observe maternal and infant health care in a "highly organized" setting. Nurses applying for the new maternal and infant hygiene positions visited the training station to observe for a short time and test new methods and ideas.²⁸⁶ In 1923, only one training nurse stayed for an extended period of five months to learn more about the field.²⁸⁷ The Bureau explained that the situation in Jefferson County did not fully prepare a nurse "for service in a pioneer field" and the nurse would have to be adaptable."²⁸⁸ Rural nurses in areas like Talladega, Barbour, and Pike Counties had to adjust to their rural circumstances. The Bureau determined that a maternity and infant hygiene program could only be successful, if the entire county health department valued and showed interest in maternal and infant health activities. It could not be a "side issue."²⁸⁹

From April to June 1923, counties with full-time health department were eligible to begin Sheppard-Towner activities.²⁹⁰ Yet, during the first year only fourteen counties

²⁸⁶ Ibid., 27-28. The ASBH later relocated the training station closer to Montgomery.

²⁸⁷ Ibid., 28.

²⁸⁸ Ibid.

²⁸⁹ Ibid., 29.

²⁹⁰ Ibid., 26.

participated in the program.²⁹¹ The first few months of the program included experimenting and establishing the protocols in these counties. When the Sheppard-Towner program began in Alabama in 1922, the program was supposed to teach and treat Alabama mothers and infants, regardless of race.²⁹² By the middle of 1923, the Bureau developed a “four-phase” plan of “co-operative,” work that specifically addressed racial customs in Alabama:

1. Co-operation with County Health Units.
2. Co-operation with State Department of Education.
3. Co-operation with Home Economics Division, Alabama Polytechnic Institute (Auburn)
4. Co-operation with Tuskegee Institute and Movable School.²⁹³

One of the cooperative programs involved nurses from Tuskegee. Although white nurses lectured and treated African Americans in Alabama, the State Department utilized African American nurses to specifically address African American mothers. In 1923, the ASBH Bureau of Child Hygiene and Public Health Nursing employed two African American nurses to care for Alabama’s black community. ASBH and Tuskegee hired one of the nurses, Eunice Rivers, “to teach the welfare and hygiene of maternity and infancy to the people of the negro race by public addresses and demonstrations” at Tuskegee’s

²⁹¹ Ibid., 36.

²⁹² “County Health Report,” *Our Southern Home*, January 18, 1922, 1.

²⁹³ Alabama State Board of Health, “Child Hygiene in Alabama 1919 to 1923,” 36.

Movable School.²⁹⁴ Rivers, a 1922 Tuskegee Institute graduate and best known for the Tuskegee Syphilis Study, worked in the Black Belt teaching midwives and black women safe birth practices including boiling water, using clean utensils and rags, and steps on cleaning the infant. She also assisted the ASBH registration of births of African American newborns throughout the state. She constantly traveled to serve both the African American community and the ASBH.²⁹⁵ Another African American nurse worked with the Alabama State Department of Education “in its summer school work for negroes.”²⁹⁶ These nurses’ duties were similar to their white counterparts, but the black nurses specifically treated African American, and many doctors disregarded the two nurses as professionals. Even after Rivers worked in the region for decades, some doctors believed that she was incompetent because of her race²⁹⁷ These nurses had to double their efforts to reach a large population and overcome racial and gender prejudices.

In the beginning, Mississippi did not use Alabama’s approach of educating and hiring African American women as nurses until 1926, when MSBH hired Eliza Farish Pillars, a 1914 graduate of the Hubbard Hospital School of Nursing at the Meharry

²⁹⁴ Alabama State Board of Health, “Annual Report of the State Board of Health of Alabama,” 1923, 137, Series: 028237 Box: “Department of Public Health: State Publications, 1896-1952,” Alabama Department of Archives and History. Nurse Eunice Rivers later served as the public health nurse for the Tuskegee Syphilis Study. Historian Susan Reverby explained that Rivers served the African American community, while navigating the racial politics of public health. Susan Reverby, *Examining Tuskegee: The Infamous Syphilis Study and Its Legacy* (Chapel Hill: The University of North Carolina Press, 2009), 170. For more information on Nurse Rivers see: James Jones, *Bad Blood: The Tuskegee Syphilis Experiment, New and Expanded Edition* (New York: The Free Press, 1993), 109-115.

²⁹⁵ Alabama State Board of Health, “Annual Report of the State Board of Health of Alabama,” 1923, 137; Reverby, *Examining Tuskegee*, 170.

²⁹⁶ Alabama State Board of Health, “Annual Report of the State Board of Health of Alabama,” 1923, 137.

²⁹⁷ For an example see: Reverby, *Examining Tuskegee*, 181.

Medical College in Nashville, Tennessee. Like the African American nurses in Alabama, Pillars worked with black midwives and advised black schools about health curriculum. Instead of a Moveable School, Pillars used funds from the Sheppard-Towner Act and the Rockefeller Foundation's Rosenwald Fund to set up delivery clinic rooms in rural communities. The MSBH charged Pillars with a wide array of duties including teaching about maternal and infant care, administering vaccines, and hygiene classes.²⁹⁸

Alabama's program had stronger institutional support because the ASBH cooperated with Tuskegee Institute. Mississippi African American women did not have the same access to nursing education in their state as black nursing students in Alabama. Mississippi's Alcorn Agricultural and Mechanical College did not offer formal nursing education until the second half of the twentieth century, while Tuskegee Institute had had some form of nursing education since the last decade of the nineteenth century.²⁹⁹ Local institutions influenced the way maternal and infant healthcare developed in both states.³⁰⁰ Public health nurses needed a strong educational background, so they could teach the public.

²⁹⁸ Vern L. Bullough and Lilli Sentz, eds., *American Nursing: A Biographical Dictionary, Volume 3* (New York: Springer Publishing Company, 2000), 231-234; Kelena Maxwell, "Birth Behind the Veil," 93-94.

²⁹⁹ M. Elizabeth Carnegie, "Black Nurses in the United States, 1879-1992," in *Nursing Issues in the 21st Century: Perspectives from the Literature*, ed., Eleanor Hein (Philadelphia: Lippincott, 2001), 122.

³⁰⁰ Wailoo, *Dying in the City of the Blues*, 29-30.



Figure 3.6 The Tuskegee Movable School in 1931. The unidentified nurse standing in the middle is one of a handful of African American public health nurses in Alabama during the 1920s and early 1930s.

“First and Present Movable Schools (1931),” Archives Department, Tuskegee University Libraries, Tuskegee, Alabama.

In Montgomery County, Frances Taylor served as a Sheppard-Towner maternity and infant hygiene nurse. According to Frances Montgomery of the ASBH, Taylor’s work was “for the most part of an educational nature,” but she also provided “practical” assistance to the County Board of Health.³⁰¹ Like Taylor, Marshall County public health nurse Jessie Elam offered educational advice and examined infants and children. Elam held the county health officer provided full physical examinations consisting of “height, weight, chest expansion, teeth, vision, hearing, diseases of the eye, ear tonsils, glands,

³⁰¹ Frances C. Montgomery, “Place of Maternity and Infancy Work in a Public Health Program,” *Montgomery Journal*, n.d., Series: 13499 Folder: “Alabama Dept. of Public Health. Newspaper Articles, Scrapbooks, 1923-1924,” Alabama Department of Archives and History.

lungs, heart, nervous diseases, skin diseases, rickets, and hookworm.”³⁰² In addition, the Marshall County Health Department provided the children toothpaste and a toothbrush to improve overall oral hygiene. In 1924, Elman taught maternity and infant hygiene classes for mothers at the Guntersville Court House. At these clinics, Elam weighed and measured the infants and young children to ensure that the infants and preschool age children were meeting health goals. She encouraged mothers to nurse and provided guidance for feedings.³⁰³ In other counties, health nurses traveled to offer similar care at child hygiene clinics.

Some nurses like Rivers traveled extensively to advise and treat mothers and infants. In the Alabama wiregrass, one public health nurse traveled over two thousand miles in two months to care for the mothers and children of Coffee County.³⁰⁴ She helped the Health Officer H.P. Rankin with typhoid vaccination clinics from July 17th to September 17, 1925. The two public health officials administered 12,196 doses to a total of 4,288 people. In the 1920s, Alabama health officials subcutaneously injected patients with three doses of dead whole-cell parenteral typhoid vaccines, a dose every ten days.³⁰⁵

³⁰² “County Health Unit News,” *The Guntersville Democrat*, November 5, 1924, 3.

³⁰³ *Ibid.*

³⁰⁴ “Summary of Health Unit Activities Is Given; Dr. Rankin Thanks People,” *The Elba Clipper*, September 24, 1925, 1. Coffee County’s population was overwhelming, Caucasian (25,723). Yet, the county was also home to 6, 585 African Americans.

³⁰⁵ Myron M. Levine, Rosanna Lagos, and Jose Esparza, “Vaccines and Vaccination in Historical Perspective,” University of Maryland School of Medicine, accessed March 2018, <http://www.medschool.umaryland.edu/media/SOM/Research-Centers/Center-for-Vaccine-Development-CVD/docs/Levine-1-23-17-handout-2.pdf>, 4, 8; “The Prevalence of Typhoid Carriers in a General Population,” *Therapeutic Notes* 32, no. 6 (December 1925): 170; Sandhya A. Marathe, et al., “Typhoid Fever & Vaccine Development: A Partially Answered Question,” *The Indian Journal of Medical Research* 135, no. 2 (February 2012): 161-169. Richard Pfeiffer and Almroth Wright separately created effective typhoid vaccines in 1896. Both men heated *Salmonella typhos* or the typhoid bacillus to inactivate the bacterium. The vaccine was made with the inactive typhoid bacillus. In 1904, the United States army

The nurse reported that she held two infant hygiene clinics for mothers to teach the mothers about feeding their newborns. Some mothers needed personal visits at home for various reasons. For instance, she made five post-partum visits that would have included a physical examination of the mothers. She more than likely checked the mothers' temperature, blood pressure, and urine. If mothers needed more one-on-one instruction about infant hygiene, the nurse made home visits to weigh the baby and give mothers instructions for proper feeding. During this period, she visited schools to examine children with possible defects. The nurse found seventeen out of twenty children were "defective." These children might have had dental issues or might have been ten percent below the proper weight and height for their age.³⁰⁶ Dr. Rankin, the health officer, explained to the public that during the fall, the health department wished to examine the 12,000 school children for physical defects and hookworm. Rankin believed that Coffee County public health was improving because of "co-operation."³⁰⁷ If the community cooperated everyone would reap the rewards of better health.

On September 27, 1927, Jessie L. Marriner, the Director of the ASBH Bureau of Public Health Nursing, addressed the Alabama county health officers. Marriner considered "what are the major health problems common to all the counties of Alabama?" She then wondered how nursing activities could improve these problems.

began an oral typhoid fever vaccine campaign that led to an outbreak of the disease. Thereafter, the army turned to an injectable vaccine that proved more effective in preventing the fever. By 1909, nearly all United States Army soldiers took Wright's vaccine and the type of vaccine he created became popular for public use in the mid-1910s. The United States would not have an effective oral typhoid vaccine until 1989 when Ty21a entered the market.

³⁰⁶ "Summary of Health Unit Activities Is Given; Dr. Rankin Thanks People," 1.

³⁰⁷ *Ibid.*, 4.

Marriner identified the nursing problems as “hygiene of maternity and infancy, pre-school hygiene, school hygiene and communicable disease control.”³⁰⁸ Based on her current statistics, Marriner cited that over nineteen out of one hundred women died of puerperal causes. In addition, nearly four more women per hundred died from puerperal septicemia.³⁰⁹ Through observation and her knowledge of the difference in maternity and infant hygiene in counties, she knew that some areas still relied on traditional methods for maternal care. She suggested that county health workers and others follow a “more scientific selection” of maternal and infant care.³¹⁰ The Sheppard-Towner Act helped fund nurses to provide maternal and infant care, but ASBH had yet to set specific standards for each maternal visit. Marriner suggested that nurses needed more supervision or “specific instruction” for prenatal visits versus other maternity calls.³¹¹ The nurse was not the only actor to consider when thinking about maternity care. The ASBH officials viewed midwives similarly to MSBH personnel. Marriner recommended that the midwives follow laws regarding birth registration, administer eye drops to infants, and guidelines provided by the ASBH. If the midwives, did not uphold these standards the state should forbid them from practicing.³¹² The nursing director believed

³⁰⁸ Jessie L. Marriner, “Nursing Problems,” September 27, 1927, 2, Series: 7074 Box: “Department of Public Health: Administrative Files of the State Health Officer,” Folder: “Maternity and Infancy Hygiene, 1927” Alabama Department of Archives and History.

³⁰⁹ Ibid., 3; “Deaths Among Females, 15-44: According to Principle Causes and Color, Alabama, 1925,” Series: 7074 Box: “Department of Public Health: Administrative Files of the State Health Officer,” Folder: “Maternity and Infancy Hygiene, 1927” Alabama Department of Archives and History.

³¹⁰ Marriner, “Nursing Problems,” 6.

³¹¹ Ibid.

³¹² Ibid.

that more attention from public health officers and nurses to maternal and infant health would help save mothers and babies in their county. Increased public health activities required a larger labor force.

By the end of 1928, Alabama and its counties staffed ninety-six nurses. Seventy-five of those nurses were white, but unlike Mississippi, which had only one African American public health nurse, Alabama employed twenty-one African American public health nurses. This was partially due to Tuskegee's nursing program and its cooperation with the ASBH. The nurses and other public health officers made a difference in the level of care poor whites and African American women received maternal care. In the last two years of the Sheppard-Towner program, Alabama county health nurses monitored over 67,000 prenatal cases and hosted nearly 4,000 infant-preschool conferences with the help of a physician or public health officers. The busy nurses also evaluated 77,000 infants.³¹³ In 1929 alone the county nurses examined over 120,000 school children.³¹⁴ The nurses' activities led Alabama mothers to have a better understanding of maternal hygiene and the nurses monitored the mother-to-be throughout her pregnancy. The nurses ensured that women who chose to deliver with a midwife had a permitted midwife with proper instruction.³¹⁵ Public health officials including physicians and nurses examined children and babies more frequently than ever before. This allowed the health personnel to detect

³¹³ Alabama State Board of Health, "Biennial Report of the State Board of Health of Alabama for the Fiscal Years 1928-1929," 211, Alabama State Department of Archives and History.

³¹⁴ Ibid.

³¹⁵ Ibid. County nurses recorded that 1,626 out of 2,216 midwives had completed a required course. The nurses permitted 416 midwives out of the 2,216. This many contribute to hundreds of the midwives not completing midwifery courses.

health problems early, so the health officials could correct or treat the issue. During the 1920s, the ASBH tried to improve conditions, but lagged behind its sister state, Mississippi.

FIELD ACTIVITIES OF COUNTY NURSES	
1929	
1,886 infant-preschool conferences with physicians	1,481 expectant mothers attended conferences
7,944 number examined	2,770 mothers of infants attended group conferences
1,270 number visits to conferences	2,550 mothers of preschool children attended conferences
1,537 number found defective	2,216 midwives under supervision
1,318 number defects found	416 permits issued to midwives
1,255 corrections secured	1,626 midwives completed standard course of instruction
284 prenatal conferences with physicians	124,391 home visits
2,991 prenatal examinations by physicians	tuberculosis 14,026
1,880 visits by mothers to conferences	prenatal 16,469
60,736 new prenatal cases under supervision	post-partum 7,391
292 group conferences conducted by nurses	infant hygiene 37,585
	preschool 19,877
	school 25,547
	120,915 school children inspected by nurses.

Figure 3.7 The number of maternal and infant hygiene related activities carried out by county health nurses in 1929 Alabama. Alabama had started the decade with very little public health nursing, but with the Sheppard-Towner funds expanded its program to reach hundreds of thousands of Alabamians.

Alabama State Board of Health, "Biennial Report of the State Board of Health of Alabama for the Fiscal Years 1928-1929," 211, Alabama State Department of Archives and History.

By the end of 1929, Alabama ranked in the bottom six states for puerperal mortality. Although the national maternal mortality rate was seven per 1000, Alabama's total hovered at approximately ten per 1000 live births. Alabama's white women of childbearing age were slightly higher than the national average at almost eight maternal deaths. Yet, Alabama's African American women of the same age had a much higher possibility of death at 13.5 per 1,000.³¹⁶ Even though the status of Alabama maternal health in 1929 looked sub-par, the rate was a major improvement since 1925's higher rate of nineteen per 100.³¹⁷ By the end of the 1920s, Alabama still did not officially report infant mortality. The national average in 1923, the year Alabama accepted Sheppard-Towner funds, was approximately 87.5 deaths per 1,000 infants under one year old.³¹⁸ By 1929, the Alabama infant mortality rate was 73.6 per 1,000 live births. The likelihood of infant mortality for white and black newborns varied significantly. Alabama white infants had a better chance of living past one year old than the average American infant. The states' white infant mortality rate was sixty-four per 1,000 live births, while the national infant mortality was 67.6 per 1,000 live births. Alabama African American infant mortality rates were staggeringly high, averaging 91.2 infant deaths per 1,000 live births in 1929. When examining both white and black infant mortality rates, Alabama averaged

³¹⁶ U.S. Department of Commerce, *Mortality Statistics 1929* (Washington, D.C.: United States Government Printing Office, 1932, 36.

³¹⁷ "Deaths Among Females, 15-44: According to Principle Causes and Color, Alabama, 1925."

³¹⁸ U.S. Department of Commerce, *Mortality Statistics 1924* (Washington, D.C.: United States Government Printing Office, 1927, 82. This average derived from the infant mortality rates of states in birth registration area. Over fifteen states did not participate in this study because the states did not have complete records on infant mortality.

six more infant deaths per 1,000 than the national average.³¹⁹ Although Alabama's Shepard-Towner program offered maternal and infant care to both white and black mothers, white mothers had access to more nurses and white mortality rates were much lower. Even so, the ASBH and local health departments made noteworthy improvements to lower mortality rates for both races during the decade. In the mid-1920s, the ASBH started tracking these death rates to measure improvement. The Sheppard-Towner Act had a direct impact on Alabama public health and helped usher in scientific maternal and infant care. During the 1920s, Alabama like Mississippi began monitoring midwives and teaching mothers and midwives appropriate ways to feed, clothe, and raise their babies. The population had more knowledge on maternal and infant hygiene that led to lower mortality rates and a healthier community. The community maternity and infant health program gave Alabama mothers, infants, and children access to care that sought to reduce deficiencies. At the end of the decade, public health officials continued to evaluate what adequate care meant.

When the Sheppard-Towner funds ended on June 30, 1929, the interest in improving maternal and child health continued.³²⁰ Public health officials faced some hurdles, including the discontinuation of the Sheppard-Towner Act and budget cuts that some public health departments faced in 1929 and the early 1930s. The CB, the administering agency of the Sheppard-Towner Act, continued to lobby for appropriation

³¹⁹ United States Bureau of the Census, *Birth, Stillbirth, and Infant Mortality Statistics 1933*, 25.

³²⁰ The AMA finally defeated the national maternal and infant hygiene program by the end of the 1920s. In a conservative political climate, the AMA successfully lobbied Congress to cut the social welfare program. Many scholars point to the defeat of the Sheppard-Towner programs as a major setback for the CB and its goal to be the bureau that focused on the whole child. Lindenmeyer, *'A Right to Childhood,'* 100-102; 106. Also see: Ladd-Taylor, *Mother-Work*, 184-190; Alexandra Stern, *Formative Years*, 108, 142.

for children's health and for maternal care. By the time the Sheppard-Towner funds ended, CB officials and local child health advocates were planning the 1930 White House Conference on Child Health and Protection (WHCCHP). At this conference, the delegates debated how to fill the void in a national maternal and infant health plan. Secretary of the Interior Ray L. Wilbur, who served as the AMA President from 1923 to 1924 and was an anti-Sheppard-Towner Act physician, served as the chairman for the conference and wanted to place maternal and child health under the USPHS.³²¹ While facing great opposition at the WHCCHP meeting, CB delegates including Chief Grace Abbott and Dr. Martha Eliot guaranteed that the Bureau would maintain control of maternal and child hygiene throughout the 1930s.³²²

³²¹ Kriste Lindenmeyer, *"A Right to Childhood,"* 164-165.

³²² *Ibid.*, 170.

CHAPTER IV

A “TREMENDOUS STIMULUS”: MATERNAL, INFANT, AND CHILDREN’S HEALTH DURING THE GREAT DERPESSION³²³

On March 4, 1929, Herbert Hoover inherited an American economy that many people believed was unshakable, but upon further examination, it was unstable. That summer as the economy continued to suffer under the surface, the Hoover administration thought of the health of American children. Since the 1909 White House Conference on Children, children’s health experts had met each decade to discuss the status of American children and to address current concerns. The Hoover administration was responsible for hosting the third White House Conference on Children or the White House Conference on Child Health and Protection (WHCCHP) the following year, 1930. The American Medical Association (AMA) successfully lobbied against the renewal of the Promotion of the Welfare and Hygiene of Maternity and Infancy Act or the Sheppard-Towner Act, which meant the Children’s Bureau (CB) national maternal and child hygiene program hung in the balance.³²⁴ While the Hoover administration members considered the state of the

³²³ Felix J. Underwood, “New Trends in Public Health,” May 11, 1937, Series: 2012, Box: 8579, Folder: “Public Health, Public Health Library Subject Files, 1931-1985,” Mississippi Department of Archives and History, Jackson, Mississippi.

³²⁴ Molly Ladd-Taylor, *Mother-Work: Women, Child Welfare, and the State, 1890-1930* (Urbana: University of Illinois Press, 1994), 188.

American economy, they also planned the third series of the White House Conference on Children. Since Sheppard-Towner funds ended in 1929, many members of the CB and other child welfare advocates wanted to address the status of maternal and children's health.³²⁵ In July, the administration announced the upcoming conference and over 1,200 experts studied American children's health and prepared for the 1930 White House Conference. The main goals of the conference were to determine the state of American children's health and establish future child welfare programs and health standards. Over 3,000 men and women concerned about American children attended the conference in Washington, D.C. from November 19th to 22nd, 1930.³²⁶ At his opening speech, President Hoover addressed the attendees, "If we could have but one generation of properly born, trained, educated, and healthy children, a thousand other problems of government would vanish. We would assure ourselves of healthier minds in more vigorous bodies, to direct the energies of our Nation to yet greater heights of achievement."³²⁷ Throughout the Great Depression, child welfare advocates established healthcare standards to raise up such a generation.

³²⁵ For more on the Children's Bureau during 1929 and the 1930s see: Robyn Muncy, *Creating a Female Dominion in American Reform, 1890-1935* (New York: Oxford University Press, 1991) 125,150-157; Kriste Lindenmeyer, "A Right to Childhood," *The U.S. Children's Bureau and Child Welfare, 1912-1946* (Urbana: The University of Illinois Press, 1997), 163-212; Alexandra M. Stern and Howard Markel, eds., *Formative Years: Children's Health in the United States, 1880-2000* (Ann Arbor: The University of Michigan Press, 2004), 107, 111-112, 116, 143,165; Alice Smuts, *Science in the Service of Children, 1893-1935* (New Haven: Yale University Press, 2008), 4,96,228,249-251,355-356.

³²⁶ White House Conference on Child Health and Protection, *White House Conference 1930: Addresses and Abstracts of Committee Reports* (New York: The Century Company, 1931), v.

³²⁷ *Ibid.*, 7.

With the American economy in turmoil and uncertainty about the future of federal maternal and child health program, children's welfare and health experts studied children's health for sixteen months and recommended reforms in child health to protect forty-five million children from preventable illnesses, the future generation of Americans. While the experts failed to meet all goals set forth by the 1930 White House Conference, they made visible improvement to children's health during the worst economic downturn in American history, the Great Depression. Maternal and child health welfare advocates continued to emphasize the importance of protecting children during the Depression by meeting at conferences and pushing new legislation. The Depression made it even more important to the reformers, and they attempted to protect maternal and child health.

The WHCCHP, the Social Security Act's Title V: Grants to States for Maternal and Child Welfare, and the White House Conference on Children in a Democracy (WHCCD) offer examples of child welfare work that improved maternal and child healthcare throughout the 1930s. First, the 1930 WHCCHP delegates addressed the shortcomings of American child health programs, especially since the end of the Sheppard-Towner Act. The experts believed that the United States had an obligation to children as citizens to provide quality healthcare. Second, the first part of Title V allowed public health departments to expand their maternal and child healthcare throughout the United States. This chapter provides a case study of Title V work in New York and Mississippi, where both states offered care to mothers and children. Finally, the WHCCD delegates declared that as a democracy, the United States must provide access to quality healthcare for mothers and children. Healthy children were vital to maintain democratic ideals. This chapter argues that during the Great Depression, child welfare advocates

guaranteed a continued growth in maternal and child health programs by focusing on needy mothers and children. By the 1930s, child welfare experts knew that some Americans used private healthcare providers, but many Americans did not have access to or could not afford private care. The emphasis on mothers and children from rural or low socio-economic backgrounds allowed for public maternal and infant health programs to grow throughout the nation and during a time of economic distress. Furthermore, maternal and child healthcare improved because more physicians and nurses received better training and they offered more services. Despite economic hardships and lack of food in certain areas, American maternal and infant mortality rates decreased in the 1930s.

During the Great Depression, many Americans struggled to maintain a proper diet, and some became ill because of nutritional deficiency and general living conditions. Historians of the Great Depression and New Deal often passingly mention American health to describe the extreme nature of the Depression or briefly discuss the Social Security Act.³²⁸ In his synthesis, David Kennedy explained living conditions, but disregarded health until his discussion of the Social Security Act. He noted that the portions of the Social Security Act regarding healthcare “were to survive in the final act only as a residue, in the form of small grant-in-aid to the states for rural public health programs and services for the physically handicapped.”³²⁹ The federal maternal and child

³²⁸ For more information on the Great Depression see: Robert S. McElvaine, *The Great Depression: America, 1929- 1941*, “Twenty-Fifth Anniversary Edition” (New York: Three River Press, 2009); David Kennedy, *Freedom from Fear: The American People in Depression and War, 1929-1945* (New York: Oxford University Press, 1999).

³²⁹ Ibid., 264.

health programs did more than just provide small grants-in-aid to states; rather the programs helped the states provide health care to millions of American women and children during the Great Depression.

Many historians including Robyn Muncy and Molly Ladd-Taylor view the 1920s and the 1930s as an era when the CB lost power as the Bureau struggled to maintain control of child welfare including children's health.³³⁰ Molly Ladd-Taylor asserted that the CB members and other maternalists lost because Title IV: Grants to States for Aid to Dependent Children and Title V: Grants to States for Maternal and Child Welfare of the Social Security Act of 1935 only offered help to children of low socio-economic backgrounds. The CB's goal was to promote the welfare of all American children rather than a specific group of children.³³¹ While the CB did not gain its goal of offering healthcare to all American children, the CB set the standards for providing healthcare to low-income or rural mothers and children for decades to come. By concentrating on these mothers and children, the CB and other child welfare advocates ensured that federal maternal and child health programs continued and thrived.

During the Great Depression, maternal, child, and infant health programs grew exponentially by offering more care to American mothers and children and by increasing

³³⁰ Robyn Muncy, *Creating a Female Dominion in American Reform, 1890-1935*, 124-125, 150-157; Molly Ladd-Taylor, *Mother-Work*, 197-199. Robyn Muncy argued that female reformers' authority declined from 1924 to 1935. She asserts that Congressmen threatened female policymakers from the CB, which led to the erosion of the Bureau's political clout after the passage of the Social Security Act. For more information on the CB's work in the 1930s see: Kriste Lindenmeyer, "A Right to Childhood," 163-202; Alexandra M. Stern and Howard Markel, eds., *Formative Years*, 107, 111-112, 116, 143, 165; Alice Smuts, *Science in the Service of Children, 1893-1935*, 4, 96, 228, 249-251, 355-356.

³³¹ Molly Ladd-Taylor, *Mother-Work*, 198-199. For additional information on Title IV see: Linda Gordon, *Pitied but not Entitled: Single Mothers and the History of Welfare, 1890-1935* (New York: Free Press, 1994).

opportunities for medical professionals to receive training. Throughout the 1930s, child welfare advocates attempted to construct a program that improved the overall standard of living for American children. Maternal and child health reformers from the CB and other federal agencies visited conferences and voiced their opinions on child health using the same rhetoric as they had over a decade earlier. These reformers noted that children were the future citizens and leaders of America, and they needed proper healthcare to ensure that they could protect American democracy in the future. The WHHCP debates surrounding the SSA and the WHCCD offered the platform that reformers needed to expand maternal and child healthcare to women and children in need. During the Great Depression, maternal and child health reformers helped create a program and made recommendations that led to improved maternal and child health while many Americans lacked essential healthcare and proper nutrition.

In 1926, CB leaders lobbied for an extension of the Sheppard-Towner Act appropriation. The act was set to expire at the end of June 1927, but the CB wanted to ensure that its maternal and infant health program continued. According to scholar Robyn Muncy, the Sheppard-Towner Act already faced many obstacles by 1924 that continued during the CB 1926 extension campaign. For instance, Congress was reducing spending for public health and the CB faced opposition from many medical professionals³³² Even with opposition in Congress and from the American Medical Association, the CB secured a vote on the Sheppard-Towner Act. The renewal of the Sheppard-Towner inched through both houses of Congress with a compromise because many in the Senate wanted

³³² Robyn Muncy, *Creating a Female Dominion in American Reform*, 125, 135.

to repeal the act. The renewal was contingent on the program ending on June 30, 1929.³³³ Although the CB and other maternal and child welfare advocates attempted to save the Sheppard-Towner Act, the program ceased in the summer of 1929. That same summer, the Hoover administration was in the planning process for the third White House Conference on Children.

In July 1929, the Hoover administration announced the conference and recruited experts to participate in studies and serve on committees. Approximately 1,200 maternal and child welfare experts from a variety of fields examined the status of American children and planned for the upcoming 1930 WHCCHP. The experts divided into seventeen committees to consider the needs of American children. On November 19-22, 1930, 3,000 advocates for children attended the WHCCHP where the committees recommended new health and child welfare standards.³³⁴ The committees considered the overall wellbeing of American children, but many committees focused more directly on children's health.³³⁵ The committees concerning health were designed to ensure that American children citizens were healthy in both the present and the future.

One of the 1930 White House Conference study groups, the Committee on Public Health Organization, began planning for the conference in the last half of 1929. The committee members tried to determine how to strengthen public health initiatives for

³³³ Ibid., 125.

³³⁴ White House Conference on Child Health and Protection. *White House Conference 1930: Addresses and Abstracts of Committee Reports* (New York: The Century Company, 1931), v.

³³⁵ Some committees' minutes were not widely available, but committees did publish preliminary findings, excerpts of minutes, and final findings. These publications were mostly repositied in university libraries or individual delegates saved copies.

children, but some disagreed about which federal agency should control maternal and infant healthcare. The Sheppard-Towner Act funds were no longer available and without the funds, the CB struggled to maintain its authority. According to historian Kriste Lindenmeyer, during the WHCCHP the Hoover Administration and the CB leadership fought over control of maternal and infant healthcare.³³⁶ At the committee meetings, members debated the best measures to improve children's health. In one debate on the repeal of the Sheppard-Towner Act, Grace Abbott, Chief of the CB and a member of the committee, explained to the group of mostly male physicians that she was not the chief when Congress enacted the Sheppard-Towner Act, but she was disappointed in its repeal. She argued that the CB should retain control of children's health because parents still solicited advice from the bureau and historically the agency cooperated with state departments of health and child welfare.³³⁷ She noted, "The repeal voted two years ago did not reflect Senate opinion about the measure but showed the power of two or three persons to prevent a vote under the Senate rules."³³⁸ Another committee member, Dr. Olin West, denounced both the Sheppard-Towner Act and Abbott. He stated, "I do not believe in the Sheppard-Towner legislation. Miss Abbott knows I do not...I think the Sheppard-Towner law unduly magnified a narrow field in public health..."³³⁹ The

³³⁶ Kriste Lindenmeyer, "*A Right to Childhood*," 169.

³³⁷ "White House Conference on Child Health and Protection Section II. Public Health Service and Administration, Meeting of the Committee on Public Health Organization," November 7, 1929, 74, Manuscript Collection: Bishop, Eugene L., White House Conference on Child Health, 1929-1931, Box: 1, Folder: "Minutes of Committee on Public Health Organization: White House Conference on Child Health, 1929-1931," National Library of Medicine, History of Medicine Division, Bethesda, Maryland.

³³⁸ *Ibid.*, 74.

³³⁹ *Ibid.*, 75.

debates about a national child health program led to the committee issuing a majority and minority report regarding suggestions.

The chairman of the Committee on Public Health Organization, Dr. E.L. Bishop, issued the “Statement of General Principles Relative to Public Health in the United States,” the majority report, for recommendations on improving child health programs. Bishop noted that the United States Public Health Service should serve as the agency to assist state health departments and strengthen local child hygiene divisions. In response, Abbott offered a minority report.³⁴⁰ She argued that the CB and American mothers should continue to play a large role in children’s health. The debate between Bishop and Abbott provides an example of the ongoing struggle for control over child healthcare. Since the late 1910s and early 1920s, leading male physicians argued that all health programs including maternal and child health programs should be under the USPHS authority. However, Congress allowed the CB and its Maternity and Infancy Division to manage the Sheppard-Towner Act program in the 1920s. After the Sheppard-Towner program ended, the CB leaders had to fight to maintain control of children’s healthcare. The CB wanted to serve all the child’s needs including healthcare.³⁴¹ Some of the experts on this

³⁴⁰ “Statement of General Principles Relative to Public Health in the United States Adopted by the Committee on Public Health Organization of the White House Conference on Child Health and Protection,” Manuscript Collection: Bishop, Eugene L., White House Conference on Child Health, 1929-1931, Box: 1, Folder: “Minutes of Committee on Public Health Organization: White House Conference on Child Health, 1929-1931;” “Minority Report to Accompany Statement of General Principles Relative to Public Health in the United States Adopted by the Committee on Public Health Organization of the White House Conference on Child Health and Protection,” Manuscript Collection: Bishop, Eugene L., White House Conference on Child Health, 1929-1931, Box: 1, Folder: “Minutes of Committee on Public Health Organization: White House Conference on Child Health, 1929-1931.”

³⁴¹ For more on the struggle for control of American children’s public healthcare see: Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982), 260-261, Molly Ladd-Taylor, *Mother-Work*, 169, 171-175, 184-185, 188-189; Robyn Muncy, *Creating a Female Dominion in American Reform, 1890-1935*, 124-125, 128, 132-140, 142, 147-148, Alexandra M. Stern and Howard Markel, *Formative Years*, 9.

committee disagreed about the logistics, but they all wanted to improve maternal and children's health.

In the end, the organizers of the White House Conference excluded the Committee on Public Health Organization's final report from the conference's *Addresses and Abstracts of Committee Reports* book because "the report touches controversial points which require further consideration."³⁴² The feud over which organization controlled children's health was a contentious battle. In the committee's report, the final recommendations hinted at the tensions within the group. "The committee has considered but does not concur in the opinion that the child and the needs of the child as a whole should be considered by one federal bureau separate from the central federal health organization."³⁴³ Most wanted to relieve the CB Division of Maternity and Infant Hygiene of its health programs and incorporate them into the USPHS.³⁴⁴ This recommendation would have allowed the Public Health Service to control assistance and funding for states' children's health programs.³⁴⁵ These recommendations faced objection from at least three committee members, Abbott, West, and F.C. Warnshuis. Abbott

³⁴² White House Conference on Child Health and Protection, *White House Conference 1930: Addresses and Abstracts of Committee Reports*, 113.

³⁴³ E. L. Bishop, "Report of Committee on Public Health Organization: Section II White House Conference on Child Health and Protection, 1931, 156, Manuscript Collection: Bishop, Eugene L., White House Conference on Child Health, 1929-1931, Box: 1, Folder: "Report of the Committee on Public Health Organization-Section II-1931;" United States Children's Bureau, *The Children's Bureau Legacy: Ensuring the Right to Childhood* (Washington D.C., United States Children's Bureau, 2013), 63-64, accessed June 2016, https://cb100.acf.hhs.gov/sites/default/files/cb_ebook/cb_ebook.pdf.

³⁴⁴ Bishop, "Report of Committee on Public Health Organization," 156.

³⁴⁵ Ibid.

continued to defend her agency, while the other two objected to federal subsidies.³⁴⁶ At the end of the 1930 White House Conference, the debate over American children's health management remained unsolved. Based on the committee's majority opinion, Congress should streamline children's health into the USPHS; however, tensions between the CB and Public Health Service camps continued into the 1930s.

While the Committee on Public Health Organization bickered over the administration of federal maternal and child health programs, other committees considered ways to protect the future generation of American citizens. Dr. Fred L. Adair, Chairman of the Committee on Prenatal and Maternal Care, an obstetrician, and the chief at the Chicago Lying-In Hospital, suggested that American mothers seek pre-conceptional care because "many things happen prior to pregnancy which have a definite influence on both mother and infant."³⁴⁷ These conditions ranged from environmental circumstances to venereal diseases. Adair advocated for maternal and infant care ranging from antepartum to postpartum care. He also argued against the use of untrained midwives and explained that the "midwifery problem" would not be easy to fix considering the economic climate. He believed that medical personnel should train midwives and that low socio-economic areas should receive economic aid.³⁴⁸ Public health doctors, and especially nurses, increasingly trained and regulated midwives in the

³⁴⁶ E.L. Bishop, "Report of Committee on Public Health Organization: Section II," 165-169.

³⁴⁷ White House Conference on Child Health and Protection. *White House Conference 1930: Addresses and Abstracts of Committee Reports*, 69.

³⁴⁸ *Ibid.*, 85.

1930s. In addition, the physicians and nurses were vital to pediatric preventative medicine.

The Committee on Medical Care for Children studied the current preventive public health campaigns and recommended improvements for the future. The committee divided their study of preventive care into case studies of the American urban and rural populations. The committee realized that preventive care initiatives lacked coordination and the committee recommended that local officials conduct studies to develop a complete children's health program. The committee further believed public health officials should better educate the public about preventative medicine because many Americans did not value it.³⁴⁹ The Committee on Medical Care for Children realized that many American parents did not vaccinate their children and that health officials needed to reach more children than they had in the late 1920s. By 1930, private and public health doctors and nurses vaccinated against smallpox and immunized against diphtheria in a portion of the American children population. According to the committee's survey, urban smallpox vaccination rates ranged from two to forty-seven percent, with average rate of 16.4 percent; however, rural vaccination rates ranged from zero to forty-two percent, with an average of nine percent.³⁵⁰ The committee advocated for higher vaccination rates and recommended more preventative medical programs throughout the country.

³⁴⁹ Ibid., 108-109.

³⁵⁰ Ibid., 102-104.

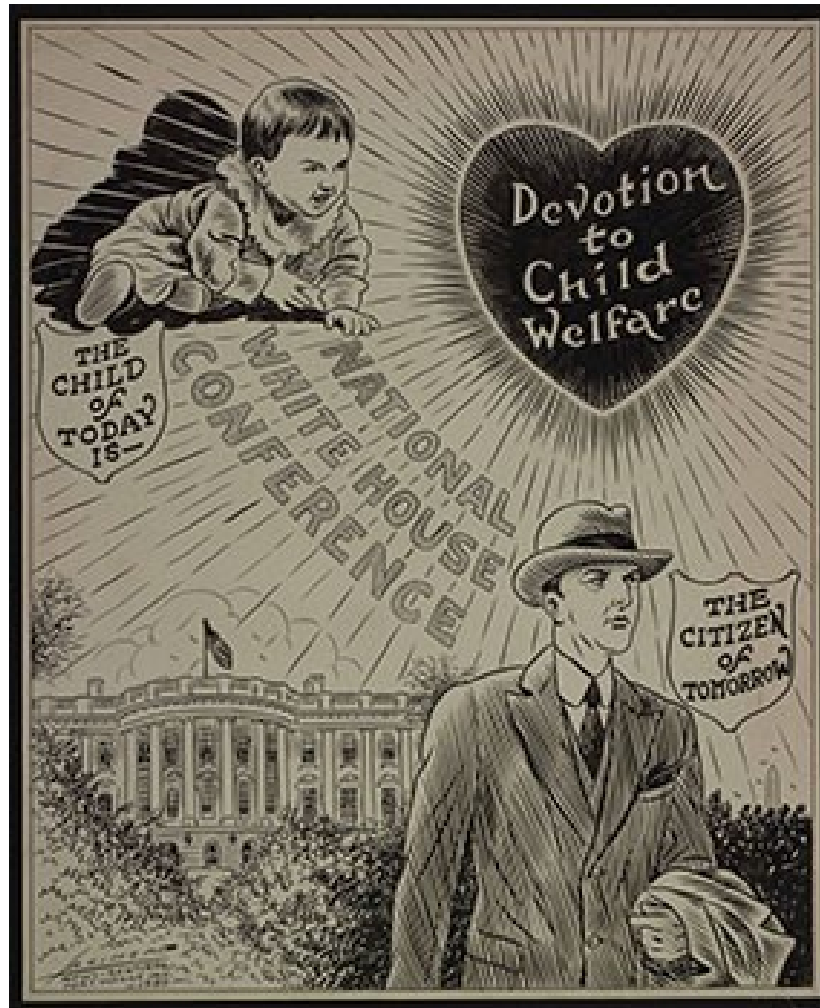


Figure 4.1 A flyer from the 1930 White House Conference on Child Health and Protection. The text of the flyer highlights the rhetoric used by the child welfare reformers. The experts argued that children were future citizens, whose health needed to be protected.

“Image from White House Conference on Children, 1930 materials,” White House Conference on Child Health and Protection Records, Box 145, Hoover Institute Library & Archives, Stanford University, Stanford, California.

To achieve better vaccination rates and combat communicable diseases, the Committee on Communicable Disease Control argued that each city and rural community needed a “well-organized” and funded health department.³⁵¹ The communicable disease control committee’s study indicated that only twenty-four percent or 505 rural counties had public health departments; therefore, the committee called for the establishment of a public health district in each county.³⁵² These health departments needed better-trained physicians, and the committee believed that health departments needed to rely more heavily on public health nurses. The communicable disease control committee report noted, “Public health nurses can be, and are one of the most important agents in the administrative machinery of communicable disease control.”³⁵³ The Committee on Medical Care for Children also valued health nurses and explained that, in the first thirty years of the twentieth century, “the demand for nurses in public health work has increased by leaps and bounds.”³⁵⁴ In the 1930s, public health nurses vaccinated and treated thousands of children and taught midwives modern techniques about childbirth. Yet, the committees believed that public health officials including nurses and doctors also needed improved training.

Many of the committees believed that doctors needed better education to better serve mothers and children. The Committee on Communicable Disease Control argued that medical students should learn more about public health and that physicians should

³⁵¹ Ibid., 122.

³⁵² Ibid.

³⁵³ Ibid., 116.

³⁵⁴ Ibid., 96.

conduct extensive research on communicable diseases.³⁵⁵ For instance, studies on whooping cough could lead to an effective vaccine or a way to control the disease.³⁵⁶ Other committees suggested new education standards for areas such as obstetrics.³⁵⁷ These new standards demanded improvements in medical education, scientific research, and public health to protect American children.

The call for better medical education was not new because medical education reform began before the Flexner Report of 1910.³⁵⁸ Medical schools that met new standards, which included more prerequisites for admission and more science courses, were overwhelming white medical schools that the student body was mostly male. Furthermore, the schools that survived the reform years of the 1910s and 1920s, were mostly located in urban settings and many were in the northeast. This led to a shortage of doctors in low socio-economic and rural areas. Most new doctors opened practice in urban and wealthy areas.³⁵⁹ The need for more educated physicians in rural areas remanded a concern of the WHCCHP delegates, who wanted to bring new standards to the country.

In particular, the delegates wanted to improve medical education including education for specialties such as obstetrics and pediatrics. In the late ninetieth and early

³⁵⁵ Ibid., 123.

³⁵⁶ Ibid., 124.

³⁵⁷ Ibid., 82-83.

³⁵⁸ For more on the Flexner Report see: Paul Starr, *The Social Transformation of American Medicine*, 118-121, 123-126, 131, 224, 230, 355; John C. Burnham, *Health Care in America: A History* (Baltimore: Johns Hopkins University Press, 2015), 212-213.

³⁵⁹ Paul Starr, *The Social Transformation of American Medicine*, 123-125.

twentieth centuries, pediatrics slowly gained legitimacy as a field. Pediatricians worked in children's hospitals and some joined the American Pediatric Society, which was established in 1888. Even with a professional organization, pediatrics was still in its infancy. From the 1880s to the early decades of the twentieth century, physicians including Abraham Jacobi, the founder of American pediatrics and a President of the AMA, advocated for educational training in pediatrics. By 1930, a few medical colleges had professors to teach pediatrics as a specialty. At the same time, pediatricians organized and created the American Academy of Pediatrics, which furthered the professionalism of these physicians. Sociologist Sydney Halpern reports that the Academy stemmed from the WHCCHP and notes that in the 1930s and 1940s pediatrics became an established specialty in American medicine.³⁶⁰ The debates at the WHCCHP and the later WHCCD played a role in shaping pediatrics.

Despite some internal squabbling during the planning of the 1930 White House Conference, the experts from various committees agreed to The Children's Charter. This charter was an agreement that recognized "the rights of the child as the first rights of citizenship."³⁶¹ It included nineteen points that were "the main recommendations of the committees" and "the core of the Conference findings."³⁶² One of the aims of The Children's Charter was that all American children had the right to "child health

³⁶⁰ Sydney Ann Halpern, *American Pediatrics: The Social Dynamics of Professionalism, 1880-1980* (Berkeley: University of California Press, 1988), 3, 205. For more on American pediatrics see: Sydney Ann Halpern, *American Pediatrics*; Alexandra M. Stern and Howard Markel, *Formative Years*, 23-90.

³⁶¹ White House Conference on Child Health and Protection. *White House Conference 1930: Addresses and Abstracts of Committee Reports*, 46; Kriste Lindenmeyer, "A Right to Childhood," 170.

³⁶² White House Conference on Child Health and Protection. *White House Conference 1930: Addresses and Abstracts of Committee Reports*, 45.

protection from birth through adolescence,” which included regular examinations and preventative medicine.³⁶³ In the last point, the experts agreed upon “minimum protections of the health and welfare of children,” which included local public health organizations with full-time public health officials including physicians, sanitary and laboratory specialists, and public health nurses. In addition, each district or county needed a local welfare department to provide aid to children in need.³⁶⁴ The 1930 White House Conference set forth standards that child welfare and public health officials sought to achieve throughout the Great Depression.

One goal of the 1930 Children’s Charter was the establishment of local public health organizations with full-time public health officials. Some county health departments opened during the early 1930s, but many cut funds in the early 1930s. In Mississippi, the State Board of Health operated under reduced budgets until 1934.³⁶⁵ By the mid-1930s, the United States expanded public health programs at the state and local level. When the appropriations of the Social Security Act of 1935 became available in early 1936, state health departments gained federal funds, administered by the CB, for maternal and child health. In addition, the Public Health Service granted appropriations for general public health including training public health physicians and nurses who treated adults and children.³⁶⁶ These federal funds helped state and local health

³⁶³ Ibid., 46.

³⁶⁴ Ibid., 48.

³⁶⁵ Harry E. Handley, *The Field Unit in Local Public Health Service: Tennessee and Mississippi, 1930-1937* (New York: The Commonwealth Fund, 1938), 6.

³⁶⁶ White House Conference on Children in a Democracy, *Preliminary Statements Submitted to the White House Conference on Children in a Democracy, January 18-20, 1940* (Washington, D.C.: Superintendent of Documents, 1940), 172.

departments operate and expand to serve children during the Great Depression. For example, in 1936, Mississippi public health nurses made 65,828 maternal and child hygiene visits, which was almost double the number of visits two years earlier (32,967 in 1934).³⁶⁷ By the end of the decade, the number of public health nurses in Mississippi increased from thirty-five to 183.³⁶⁸ In Mississippi, the additional funds even allowed some counties to expand and others to establish health departments and hire more personnel. By 1939, at least 1,300 counties nationwide had health departments or associated with a district organization, an increase of at least forty percent from 1936.³⁶⁹ By the end of the decade, experts met many of the 1930 standards or were moving toward accomplishing the child health recommendations.

The Social Security Act (SSA) stemmed from many social reforms. According to historian David Kennedy, “The needs of the country were plain enough.”³⁷⁰ However, many voices clashed as they attempted to build a social insurance plan. Linda Gordon, who offers an in-depth analysis of Title IV or the Aid to Dependent Children program, contends that the SSA established a program that was created by “rejecting some alternative and compromising over others.”³⁷¹ Roosevelt charged the Committee on

³⁶⁷ Harry Handley, *The Field Unit in Local Public Health Service*, 47. The numbers of visits are based on the twenty-four full-time health departments in Mississippi during the 1930s. Other counties also employed public health nurses that treated mothers and children.

³⁶⁸ Margaret Morton, Edna Roberts, and Kaye Bender, *Celebrating Public Health Nursing: Caring for Mississippi's Communities with Courage and Compassion, 1920-1993* (Jackson: Mississippi State Department of Health, 1993), 26.

³⁶⁹ White House Conference on Children in a Democracy, *Preliminary Statements Submitted to the White House Conference on Children in a Democracy, January 18-20, 1940*, 172.

³⁷⁰ David Kennedy, *Freedom from Fear*, 262.

³⁷¹ Linda Gordon, *Pitied but Not Entitled*, 3, 263.

Economic Security (CES) to make a social security program that included an old age pension, unemployment insurance, and an American healthcare program.³⁷² During 1934 and 1935, CES members had to compromise with many social reformers on which welfare programs should be included in the social security plan.³⁷³ Kennedy notes that the only portions of the healthcare program to survive were “in the form of small grants-in-aid to the states for rural public health programs and services for the physically handicapped.”³⁷⁴ His assessment overlooked Title V: Grants to States for Maternal and Child Welfare of the Social Security Act of 1935, which called for the United States to increase attention for maternal and child healthcare.

Congress allowed the CB to operate Title V, a program that the CB had fought for since the early twentieth century. The CB gave maternal and infant hygiene appropriations to state departments of health, and state public health officials determined how to allocate the funds for maternal and child health projects. Molly Ladd-Taylor concluded that the SSA was the “first permanent acknowledgement of federal responsibility for maternal and child welfare.”³⁷⁵ The USPHS attempted to gain control of the maternal and infant care program, but the CB maintained its control of maternal and children’s health.³⁷⁶

³⁷² Ibid., 263. Also see: Muncy, *Creating a Female Dominion in American Reform*, 152.

³⁷³ David Kennedy, *Freedom from Fear*, 262.

³⁷⁴ Ibid., 264.

³⁷⁵ Molly Ladd-Taylor, *Mother-Work*, 198.

³⁷⁶ Ibid.

Part One of Title V or the Grants to States for Maternal and Child Welfare of the Social Security Act of 1935 offered funds to states to “extend and improve” “services for promoting the health of mothers and children, especially in rural areas and in areas suffering from severe economic distress.”³⁷⁷ All states and territories were eligible for \$20,000 for maternal and child health and the states could receive additional funds based on the ratio of live births in-state to total United States live births. The second appropriation had the stipulation that the states had to match the funds. Some states took more advantage of this than others, but the program helped all of the states to continue or start maternal and child health programs.³⁷⁸ To receive funds from Title V, a state had to submit a plan that outlined the state’s financial contributions toward maternal and infant care, describe the administration of maternal and infant care, and provide reports on activities and attempts to improve maternal and infant care.³⁷⁹ State public health agencies had to hold demonstrations about infant care and maternal hygiene. Title V also offered funds for psychically disabled children and children welfare services.³⁸⁰ The CB

³⁷⁷ *The Social Security Act of 1935*, Public Law #74-271, 74th United States Congress, Session I (August 14, 1935), accessed June 2016, <https://www.ssa.gov/history/35actinx.html>. Part One of Title V is referred to as Title V in this chapter.

³⁷⁸ Albert McCown, “Part I-Maternal and Child-Health Services,” *The Child* 1, no. 1 (July 1936):6-7. In June 1934, only thirty-one states had maternal and child hygiene divisions. Title V made it possible for all states to have a specific division for maternal and child health.

³⁷⁹ *The Social Security Act of 1935*, Public Law #74-271.

³⁸⁰ This chapter focuses on Part I of Title V or the maternal and child public health grants. A few scholars have expanded on the importance of Title V, Part II and Title V, Part III. For more information, consult: L. Hitchcock and B.A. Mulvihill, “The Early Years of Title V: Extending and Improving Care for Children with Special Health Care Needs, 1935-1941,” *Maternal and Child Health Journal* 15, no. 2 (February 2011): 139-147; H. T. Ireys, R. J. Hauck, and J. M. Perrin, “Variability Among State Crippled Children’s Service Programs: Pluralism Thrives,” *American Journal of Public Health* 75, no. 4 (April 1985): 375-381; Arthur J. Lesser, “The Origin and Development of Maternal and Child Health Programs in the United States,” *American Journal of Public Health* 75, no. 6 (June 1985):590-598; Brenda G. McGowan, “Historical Evolution of Child Welfare Services” in *Child Welfare for the Twenty-First Century*, ed., Gerald P. Mallon (New York: Columbia University Press, 2005), 10-46.

noted that all states submitted plans, which met standards, by the end of 1936.³⁸¹ These requirements ensured that states' maternal and health programs operated similar, but states operated plans within existing public health infrastructure. For instance, southern public health officials could operate segregated clinics. Dr. Albert McCown, the Director of the CB's Maternal and Child-Health Division, explained that states' maternal and child hygiene programs "vary widely."³⁸² Most of the plans outlined public health nursing activities and educational opportunities for public health officials and the public. In addition, some states added nutrition programs for mothers and children.³⁸³ For instance, New York and Mississippi both opted to accept funds from Title V, but approached maternal and infant care differently.

In the 1930s, New York and Mississippi operated state maternal and child hygiene programs. These programs reflected the history of public health infrastructure of the state, society, economy, and population of the state. In 1930, New York's population was over twelve and a half million people. That year over 189,000 newborns lived in the state. Mississippi's population was much smaller with approximately two million inhabitants, including over 44,000 infants.³⁸⁴ The two states differed on several levels

³⁸¹ United States Children's Bureau, *Maternal and Child-Health Services Under the Social Security Act, Title V, Part I, Development of Program, 1936-1939*, Bureau Publication 259 (Washington, D.C.: United States Government Printing Office, 1941), 3-4; Albert McCown, "Part I-Maternal and Child-Health Services," 6.

³⁸² Ibid.

³⁸³ Ibid., 8.

³⁸⁴ United States Bureau of the Census, *Fifteenth Census of the United States: 1930, Population Vol. III, Part I* (Washington, D.C.: United States Government Printing Office, 1932), 1265-1266; United States Bureau of the Census, *Fifteenth Census of the United States: 1930, Population Vol. III, Part II* (Washington, D.C.: United States Government Printing Office, 1932), 259-260.

from population size, demographics, economy, and culture. In New York, most people lived in urban and industrialized settings. Almost a fourth of New York's inhabitants were immigrants.³⁸⁵ In Mississippi, most lived in rural and agricultural areas, and the population was nearly split evenly between African American and white inhabitants.³⁸⁶ Many Mississippians, especially African Americans, worked as sharecroppers and were consequently trapped in a cycle of debt. Although their economies varied, the two states like the rest of the nation struggled economically. Both states experienced bank failures, unemployment, and faltering agriculture and other industries. Both states turned to the federal government for funds to stimulate maternal and child health programs in the mid-1930s.

New York was the first state to create a special division for children's health in 1913.³⁸⁷ During the 1910s, the Division of Child Hygiene focused on infant clinics, birth registration campaigns, and securing clean milk supplies for New York's children.³⁸⁸ Some local health departments provided free milk to children in need, while in other areas societies or charitable organizations like the Salvation Army periodically dispensed milk to low-income kids.³⁸⁹ The New York State Department of Health also

³⁸⁵ Ibid., 259.

³⁸⁶ United States Bureau of the Census, *Fifteenth Census of the United States: 1930, Population Vol. III, Part I*, 1265.

³⁸⁷ Livingston Farrand and Thomas Parran, Jr., *Public Health in New York State: Report of the New York Health Commission to His Excellency, The Honorable Franklin D. Roosevelt, Governor of the State of New York* (Albany: State of New York Department of Health, 1932), 273.

³⁸⁸ Ibid., 274.

³⁸⁹ "Want Free Milk Stations Established," *Buffalo Evening News*, July 11, 1914, 12; "Free Milk for the Needy," December 30, 1918, 6.

recommended pasteurized milk for children to prevent illness from consumption.³⁹⁰ The Division of Child Hygiene offered health clinics and educated mothers on nutrition. By 1922, New York merged the Division of Child Hygiene with the Division of Maternal, Infancy, and Child Hygiene to survey maternal and infant health. Under the Sheppard-Towner Act (1921-1929), New York public health officials worked to educate mothers and supported scientific motherhood.³⁹¹ Scientific motherhood required mothers to seek childrearing advice from science and education, not folklore or tradition.³⁹² The public health personnel especially instructed immigrant mothers on up-to-date nutrition and child care standards.

Throughout the 1920s, the New York State Department of Health steadily offered maternal and infant care. Public and private physicians and nurses attended to mothers and newborns. By 1930, New York midwives delivered five percent of births and only 314 midwives had a license to practice in the state. The Health Commission reported that 257 midwives, who served eighty-nine communities, attended educational classes.³⁹³ Midwifery was quickly declining because physicians and public health officials claimed medical authority over maternal and infant care.³⁹⁴

³⁹⁰ Hermann M. Biggs, ed., *Fortieth Annual Report of the New York State Department of Health for the Year Ending December 31, 1919, Volume 1* (Albany: J.B. Lyon Company, Printers, 1920), 261. For more information on clean milk campaigns see: Jacqueline H. Wolf, *Don't Kill Your Baby: Public Health and the Decline of Breastfeeding in the 19th and 20th Centuries* (Columbus: The Ohio State University Press, 2001).

³⁹¹ Livingston Farrand and Thomas Parran, Jr., *Public Health in New York State*, 274, 276.

³⁹² Molly Ladd-Taylor, *Mother-Work*, 4, 45.

³⁹³ Livingston Farrand and Thomas Parran, Jr., *Public Health in New York State*, 279.

³⁹⁴ For more information on physicians, especially obstetricians, fight for authority over childbirth in the twentieth-century see: Paul Starr, *The Social Transformation of American Medicine*, 223; John C. Burnham, *Health Care in America*, 146.

In the early 1930s, physicians and nurses managed most of maternal and infant cases. In upstate New York, 269 infant welfare stations operated where physicians and nurses examine newborns and provided mothers with hygiene instructions. The nurses recommended breastfeeding and offered preventive care. In other parts of the states, public health nurses hosted group clinics where they taught prenatal and infant hygiene classes.³⁹⁵ The Health Commission concluded that the local health department and health agencies were not doing enough in the field of maternal health and outlined an “ideal maternity program” that included physician and dental visits for expectant mothers. The program emphasized “antepartum, intrapartum, and postpartum” care.³⁹⁶ The maternal mortality rate for upstate New York at the beginning of the decade was 57.1 per 10,000 births and the infant mortality rate was nearly sixty per 1,000 live births.³⁹⁷ Throughout the early 1930s, the public health agency in New York continued to work on improving maternal and infant health and mortality rates. In 1935, New York City’s infant mortality rate had fallen to forty-eight per 1,000 births, which was the exact same as the state average.³⁹⁸ Maternal mortality had also improved to forty-eight and a half deaths per 10,000 births.³⁹⁹ To improve maternal and infant hygiene, the Administration Division of

³⁹⁵Livingston Farrand and Thomas Parran, Jr., *Public Health in New York State*, 282-283.

³⁹⁶ *Ibid.*, 285.

³⁹⁷ *Ibid.*, 263,269.

³⁹⁸ John L. Rice, Margaret Barnard, Thomas J. Duffield, and Jules L. Blumenthal, “Infant Mortality in New York City,” *American Journal of Public Health* 27 no. 7 (July 1937): 701; United States Bureau of the Census, *Birth, Stillbirth, and Infant Mortality Statistics for the Continental United States and the Territory of Hawaii, the Virgin Islands, 1935* (Washington, D.C.: United States Government Printing Office, 1937), 20.

³⁹⁹ Thomas Parran, Jr., *Fifty-Sixth Annual Report of the Department of Health, Vol. 1* (Albany: New York State Department of Health, 1936), 18.

the Department of Health officials assigned a supervising physician to the largest eight health districts to manage maternal and infant care. With the expectation of the Social Security funds, the New York Department of Health assigned twelve additional public health nurses to local maternal and infant healthcare.⁴⁰⁰

On February 17, 1936, the CB approved New York's plan for maternal and children's health and Title V appropriations quickly funded the states' public maternal and infant health division.⁴⁰¹ From February to June 1936, the CB allocated approximately \$78,500 to New York for maternal and child hygiene, which the state matched dollar-for-dollar after the initial grant of \$20,000.⁴⁰² The New York State Department of Health reported that Title V had helped create "clinical facilities for well infant and children and expectant mothers, and for payment of local physicians, who conduct these clinics."⁴⁰³ New York paid private physicians for some of the Title V work. With the help of Title V funds, the Division of Maternity, Infancy and Hygiene expanded

⁴⁰⁰ Thomas Parran, Jr., *Fifty-Sixth Annual Report of the Department of Health, Vol. 1*, 119.

⁴⁰¹ Albert McCown, "Part I-Maternal and Child-Health Services," 9-10.

⁴⁰² Ibid. According to the Consumer Price Index Inflation Calculator, \$78,500 in June 1936 is equivalent to approximately \$1,416,261.85 in February 2018. For more information on the Consumer Price Index Inflation Calculator visit https://www.bls.gov/data/inflation_calculator.htm.

⁴⁰³ Edward S. Godfrey, Jr., *Fifty-Eighth Annual Report of the Department of Health for the Year Ending December 31, 1937, Vol. I* (Albany: New York State Department of Health, 1938), 201; United States Children's Bureau, *The Children's Bureau Legacy*, 69; Edward Godfrey, "Community Nursing: Community Nursing: A Supplementary Statewide Program of Public Health Nursing with a Special Emphasis on Beside Care (New York State)," 1936, 1-15, Series: A3274-85:New York State Department of Social Welfare, Box: 5 Folder: "Addressed Envelope- ~~Miss Marion Rickett, Medical Social Work Supervisor, Department of Social Welfare, Albany, N.Y.~~" New York State Archives, Albany, New York. In New York, the state's Temporary Emergency Relief Administration and later through federal agencies like the Civil Work Administration and the Works Progress Administration, provided funds and health officials to care for families, especially mothers and children.

its service to “rural areas and areas of special need.”⁴⁰⁴ In nine counties, the Division set up clinical facilities for maternal and infant well clinics. Forty-five local private physicians served as the providers at the clinics.⁴⁰⁵ In addition, three Division doctors worked with three public health districts to establish maternal and infant programs and later provide federal funds to employ local doctors to care for mothers and newborns.⁴⁰⁶ In 1937, the Division officials provided 2502 prenatal examination, while nearly 185,000 women needed prenatal and pregnancy care.⁴⁰⁷ The number of prenatal examinations conducted in affiliation of New York State Department of Health was low in comparison with the number of pregnancies and births. Nearly eighty percent of New York women received maternity care in a hospital rather than at public health clinics.⁴⁰⁸ Since the majority of New York women utilized the private health sector, it was logical for New York to use SSA funds to pay private physicians for maternal care.⁴⁰⁹ The funds also helped to train general practitioners in obstetrics and pediatrics.⁴¹⁰ The New York State Department of Health reported that by 1941 over 89.7 percent of births occurred in

⁴⁰⁴ Edward S. Godfrey, Jr., *Fifty-Eighth Annual Report of the Department of Health for the Year Ending December 31, 1937, Vol. I*, 201.

⁴⁰⁵ *Ibid.*

⁴⁰⁶ *Ibid.*

⁴⁰⁷ *Ibid.*, 207; Halbert L. Dunn, ed. *Vital Statistics of the United States 1937: Part II Natality and Mortality Data for the United States Tabulated by Place of Residence* (Washington: United States Government Printing Office, 1939), 49.

⁴⁰⁸ Halbert L. Dunn, ed. *Vital Statistics of the United States 1937: Part II Natality and Mortality Data for the United States Tabulated by Place of Residence*, 15.

⁴⁰⁹ *Ibid.*, 201; Edward S. Godfrey, Jr., *Fifty-Eighth Annual Report of the Department of Health for the Year Ending December 31, 1937, Vol. I*, 207.

⁴¹⁰ Joseph V. DePorte, *Sixty-Second Annual Report of the Department of Health for the Year Ending December 31, 1941, Volume I* (Albany: New York State Department of Health, 1943), 93.

a hospital and physicians attended 99.3 percent of all New York state births. In addition, the department noted that immigrant births had declined.⁴¹¹

In the 1930s, some women and newborns in rural areas or low-income areas still relied on public health clinics for maternal and infant care. In New York, doctors and public health officials had almost excluded midwives from maternity care, but they still managed a small minority of the cases. In 1937 midwives managed only 728 maternity cases. A few of these cases were on the St. Regis Indian Reservation, where the State Department of Health determined that midwifery and maternal health care was unsatisfactory.⁴¹² The Division continued to critique midwifery services and favored public health nurses serving needy mothers.

Public health nurses also offered care to some underserved mothers and newborns. The New York State Division of Maternity, Infancy, and Child Hygiene employed a few consultant nurses to educate county nurses about antepartum and postpartum care.⁴¹³ The nurses often gave vaccines for disease like diphtheria, hosted clinics, and taught mothers about scientific motherhood especially nutrition and hygiene techniques.⁴¹⁴ These nurses and other public health officials helped mothers by lecturing, giving them literature or signing them up for letters pertaining to maternal and child hygiene. Over five thousand mother received prenatal letters that prepared mothers-to-be

⁴¹¹Joseph V. DePorte, *Sixty-Second Annual Report of the Department of Health for the Year Ending December 31, 1941, Volume II* (Albany: New York State Department of Health, 1943), xxiii.

⁴¹²Edward S. Godfrey, Jr., *Fifty-Eighth Annual Report of the Department of Health for the Year Ending December 31, 1937, Vol. I*, 209, 213-214.

⁴¹³ *Ibid.*, 209.

⁴¹⁴ *Ibid.*, 124.

for motherhood. Other women obtained vitamin charts, New York Department of Health maternal and infant health publications or CB's literature on newborns and children. Through the literature program, Parents, especially mothers, received 329,822 flyers, pamphlets, or other literature.⁴¹⁵ Under Title V, the New York State Department of Health focused on expanding their maternal and infant health programs by reaching mothers and providing them with up-to-date child rearing information. Title V funds allowed the New York Division of Maternity, Infancy, and Child Hygiene to expand its maternal and infant hygiene programs by hiring more public health workers dedicated to maternal and newborn hygiene, providing information to mothers, and paying local physicians for maternal and infant health services.

Nutrition programs also benefited from Social Security funds. Public health workers hosted nutritional conferences to promote the growth and development of infants and children. For instance, in twenty New York counties nutritionists presented lectures on nutrition at meetings of "home bureau" and school organizations reaching over 12,000 people, which was an increase from the previous year.⁴¹⁶ The nutritional work was part of preventive healthcare to prevent childhood disease and to lower mortality rates. The appropriations from the federal government helped make prevention possible.

Like New York in the first half of the 1930s, Mississippi utilized public health agencies and philanthropic organizations to attend the needs of mothers and children. Despite the two states' efforts, the states never met the needs of all expectant mothers or

⁴¹⁵Edward S. Godfrey, Jr., *Fifty-Eighth Annual Report of the Department of Health for the Year Ending December 31, 1937, Vol. I*, 218-219.

⁴¹⁶ *Ibid.*, 211-212.

children. The states continued to attempt to improve healthcare as they weathered the economic downturn and the social upheaval of the Great Depression. By the last half of the 1930s, both states turned to the federal government for assistance for maternal and infant healthcare. Mississippi used its Social Security Title V maternal and infant hygiene funds to enhance the program already in place.

In Mississippi, midwives delivered the majority of newborns in the early twentieth century. These midwives had a wide range of experience and qualifications. The vast majority of these midwives were African Americans and some were illiterate. Beginning in 1921, the Mississippi State Board of Health held regular midwifery conferences that educated midwives about “cleanliness” and contacting a doctor, if the midwife suspected an abnormality at any phase of the delivery.⁴¹⁷ In the 1930s, midwives still attended midwife club meetings once a month, where the club leaders gave a lesson on an aspect of maternal and infant care and inspected the midwife’s delivery bag and equipment.⁴¹⁸ In 1932, midwives delivered 51.9 percent of Mississippi babies, but out of those deliveries, 86.6 percent were African Americans.⁴¹⁹ The majority of white parents hired private physicians to attend the delivery or a public health nurse attended the birth.⁴²⁰ By 1935, the Mississippi State Board of Health credited midwives with

⁴¹⁷ “The Relation of the Midwife to the State Board of Health,” July 1, 1940 (?), 1, 3, Series: 2028, Box: 8381, Folder: “Midwifery 1935;1940,” Mississippi Department of Archives and History.

⁴¹⁸ Ibid., 3-4.

⁴¹⁹ “The Relation of the Midwife to the State Board of Health,” January 1, 1935, 1, Series 2028, Box 8381, Folder: “Midwifery 1935;1940.”

⁴²⁰ By 1937, only 8.1 percent of Mississippi women gave birth in hospitals. Hospital births would not become the norm in Mississippi until the second half of the twentieth century. Halbert L. Dunn, ed. *Vital Statistics of the United States 1937: Part II Natality and Mortality Data for the United States Tabulated by Place of Residence*, 16.

improving infant health and the rising number of African American vaccination rates.⁴²¹ To further advance their efforts, “approximately 3,000 midwives” hosted demonstrations in conjunction with local public health officials, especially nurses.⁴²² During this era, maternal mortality ranged from 7.1 per 1,000 live births for blacks to 6.1 for white mothers per 1,000 live births, and infant mortality averaged 59 deaths under one year old per 1,000 live births for African Americans compared to 48 white newborns.⁴²³ Midwives and public health nurses worked to improve the mortality rates and maternal and infant health.

In 1930, Director Mary Osborne managed the thirty-eight public health nurses who worked for the state’s Bureau of Child Hygiene and Public Health Nursing, a branch of the Mississippi State Board of Health.⁴²⁴ During the early 1930s, the state public health nurses and other local health nurses helped educate midwives. Susan Smith explained that white nurses and black midwives worked together to improve Mississippi’s public health and were instrumental to constructing the “modern public health system.”⁴²⁵ The

⁴²¹ Ibid., 4-5.

⁴²² Ibid., 5. The report lists the number of midwives as “approximately 3,000,” but only 2,668 midwives had permits at the beginning of 1934 and 2,783 registered in January 1935.

⁴²³ “Untitled: Maternal and Infant Mortality 1930-1939,” Series: 2028, Box: 8381, Folder: “Midwifery 1935;1940.” These statistics are from 1935.

⁴²⁴ John A. Ferrell, Wilson G. Smillie, Platt W. Covington, and Pauline A. Mead, *Health Departments of States and Provinces of the United States and Canada* (Washington: United States Government Printing Office, 1932), 392.

⁴²⁵ Susan L. Smith, “White Nurses, Black Midwives, and Public Health in Mississippi, 1920-1950,” *Nursing History Review* 2 (1994): 29. Also see: Kelena Reid Maxwell, “Birth Behind the Veil: African American Midwives and Mothers in the Rural South, 1921-1962,” (Rutgers University: PhD diss., 2009); Yulonda Eadie Sano, “Health Care for African Americans in Mississippi, 1877-1946,” (The Ohio State University, PhD diss., 2010).

public health nurses cared for and taught mothers at maternal and infant clinics and home pregnancy visits. Social security funds and money from philanthropic organizations like the Commonwealth Fund helped expand the public health nurse workforce and provided further training for nurses and doctors.



Figure 4.2 Four young Mississippians at a child health conference during the 1930s.

“Four Toddlers,” Series 2170: Mississippi State Department of Health Photograph Album, ca. 1930s, Mississippi State Department of Archives and History, Jackson, Mississippi.

On March 18, 1936, the Mississippi State Board of Health received Title V funds for the states' maternal and child hygiene program. From February to June 1936, the CB appropriated approximately fifty-one thousand dollars to help mothers and infants in rural areas or low-income areas.⁴²⁶ Dr. Felix J. Underwood, the Director of the State Board of Health, explained that the SSA offered new opportunities for Mississippi public health. He noted that Mississippi public health nursing received a "tremendous stimulus."⁴²⁷ In Leflore County, the public health department held a nursing conference in 1937. The follow-up report noted, "Although everyone was very busy picking cotton, these mothers left the fields long enough to bring the babies to the public health nurse to be protected against diphtheria."⁴²⁸ That same year in Adams County, which had a seventy percent African American population, public health officials worked to improve maternal and infant hygiene. The Adams County Health Department reported that midwives delivered thirty-one percent of the county's babies. The county monitored the midwives closely and required these women to have a physical and vaccinations to maintain their licenses. The county health nurses supervised practicing midwives by inspecting midwives' bags and by attending deliveries. These nurses also made 755 prenatal nursing visits during 1937.⁴²⁹ The health department nurses conducted approximately 680 infant hygiene visits

⁴²⁶Ibid. According to the Consumer Price Index Inflation Calculator, \$51,000 in June 1936 is worth over \$920,000 in February 2018 currency.

⁴²⁷ Felix J. Underwood, "New Trends in Public Health," May 11, 1937, Series; 2012, Box: 8579, Folder: "Public Health, Public Health Library Subject Files, 1931-1985," Mississippi Department of Archives and History.

⁴²⁸Letter to Mary D. Osborne from Otha Bell Jones, August 13, 1938, Series: 2036, Box: 8416, Folder: "County Files: Hancock-Leflore 1924-1947," Mississippi Department of Archives and History.

⁴²⁹ "Ninth Annual Report of the Adams County Health Department, 1937," 1937, 7, Series: 2031 Box: 8710 Folder: "Alcorn Co. Annual Reports-1939," Mississippi Department of Archives and History. This folder is labeled Alcorn County, but it also includes Adams County Health Department reports.

because the department wanted to build “a foundation for future health and happiness” for newborns. At these visits, the nurse inspected the baby for defects or gave the mother instruction in nutrition or other scientific knowledge.⁴³⁰ Furthermore, the health department promoted health conferences and clinics for toddlers and school-age children. The Adams County public health officials reported, “Your Health Department stands ready to help you in securing the best health for your children, the future citizens of our county, state and country.”⁴³¹



Figure 4.3 Mississippi public health nurse administering diphtheria vaccine to child in the 1930s.

“Protection Against Diphtheria,” Series 2170: Mississippi State Department of Health Photograph Album, ca. 1930s, Mississippi State Department of Archives and History, Jackson, Mississippi.

⁴³⁰ Ibid.

⁴³¹ Ibid., 8.



Figure 4.4 A public health physician examining two Mississippi children, ca. 1930s.

“Two women, two toddlers, and a man with a stethoscope,” Series 2170: Mississippi State Department of Health Photograph Album, ca. 1930s, Mississippi State Department of Archives and History, Jackson, Mississippi.

Mississippi State Board of Health used a portion of Title V funds for childhood vaccines. In the first annual report of the Jones County Health Department (Mississippi), the department reported that during 1937 white children in first through fourth grades took a Schick test as a preventive measure to determine which children were susceptible

to diphtheria. 215 of 2,904 students tested positive and the county health officials immunized this group first. The health department personnel knew that preschoolers were also at risk because they were not immune to the disease.⁴³² The county attempted to encourage inoculations and during the year, the department officials recorded over 1,796 immunizations against diphtheria.⁴³³ The department focused on white children first and the report does not mention providing Schick tests to African American children. It is unclear why the department did not test black children, but it could be related to lack of funding, assumptions about particular diseases, or racial politics. While Jones County public health officials did not focus on vaccinating African American youth against diphtheria, the department workers did offer smallpox vaccinations to both white and black children. The department launched a campaign to vaccinate school children because only ten percent of school-age children had had the vaccine. The officials noted that the campaign was “fairly good” with 2,060 vaccinations completed.⁴³⁴ In Mississippi, the county health workers determined who received care and sometimes Title V funds were used to uphold a segregated healthcare system.⁴³⁵

In Mississippi, new funds helped public health nurses obtain more training in obstetrics. Prior to the August 10, 1939 amendments to the SSA, Mississippi had only

⁴³² “First Annual Report of the Jones County Health Department, 1937,” 1937, 8, Series: 2031, Box: 8710, Folder: “Lauderdale Co. Annual Reports: 1932-1936, 1939-1941,” Mississippi State Department of Health. This folder was labeled Lauderdale Co. reports, but it included Jones County reports too.

⁴³³ *Ibid.*, 8.

⁴³⁴ *Ibid.*, 9.

⁴³⁵ Keith Wailoo, *Dying in the City of the Blues: Sickle Cell Anemia and the Politics of Race and Health* (Chapel Hill: The University of North Carolina Press, 2001), 29,33, 84-85.

sent four public health nurses, Caroline Benoist, Anabelle Lester, Joyce McConnell, and Elizabeth Thornton, to an approximately two- to three-month post-graduate training course on maternal care at the Chicago Lying-In Hospital and Dispensary.⁴³⁶ Benoist, a public health nurse who served Sunflower and Pike Counties, retained a copy of the Chicago Lying-In Hospital and Dispensary's *Home Service Procedure Book*. The book included instructions for maintaining proper sanitation standards when preparing for the delivery and listed tools that the nurse would need for home deliveries or in community delivery rooms.⁴³⁷ Nurses like Benoist could carry this book and up-to-date standards back to Mississippi. By 1939, midwives, who were under the supervision of public health nurses, delivered approximately forty-two percent of babies. The nurses passed up-to-date knowledge on sanitation and maternal care to the midwives.⁴³⁸ Nurses and midwives working together increased standards of care for mothers and infants.

⁴³⁶ "Special Training-Maternity," Series: 1863 Box: 8418 Folder: "Training (Special)- 1938-1945, 1950), Mississippi Department of Archives and History. Nurses Joyce McConnell and Elizabeth were training when the 1939 amendments passed.

⁴³⁷ "Home Service Procedure Book," Chicago Lying In Hospital and Dispensary, Folder 15-10-3, Collection: Mississippi Public Health Nursing: The Historical Collection of Caroline H. Benoist, Eleanor Crowder Bjoring Center for Nursing Historical Inquiry, University of Virginia, Charlottesville, Virginia, accessed July 2016, <http://cnhi-benoist.nursing.virginia.edu/node/3117>.

⁴³⁸ "The Relation of the Midwife to the State Board of Health," July 1, 1940 (?), 2; Untitled: Maternal and Infant Mortality 1930-1939," Series: 2028, Box: 8381, Folder: "Midwifery 1935;1940." In 1939, the infant mortality rate was 55.6 per 1,000 live birth, which a decrease by 12.4 deaths per 1,000 births since 1930.



Figure 4.5 A woman, most likely a midwife, with two infants, ca. 1930s.

“Midwifery: Woman holding two infants,” Series 2170: Mississippi State Department of Health Photograph Album, ca. 1930s, Mississippi State Department of Archives and History, Jackson, Mississippi.



Figure 4.6 Mississippi mothers-to-be waiting to see the doctor at a maternity clinic.

“Mothers Waiting,” Series 2170: Mississippi State Department of Health Photograph Album, ca. 1930s, Mississippi State Department of Archives and History, Jackson, Mississippi.

Both New York and Mississippi operated Social Security Title V Maternal and Child Health Services programs.⁴³⁹ Although Mississippi had a smaller population, the state received more per capita because Title V specified that the funds were for “services

⁴³⁹“Federal Grants to States for Maternal and Child Welfare Services under the Social Security Act,” General Records: President’s Interdepartmental Committee to Coordinate Health and Welfare Activities Box: 22, Folder: “Dept. of Labor: Children’s Bureau National and Child Health Division (Source Material), Franklin D. Roosevelt Presidential Library and Museum, Hyde Park, New York.

for promoting the health of the mothers and children, especially in rural areas and in areas suffering from severe economic distress.”⁴⁴⁰ These two states had major similarities and differences. The national program allowed the states to create a program that met state needs as long as the state’s plan reached the federal requirements. The new funds provided the opportunity to hire and train more public health officials in both states. Public health nurses were vital in both areas to educate the public on maternal hygiene, and they also offered care to mothers and young children. In addition, public health agencies sponsored more maternal and infant health conferences. While the two states had differences in their population, economy, and society, Title V provided the funds that they both needed to improve the health and wellbeing of pregnant women, infants, and children.

New York often used funds to pay private physicians for maternal and infant care and did not heavily rely on midwives. In Mississippi, the State Board of Health used Title V funds to build up the public health workforce and infrastructure. The state continued to use public health nurses to instruct midwives, who were essential to maternal and infant care. Segregation remained paramount in Mississippi public health infrastructure. Finally, by the early 1940s over ninety percent of New York births took place in hospitals, while less than ten percent of Mississippi births did.⁴⁴¹ Despite these differences, Title V allowed maternal and infant health care to remain a public health priority and to grow exponentially during the Great Depression.

⁴⁴⁰ *The Social Security Act of 1935*, Public Law #74-271.

⁴⁴¹ Halbert L. Dunn, ed. *Vital Statistics of the United States 1937: Part II Natality and Mortality Data for the United States Tabulated by Place of Residence*, 15-16.

Nationally, many public health officials welcomed Title V and considered expanding their maternal, infant, and child hygiene programs. On April 7-8th, 1937, the General Advisory Committee on Maternal and Child-Welfare Services, a group of medical and child welfare workers including those with ties to the CB, met to recommend alterations to the SSA, specifically to Title V.⁴⁴² The committee proposed that Congress should extend public health works under Title V by offering economic and medical care for mothers in need.⁴⁴³ The committee endorsed a program that would allow mothers to seek “expert obstetric and pediatric consultation service,” increase educational opportunities for “urban and rural practitioners of medicine and nurses,” and cooperation at all levels to carry out the program.⁴⁴⁴ The CB also sponsored a January 1938 conference to consider the status of maternal and infant welfare. The goal of the conference was to “consider the existing resources for the care of mothers and newborn infants in the United States” and to reduce maternal and infant mortality rates.⁴⁴⁵ The conference’s Committee on Findings reported that thousands of “unnecessary” maternal and infant deaths occurred due to the “inadequacy of medical and nursing care.”⁴⁴⁶ Even with these shortcomings, the CB women and men and other maternal and child welfare advocates realized that during the first third of the twentieth century American maternal

⁴⁴² “Recommendations of General Advisory Committee on Maternal and Child-Welfare Services with respect to Extension of Maternal and Child-Health Services,” April 7-8, 1937, 1, Series: 2012, Box: 8751, Folder: “Maternal Welfare,” Mississippi Department of Archives and History.

⁴⁴³ Ibid.

⁴⁴⁴ Ibid., 1-2.

⁴⁴⁵ United States Children’s Bureau, *Proceedings of Conference on Better Care for Mothers and Babies, Held in Washington, D.C., January 17-18, 1938* (Washington, D.C.: Department of Labor, 1938), viii.

⁴⁴⁶ Ibid., 128-129.

and child healthcare had greatly improved and sought to make further recommendations. The Committee on Findings credited Title V, Part I with the growth of maternal and infant healthcare from 1936 to 1938.⁴⁴⁷ The committee also recognized that medical professionals needed more training in obstetrics and pediatrics.⁴⁴⁸ CB leaders considered the recommendations of these two committees as they lobbied for an expansion of Title V. In 1939, Congress responded to calls from a number of reformers to amend the SSA, but the only alteration to Title V was the appropriation amount from \$3,800,000 to \$5,820,000.⁴⁴⁹ The increase in appropriations did allow for a growth in the Social Security maternity and child health programs.

When the 1939 Amendments to the SSA passed, the CB and maternal and infant child health advocates were already planning the next White House Conference on Children. A group of child welfare activists met at the first meeting of the WHCCD to study the status of children living in a democracy, the United States. The program emphasized how democracy was better for American children than Nazism. When defining the goal of the 1940 WHCCD, the conference leaders considered questions about children's welfare and democracy. During conference planning, one expert wondered, "Is not a healthy child healthy regardless of ideologies?"⁴⁵⁰ The final report of

⁴⁴⁷ Ibid., 129.

⁴⁴⁸ Ibid., 130.

⁴⁴⁹ *The Social Security Act Amendments of 1939*, Public Law #76-379, 76th United States Congress, Session I (August 10, 1939), accessed June 2016, <https://www.ssa.gov/history/pdf/1939Act.pdf>. The Consumer Price Index Inflation Calculator determined that \$5,200,000 in 1939 is equal to more than \$92,000,000 in 2018.

⁴⁵⁰ White House Conference on Children in a Democracy, *White House Conference on Children in a Democracy Final Report* (Washington, D.C.: Superintendent of Documents, 1940), 3.

the conference responded to this question about health and ideology, “In a democracy the objective in assuring children’s health, growth, and development is to produce persons with vitality, initiative, competence, and sufficient vigor to enable them to give expression to their unique qualities of personality.”⁴⁵¹ The experts argued that this conference showed a marked difference from nondemocratic countries’ child health efforts. The experts believed that these nondemocratic governments only promoted child healthcare as a means to produce citizens and soldiers and claimed that the American children’s health program did more than just create a citizen-warrior. This claim is a clear departure from earlier child welfare advocates who used the rhetoric of saving and protecting the health of future citizens and soldiers. For instance, just ten years earlier President Hoover had described American children as future leaders and policemen.⁴⁵² Yet, he described the importance of children as individuals to American democracy. He explained that in the future, American children, who had different personalities and talents, would use their abilities to help American democracy progress.⁴⁵³ The WHCCD focused on all aspects of American children including the importance of maternal and children’s health to the democracy. Although the delegates claimed that they were not focusing on preparing children for citizenship, they continued to use rhetoric that emphasized the importance of children’s health to the nation’s future health.

⁴⁵¹ Ibid.

⁴⁵² White House Conference on Child Health and Protection, *White House Conference 1930*, 7, 9.

⁴⁵³ Ibid., 13.

On April 26, 1939, a group of 410 child welfare advocates, ranging from CB officials to First Lady Eleanor Roosevelt, met at the initial session of the fourth White House Conference on children.⁴⁵⁴ According to Lindenmeyer, delegates to the 1940 conference included “health professionals, child and family welfare bureaucrats, and interested academics.”⁴⁵⁵ During this initial meeting, President Roosevelt addressed the experts and explained that as a democracy, the United States should adopt the suggestions. For instance, “Prenatal instructions cannot assure healthy babies unless the mother has access to good medical and nursing care...”⁴⁵⁶ After Roosevelt’s opening remarks, the experts listened to speeches about the relationship between children and democracy. These men and women presented themes about children and the welfare of the nation. They believed that the children of 1939 and 1940 would be the leaders of America in a few decades.⁴⁵⁷ To prepare for the future, Americans had to consider the status of all American children, regardless of the community that they lived in or their socio-economic background.⁴⁵⁸ According to the delegates, democracy could protect children and provide them with the security that they needed to thrive.⁴⁵⁹

⁴⁵⁴ “White House Conference on Children in a Democracy, April 26, 1939,” Program, Collection: Charles Taussig Youth Files, Box: 18 Folder: “White House Conference on Children in a Democracy, April 26, 1939,” Franklin D. Roosevelt Presidential Library and Museum; United States Children’s Bureau, *Conference on Children in a Democracy: Papers and Discussions at the Initial Section, April 26, 1939* (Washington, D.C.: United States Government Printing Office, 1939), vi.

⁴⁵⁵ Kriste Lindenmeyer, *A Right to Childhood*, 203.

⁴⁵⁶ United States Children’s Bureau, *Conference on Children in a Democracy: Papers and Discussions at the Initial Section, April 26, 1939*, 3.

⁴⁵⁷ *Ibid.*, 7, 13, 23.

⁴⁵⁸ *Ibid.*, 13, 23.

⁴⁵⁹ *Ibid.*, 4, 8.

In April 1939, the planning delegates broke into sections groups to discuss the upcoming conference. In the Objectives of a Democratic Society in Relation to Children Section, delegates outlined the responsibility of a democracy to its children.⁴⁶⁰ In the discussion, James S. Plant, the Chairman, asked the group, if they wanted to begin a discourse about the “indoctrination of some sort of idea,” or let American children determine how he or she lived.⁴⁶¹ Many of the delegates supported “democratic indoctrination” and argued that it was essential that the family and school spread democratic ideals.⁴⁶² Edward L. Israel, a Jewish leader and member of this section group, defined “democratic indoctrination” included producing a “certain morale” in American children, which would help them understand the democratic process and have sympathy. To accomplish this indoctrination, schools, churches, homes, and other social institutions needed to foster a specific “psychological attitude.”⁴⁶³ Another delegate, Grace L. Coyle, a sociologist and prominent social worker, worried about fascism developing in areas of distress and she believed that democratic indoctrination would occur naturally if community and home settings were right.⁴⁶⁴ The group deliberated about how a democracy would teach its children to think democratically and what environment, such as the type of home life, the children needed to be good democratic citizens. Another

⁴⁶⁰ “White House Conference on Children in a Democracy, April 26, 1939;” United States Children’s Bureau, *Conference on Children in a Democracy: Papers and Discussions at the Initial Section, April 26, 1939*, 4, 25.

⁴⁶¹ United States Children’s Bureau, *Conference on Children in a Democracy: Papers and Discussions at the Initial Section, April 26, 1939*, 25.

⁴⁶² *Ibid.*, 24-39.

⁴⁶³ *Ibid.*, 25-26.

⁴⁶⁴ *Ibid.*, 28-29.

discussion group determined that community services for children, including healthcare, were necessary to maintain democracy.

Chairman Frank Bane of The Child and Community Services for Health, Education, and Social Protection Section outlined goals of the community services, including child health. He noted that the attendees must think about areas in children's health that needed "special attention."⁴⁶⁵ Henry Helmholz, the President of the American Academy of Pediatrics, reminded the group that to improve children's health officials had to get the American public to see the importance of health programs. In addition, Helmholz pointed out that adverse economic conditions negatively affected public health programs.⁴⁶⁶ It was the delegates' responsibility to maintain public health programs for children. Joseph Mountain, the Chief of the Division of Public Health Methods at the National Institute of Health, echoed the importance of health programs. He saw the conference as an opportunity to address problems in public health, such as the lack of certification for midwives.⁴⁶⁷ At the initial meeting, the community services group briefly started a discussion on health, education, and public welfare. Bane closed the discussion by asking delegates to think about community services offered to children.⁴⁶⁸ The questions raised at the initial meeting shaped the health program recommended in the final report. The group meeting adjourned and the delegates went to a dinner party.

⁴⁶⁵ Ibid., 85.

⁴⁶⁶ Ibid., 86.

⁴⁶⁷ Ibid., 99.

⁴⁶⁸ Ibid., 100.

Secretary of Labor Frances Perkins welcomed the guests to dinner and after a brief speech by Secretary of Agriculture Henry Wallace, Perkins opened the floor to the chairmen of the four focus groups. Dr. Plant informed the dinner guests that the group that discussed the responsibilities of a democracy to its children decided that indoctrination of children could be achieved by teaching children about democracy and by promoting a democratic way of living.⁴⁶⁹ Bane also presented the finding of the community services group explaining that community programs had grown in the last decade, but noting that the programs could not meet the current demands. Although other groups met and their chairmen presented opinions, these two groups highlight the connection of child health and American democracy. To uphold American democracy, the delegates argued that healthcare for children was a requirement. The initial meeting provided the delegates with many questions as they continued to prepare for the final meeting in early 1940.

The maternal and child health advocates used the WHCCD as a platform to advance maternal and infant hygiene. In the “Preliminary Statements Submitted to the White House Conference on Children in a Democracy,” the experts noted that “to rear our children so they may successfully participate in our democratic way of life is the goal.”⁴⁷⁰ The committee considered this goal as they developed six recommendations for the final meeting of the WHCCD. They argued that the American public had a

⁴⁶⁹ Ibid., 105-106.

⁴⁷⁰ White House Conference on Children in a Democracy, *Preliminary Statements Submitted to the White House Conference on Children in a Democracy, January 18-20, 1940* (Washington, D.C.: Superintendent of Documents, 1940), 163.

“responsibility” to provide “adequate provision to assure satisfactory growth and development and protection of the health of the children.”⁴⁷¹ The health program should include up-to-date scientific standards and pay particular attention to children and mothers in need.⁴⁷² The report committee argued that public and private health agencies would play important roles in making sure family maintained proper nutrition and received adequate healthcare.⁴⁷³ In the area of maternal and infant health, healthcare workers and the general public needed more education. In the general report, “Conserving the Health of the Children,” the report committee asserted that the American child health program would “have important new assets” such as nutrition programs.⁴⁷⁴ The committee wanted to reduce maternal and infant mortality rates and to increase scientific knowledge that doctors and nurses had access to in the upcoming decade.⁴⁷⁵

From January 18-20, 1940, six hundred and seventy-six child welfare advocates met in Washington D.C. to issue recommendations on the status of American children living in a democratic society.⁴⁷⁶ The report committee offered recommendations for a health program that prevented disease and improved health.⁴⁷⁷ The key to success was the

⁴⁷¹ Ibid.

⁴⁷² Ibid., 164.

⁴⁷³ Ibid., 164-165.

⁴⁷⁴ White House Conference on Children in a Democracy, *Children in a Democracy: General Report* (Washington, D.C.: United States Government Printing Office, 1940), 53.

⁴⁷⁵ Ibid., 55-56.

⁴⁷⁶ Secretary of Labor Frances Perkins reported that the number of conference members number 676. Ibid., v.

⁴⁷⁷ White House Conference on Children in a Democracy, *White House Conference on Children in a Democracy Final Report*, 293.

expansion of scientific knowledge to all Americans. The experts planned to raise the standards of child healthcare to include existing and up-to-date medical knowledge.⁴⁷⁸ To reach new standards, America needed to invest its money, people, and time into the research of children's health and the health of the entire family.⁴⁷⁹ The advocates utilized the WHCCD as a platform to bring attention to maternal and children health. The health experts targeted two health "fronts," preventative medicine and treatment of existing illnesses.⁴⁸⁰ Although public and private health practices had already focused on these two areas of healthcare, they argued that special attentions to maternal and child health was necessary.⁴⁸¹ As World War II continued in Europe, child welfare leaders again argued that the United States had a responsibility to protect American mothers and children.

The 1940 conference culminated a little over a decade of work in maternal and child health. During the 1940 conference, some experts studied healthcare for American children and traced the changes in child health from 1930 to 1939. These experts saw tremendous advancements in children's health ranging from scientific discoveries and research to decreased mortality rates. The experts reported that "many of the gaps in knowledge pointed out by the White House Conference of 1930 have been filled."⁴⁸² The

⁴⁷⁸ Ibid., 313.

⁴⁷⁹ Ibid., 313-314.

⁴⁸⁰ White House Conference on Children in a Democracy, *Children in a Democracy*, 52.

⁴⁸¹ Ibid., 53.

⁴⁸² White House Conference on Children in a Democracy, *Preliminary Statements Submitted to the White House Conference on Children in a Democracy, January 18-20, 1940*, 168.

final report of the 1940 conference noted, “Even under the adverse economic conditions of the 1930’s improvements in health conditions added about 3 years to the expectation of life at birth.”⁴⁸³ The experts believed that this increase in life expectancy was due in part to preventive child health measures implemented in the 1930s.⁴⁸⁴ Maternal mortality rates dropped from 70 to 38 per 10,000 live births from 1930 to 1940. The infant mortality rate dropped 19 percent from 1933 to 1940. The improvements in maternal and children’s public health took place during America’s greatest economic Depression because child welfare experts and the government saw protecting children’s health as a measure to safeguard future citizens. The 1940 report argued that “standards can never be static or rigid. They have advanced appreciably since the White House Conference of 1930, notwithstanding—in fact, partly because of—the unfavorable economic conditions of the decade.”⁴⁸⁵ These experts believed America had a duty to protect its children to guarantee productive citizens.

After the 1930 conference, child welfare advocates from the CB, other organizations, and physicians insisted on provided better preventative healthcare by lobbying for funds for maternal and child health programs. During this era, public health officials immunized more children with an improved vaccine against diphtheria.⁴⁸⁶ The Great Depression era saw an expansion of the public health infrastructure, which included the establishment of new local health departments. Although the repeal of the

⁴⁸³ White House Conference on Children in a Democracy, *White House Conference on Children in a Democracy Final Report*, 284.

⁴⁸⁴ *Ibid.*, 285.

⁴⁸⁵ *Ibid.*, 294.

⁴⁸⁶ White House Conference on Children in a Democracy, *Preliminary Statements Submitted to the White House Conference on Children in a Democracy, January 18-20, 1940*, 169.

Sheppard-Towner Act created a void in American maternal and child healthcare, child health and welfare experts confronted this issue when they met to evaluate the state of children's health during the 1930 White House Conference. Through studies and various committee meetings, the experts provided the groundwork for advancements in children's public health throughout the 1930s, which expert praised during 1940 White House Conference. The 1930s proved to be a momentous decade for maternal and child health public health programs. The creation and subsequent expansion of Title V and the WHCCD set the tone for advancement in maternal and infant healthcare during World War II when the government created a new program, the Emergency Maternity and Infant Care Program, to protect the wives and infants of American soldiers.

CHAPTER V

HOT WATER ON THE HOME FRONT: THE EMERGENCY MATERNITY AND INFANT CARE PROGRAM, 1943-1949

In 1943, Corporal Bill Kelly and his wife, Mary, decided to expand their family. While Corporal Kelly was away serving his country, pregnant Mary Kelly visited with the county public health nurse, who asked Mrs. Kelly if her husband was in the military and what his rank was. Once the public health nurse determined that she qualified for the Emergency Maternity and Infant Care (EMIC) program, the nurse recommended that Mrs. Kelly visit her physician.⁴⁸⁷ Her doctor helped her apply for maternity care under

⁴⁸⁷ Corporal Kelly and His Son” was an “interesting interpretation” of EMIC. “Corporal Kelly and His Son: The Emergency Maternity and Infant Care Program,” *The American Journal of Nursing* 44, no. 4 (April 1944): 366. For more information on the EMIC see: Nathan Sinia and Odin W. Anderson, *Emergency Maternity and Infant Care: A Study of Administrative Experience* (Ann Arbor: University of Michigan, 1948); Rima Apple, *Perfect Motherhood: Science and Childrearing in America* (New Brunswick: Rutgers University Press, 2006), 66-67; Ruth L. Fairbanks, “A Pregnancy Test: Women Workers and the Hybrid American Welfare State, 1940-1993” (PhD diss., University of Illinois, 2015), 72-89; Eden Abigail Goldman, “‘A Right to be Safely Born’: The Quest for Health Justice for American Mothers and Children, 1890-1965” (PhD diss., Duke University, 2014), 155-176; Beatrix Hoffman, *Health Care for Some: Rights and Rationing in the United States Since 1930* (Chicago: The University of Chicago, 2012), 47-53; Kriste Lindenmeyer, “*A Right to Childhood*”: *The U.S. Children’s Bureau and Child Welfare, 1912-46* (Urbana: University of Illinois Press, 1997), 3-4, 215, 237-246, 257-258, 260; Karen Kruse Thomas, *Deluxe Jim Crow: Civil Rights and American Health Policy, 1935-1954* (Athens: The University of Georgia Press, 2011) 57, 96-98, 124, 135; Jacqueline H. Wolf, *Deliver Me from Pain: Anesthesia and Birth in America* (Baltimore: The Johns Hopkins University Press, 2009), 111-112; Joan Mulligan, “Three Federal Interventions on Behalf of Childbearing Women: The Sheppard-Towner Act, Emergency Maternity and Infant Care, and the Maternity and Child Health and Mental Retardation Planning Amendments of 1963” (Ann Arbor: The University of Michigan, 1976), 61-100. Also for the history of American childbirth see: Richard W. Wertz and Dorothy C. Wertz, *Lying-in: A History of Childbirth in America, Expanded Edition* (New Haven: Yale University Press, 1989); Margaret Sandelowski, *Pain, Pleasure, and American* (Westport: Greenwood Press, 1984); Judith Walzer Leavitt, *Brought to Bed: Childbearing in American*,

the EMIC program and Mrs. Kelly informed her husband of the EMIC program. She explained that she would receive maternity care at a hospital. Corporal Kelly was concerned about the quality of care that his wife and his son would receive. He explained, “I thought that because I wasn’t going to pay, there would be questions about our finances. But it was all right, and she got the same good care as if we were paying for it ourselves.” Shortly after the infant was born in 1944, Corporal Kelly returned home “on furlough” and attended Baby Kelly’s first child health conference. At the health conference, a public health nurse interviewed the Kellys, and Corporal Kelly learned that the government would also pay for illness care for his infant during his first year of life. The nurse and the pediatrician weighed, measured, and examined the infant. The EMIC covered both maternal and infant care for the Kellys.⁴⁸⁸ The program had national standards, but it also varied from state to state. Some mothers and children would not qualify for the program, but approximately 1,200,000 American women received care under the EMIC.⁴⁸⁹

In the fall of 1944, another United States Army Corporal, Joseph Dominique Fluet, and his wife, Yvette Dostie Fluet, were expecting. Corporal Fluet was serving overseas and Mrs. Fluet returned to her hometown to be with her mother as she prepared to give birth.⁴⁹⁰ The Fluets applied for the EMIC program because Joseph Fluet’s military

1750-1950, 30th Anniversary Edition (Oxford: Oxford University Press, 2016); Jacqueline Wolf, *Deliver Me from Pain: Anesthesia and Birth in America* (Baltimore: Johns Hopkins University Press, 2009).

⁴⁸⁸ “Corporal Kelly and His Son,” 366.

⁴⁸⁹ Kriste Lindenmeyer, “*A Right to Childhood*,” 242.

⁴⁹⁰ “Untitled Hospital Saint-Luc Baptism Record of Joseph Paul Dominique,” October 30, 1944, Record Group 102: Records of the Children’s Bureau, 1908-1969, Box 216: “Central File, 1941-44, 13-2-2-(0) to 13-2-4-0,” Folder: “13-2-4(0) Appeals for Help (General)” The National Archives at College Park, College

service and rank qualified his wife for fifty dollars of obstetric care and a year of medical care for their infant.⁴⁹¹ On October 26, 1944, Yvette Dostie Fluet gave birth to a son at the Hôpital Saint-Luc in Montreal, Canada, Mrs. Fluet's hometown.⁴⁹² She named her son Joseph Paul Dominique Fluet, after her husband, and had her son baptized a few days after his birth.⁴⁹³ Mrs. Fluet gathered receipts from her doctor, Alfred Le Roy, and the Hôpital Saint-Luc.⁴⁹⁴ She sent in an application for EMIC and inquired about the payment. She explained that she planned to return to the United States because she only had a six month pass to Canada, which meant she intended to raise her son in America.⁴⁹⁵ On December 21, 1944, Dr. A.L. Van Horn, the Director of the Children's Bureau (CB) Division of Health Services, replied that Mrs. Fluet did not qualify for delivery cost under the EMIC program because she lived "outside of the United States or its Territories."⁴⁹⁶ Van Horn also informed Ms. Fluet that her son could receive care until he turned one, if

Park, Maryland; Yvette S. Fluet, letter to Personal Affairs Division, November 22, 1944, Record Group 102: Records of the Children's Bureau, 1908-1969, Box 216: "Central File, 1941-44, 13-2-2-(0) to 13-2-4-0," Folder: "13-2-4(0) Appeals for Help (General)" The National Archives at College Park.

⁴⁹¹ According to the Consumer Price Index, fifty dollars in 1943 is equivalent to \$698.64 in 2016. For more information on Consumer Price Index calculations see, http://www.bls.gov/data/inflation_calculator.htm (accessed November 2016).

⁴⁹² Yvette S. Fluet, letter to Personal Affairs Division, November 22, 1944.

⁴⁹³ "Untitled Hopital Saint-Luc Baptism Record of Joseph Paul Dominique," October 30, 1944.

⁴⁹⁴ "Untitled Receipt from Docteur Alfred Le Roy, Chef du service d'obstetrique a l'hospital St-Luc to Mrs. Fluet," November 20, 1944 and "Untitled Receipt from Hopital St-Luc," November 15, 1944, Record Group 102: Records of the Children's Bureau, 1908-1969, Box 216: "Central File, 1941-44, 13-2-2-(0) to 13-2-4-0," Folder: "13-2-4(0) Appeals for Help (General)" The National Archives at College Park.

⁴⁹⁵ Yvette S. Fluet, letter to Personal Affairs Division, November 22, 1944.

⁴⁹⁶ A.L. Van Horn, M.D., letter to Yvette S. Fluet, December 21, 1944, Record Group 102: Records of the Children's Bureau, 1908-1969, Box 216: "Central File, 1941-44, 13-2-2-(0) to 13-2-4-0," Folder: "13-2-4(0) Appeals for Help (General)" The National Archives at College Park.

she and her son returned to the United States.⁴⁹⁷ Other women such as Navy wife Kathleen Brode did not meet the specific qualifications for the EMIC program because state and American territorial health agencies operated the EMIC program.⁴⁹⁸

In the First Deficiency Appropriation Act of 1943, Congress specified that the CB would manage a program for “grants to states for emergency maternity and infant care.”⁴⁹⁹ The legislation stipulated that the program was to offer “maternity and infant care for wives and infants of enlisted men in the armed forces of the United States of the fourth, fifth, sixth, or seventh grades.”⁵⁰⁰ The EMIC was the federal government’s response to lack of maternity and infant healthcare for soldiers’ wives and newborns. Since 1884, the federal government offered healthcare to all servicemen’s dependents “whenever practicable.”⁵⁰¹ The size of the 1940 draft quickly overwhelmed the current military healthcare infrastructure and the military prioritized soldiers over their dependents.⁵⁰² Thousands of WWII soldiers and wives expected maternity care, but the military could not meet their needs. With the EMIC, the CB relieved the military of providing care for over a million soldiers’ wives or newborns.

⁴⁹⁷ Ibid.

⁴⁹⁸ A.L. Van Horn, M.D., letter to Mrs. Bernard James Brode, December 20, 1944, Record Group 102: Records of the Children’s Bureau, 1908-1969, Box 216: “Central File, 1941-44, 13-2-2-(0) to 13-2-4-0,” Folder: “13-2-4(0) Appeals for Help (General)” The National Archives at College Park.

⁴⁹⁹ First Deficiency Appropriation Act, 1943, Public Law 78-11, *U.S. Statutes at Large* 57 (1943): 28-29.

⁵⁰⁰ Ibid., 29.

⁵⁰¹ Leland Maassen and David Whipple, “A History of Military Dependent Medical Care Programs,” Technical Report for Naval Postgraduate School, August 1975, 3-4; Joan Mulligan, “Three Federal Interventions on Behalf of Childbearing Women,” 68; Ruth Fairbanks, “A Pregnancy Test,” 73. The serviceman’s dependent had to receive medical care offered by the serviceman’s branch.

⁵⁰² Ibid.

Table 5.1 Pay Grade and Rank of Soldiers in the Lowest Four Pay Grades

Pay Grade	Rank
4 th	Technician Fourth Grade (Army) Sergeant (Army and Marine Corps) Field Musician Sergeant (Marine Corps) Field Cook or Cook Third Class (Marine Corps) Field Musician Sergeant (Marine Corps) Petty Officer Third Class (Navy)
5 th	Technician Fifth Grade (Army) Corporal (Army and Marine Corps) Field Musician Corporal (Marine Corps) Assistant Cook (Marine Corps) Seaman First Class (Navy)
6 th	Private First Class (Army and Marine Corps) Field Musician First Class (Marine Corps) Steward's Assistant Second Class (Marine Corps) Seaman Second Class (Navy)
7 th	Private (Army and Marine Corps) Steward's Assistant Third Class (Marine Corps) Apprentice Seaman (Navy)

During World War II, enlisted men with the lowest rank were in the seventh pay grade, but today, the lowest enlisted men are in the first pay grade or E-1. For World War II ranks and pay grades see: "History of U.S. Army Enlisted Ranks," The Institute of Heraldry, Office of the Administrative Assistant to the Secretary of the Army, accessed 2017, <http://www.tioh.hqda.pentagon.mil/Catalog/HeraldryMulti.aspx?CategoryId=9168&grp=2&menu=Uniformed%20Services>; Historical Division of the United States Marine Corps, *Marine Corps Historical Reference Pamphlet: United States Marine Corps Ranks and Grades, 1775-1969* (Washington, D.C.: United States Marine Corps Historical Division, 1970); Preston B. Perrenot, *United States Navy Grade Insignia Since 1852* (Washington, D.C.: Department of the Navy, 2010).

Congress and the CB established strict guidelines for the program because they wanted to ensure that women and infants on American soil and of lower income received priority. EMIC represented a compromise between Congress, the CB, state public health agencies, and physicians. According to scholar Eden Goldman, EMIC was “the nation’s most expansive single-payer health insurance program to date.”⁵⁰³ The government provided medical care for approximately 1,430,000 Americans, and by 1944, EMIC paid for the birth for one in seven of American newborns.⁵⁰⁴ During the 1940s, contemporaries evaluated the EMIC program and the CB’s role in administering maternal and infant health care as a benefit to soldiers and their families.⁵⁰⁵ Shortly after the war, Nathan Sinai and Odin W. Anderson of the University of Michigan School of Public Health assessed the program before the EMIC officially ended. In *EMIC (Emergency Maternity and Infant Care): A Study of Administrative Experience*, the two researchers compiled EMIC bureaucratic forms, statements from Congress and CB members, and field work notes from throughout the United States.⁵⁰⁶ The authors also attempted to access the overall effectiveness of the EMIC as a national health plan.⁵⁰⁷ Although EMIC had flaws,

⁵⁰³ Eden Goldman, ““A Right to be Safely Born,”” 155.

⁵⁰⁴ Kriste Lindenmeyer, “A Right to Childhood,” 242; Robert H. Bremner, ed., *Children and Youth in America: A Documentary History, Volume III, 1933-1973* (Cambridge: Harvard University Press, 1974), 1262. Reprinted from “The EMIC Program,” *The Journal of Pediatrics* 25 (1944): 88-91; Ruth Fairbanks, “A Pregnancy Test,” 76.

⁵⁰⁵ Kriste Lindenmeyer, “A Right to Childhood,” 240; Eden Goldman, ““A Right to be Safely Born,””, 161. Historian Kriste Lindenmeyer explained that the CB promoted EMIC as “a wartime emergency program for the nation’s most patriotic Americans.” She noted that the CB advertised EMIC as a benefit for soldiers not their wives and newborns. The CB believed it would raise the morale of soldiers. Goldman also wrote that the CB promoted the EMIC as a benefit to soldiers.

⁵⁰⁶ Nathan Sinia and Odin Anderson, *EMIC (Emergency Maternity and Infant Care)*, 5.

⁵⁰⁷ *Ibid.*, 3.

Nathan Sinai and Odin Anderson asserted, “The program included a wide variety of administrative techniques; it faced the development of national, state, and local policies...it established procedures for professional and public relations and it offered valuable material on the problems of standards and quality of services.”⁵⁰⁸

This chapter re-evaluates Sinai and Anderson’s claim and examines the EMIC on the federal and local levels. At the national level, EMIC program standardized American maternal and infant health care as a service provided by doctors and inside a hospital.⁵⁰⁹ Yet, the program still allowed for regional differences of economies, cultures, and societies. This chapter provides case studies of the EMIC program in California, New York, and especially Mississippi. The CB used the dual American health care system of public health operated by states and private healthcare to improve maternal and infant care. In addition, the EMIC helped federal and local politicians and health personnel recognize the need for better training and medical infrastructure such as hospitals. The program was a continuation of the CB providing health care for American mothers and infants to save American democracy. Further, this chapter demonstrates that at the local level the Mississippi EMIC program created the environment to improve maternal hospital care and further attest the shift to hospital births at the state and national level.⁵¹⁰

⁵⁰⁸ Ibid.

⁵⁰⁹ Kriste Lindenmeyer, “*A Right to Childhood*,” 257-258; Eden Goldman, ““A Right to be Safely Born,”” 167, 173; Joan Mulligan, “Three Federal Interventions on Behalf of Childbearing Women,” 61-100. These scholars focused on the EMIC at the national level and the program needs to be further examined at the state level.

⁵¹⁰ Other scholars have emphasized the importance of the EMIC and the move towards hospital childbirths at the national level. This chapter will provide an example on the local level in Mississippi, the state with the lowest hospital deliveries. See: Ruth Fairbanks, “The Pregnancy Test,” 77-78; Eden Goldman, ““A Right to be Safely Born,”” 172-174; Joan Mulligan, “Three Federal Interventions on Behalf of Childbearing Women,” 65, 81.

Mississippi State Board of Health data highlights the differences in care for patients of different racial backgrounds because African American patients received hospital care at a much lower rate than white EMIC patients. Wartime conditions revealed an emergency in maternal health nationwide and Mississippi, like other states, took advantage of EMIC to improve standards for mothers and their infants, while maintaining segregation.⁵¹¹

In 1941, thousands of women relocated with their husbands, who had just entered the United States Army. As the country prepared for war, many soldiers were concerned with the health of their pregnant wives and later their newborns. As the military expanded, the Army could no longer guarantee medical care for soldiers' dependents. After requests from Fort Lewis, Washington, medical personnel, the Children's Bureau sought an emergency program to provide maternal and infant health care for all wives and infants of soldiers in the lowest four pay-grades.⁵¹² Many child health reformers, including members of the Children's Bureau, had just abandoned the idealistic view of the American government providing health care for all children. These reformers asserted that parents with higher incomes should provide private health care for their children, while the government had an obligation to offer public health care for children of low socio-economic standing. In the early 1940s, the Children's Bureau determined that soldiers in the lowest four pay-grades or up to the rank of sergeant could not support their

⁵¹¹ Keith Wailoo, *Dying in the City of the Blues: Sickle Cell Anemia and the Politics of Race and Health* (Chapel Hill: The University of North Carolina Press, 2001), 29,33, 84-85.

⁵¹² Nathan Sinia and Odin Anderson, *Emergency Maternity and Infant Care*, 21-23; Eden Goldman, "'A Right to be Safely Born,'" 157.

pregnant wives or newborns while serving their country.⁵¹³ The Children's Bureau and the government had the duty to provide health care for G.I.s' wives and newborns up to one-year-old, only if the CB determined the soldier could not afford to provide health care for their families.⁵¹⁴ The Bureau's attitude towards soldiers' wives and infants was a clear departure from previous care for soldiers' dependents.

Prior to the United States entering World War II and the beginning of the EMIC, President Roosevelt and CB representatives worried about how the war would affect American children. At the final meeting of the White House Conference on Children in a Democracy (January 18th-20th, 1940), Franklin D. Roosevelt expressed concerns about American national security and how many international events threatened democracy.⁵¹⁵ Conflict in Europe continued to escalate since the initial conference meeting in April 1939. Between May and August, Nazi Germany formed an alliance with Italy and the Soviet Union and on September 1, 1939, Germany invaded Poland, which led to a chain reaction. Within two days the United Kingdom, France, and Australia declared war on Germany. An ocean away from the conflict, American leaders debated the situation for a few days and on September 5, 1939, Roosevelt proclaimed American neutrality.⁵¹⁶ Later that month, Canada entered the fight against Nazism, and the Soviets initially honored

⁵¹³ United States Congress, House of Representatives, Subcommittee of the Committee on Appropriations, *Department of Labor-Federal Security Agency Appropriation Bill for 1944: Hearings before a Subcommittee of the Committee on Appropriations*, 78th Cong., 1st sess., 1943, 243-244.

⁵¹⁴ Nathan Sinia and Odin Anderson, *Emergency Maternity and Infant Care*, 66.

⁵¹⁵ United States Children's Bureau, *Proceedings of the White House Conference on Children in a Democracy: Washington, D.C., January 18-20, 1940* (Washington, D.C.: United States Government Printing Office, 1940, 69-77.

⁵¹⁶ Franklin D. Roosevelt, "Proclamation 2348-Neutrality of the United States," September 5, 1939, accessed October 2016, <http://www.presidency.ucsb.edu/ws/?pid=15802>.

their alliance with Germany by entering the war. In Asia, a separate conflict, the Second Sino-Japanese War, continued, and the Japanese-American relations were rocky. By 1939, the Roosevelt Administration moved away from “quarantining” Japan and moved towards a more aggressive foreign policy against the nation.⁵¹⁷ Edward Miller explained, “On 15 December 1939 the administration asked U.S. producers of three strategic metals—aluminum, magnesium, and molybdenum—voluntarily to halt exports to Japan.”⁵¹⁸ The United States was moving away from neutrality and closer to war.

At the last WHCCD, the Roosevelt Administration and CB members increasingly worried about the possibility that the United States would soon enter a war and how this would impact American infants and children. Roosevelt told the child welfare advocates that American children were an essential part of national defense.⁵¹⁹ Roosevelt claimed, “Internal defense and external defense are one and the same.”⁵²⁰ None of the conference members could predict the events that would unfold over the next two years, but they were aware that current international events posed a threat to American democracy and America’s youth population. During the war years, these child welfare advocates had to address wartime issues that arose such as soldiers’ wives and infants needing healthcare.

⁵¹⁷Edward Miller, *Bankrupting the Enemy: The U.S. Financial Siege of Japan Before Pearl Harbor* (Annapolis: Naval Institute Press, 2007), PDF E-book, Chapter 6.

⁵¹⁸Ibid.

⁵¹⁹ United States Children’s Bureau, *Proceeding of the White House Conference on Children in A Democracy, January 18-20, 1940*, 70.

⁵²⁰ Ibid.

The children's health reformers including members of the CB believed that health care for all American children was a priority to protecting democracy.⁵²¹ The WHCCD conference members were committed to preventing and treating diseases and proposed objectives for the 1940s. Their goals were to reduce maternal and infant mortality and improve the availability and training of medical professionals. To accomplish these goals, the Report Committee presented nine recommendations on children's health care. They believed that all Americans should have access to health care, but unlike the 1930 White House Conference on Child Health and Protection's recommendation, the Report Committee argued that some Americans could afford health care through the private sector, while public health organizations, funded by taxes, should serve those who lacked the financial means.⁵²² By the early 1940s, the CB reconsidered the vision of providing public health care for all American children. Instead, the CB accepted the dual system of private and public health care for American families. As the United States prepared for the possibility of war, the CB also had to consider the healthcare system as the Bureau mobilized for American mothers, infants, and children.

By the 1940s, the American private versus compulsory public health insurance debate was over three decades old.⁵²³ In the early 1900s, many physicians opposed both

⁵²¹ *Conference on Children in a Democracy: Papers and Discussions at the Initial Section, April 26, 1939* (Washington, D.C.: United States Government Printing Office, 1939), 24-39.

⁵²² *Children in a Democracy: General Report Adopted by the White House Conference on Children in a Democracy, January 19, 1940* (Washington, D.C.: Superintendent of Documents, 1940), 57-61; White House Conference on Child Health and Protection. *White House Conference 1930: Addresses and Abstracts of Committee Reports* (New York: The Century Company, 1931), 45-48.

⁵²³ For more information on the development of American health insurance plans, see: Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982), 8, 55, 200-209, 228, 235-295, 298, 309-310, 327-328, 333-334, 368-370, 382, 396-398, 404-405, 413-414, 417; John Burnham, *Health Care in America: A History* (Baltimore: Johns Hopkins Press, 2015), 249-251, 247-263, 359-363, 411-416; John E. Murray, *Origins of*

private and national health insurance because doctors felt insurance threatened their professional autonomy and cut into their profits.⁵²⁴ Even though physicians did not like the idea of insurance, two different types of insurance plans, private or compulsory, competed to control the American healthcare system. Unlike many Europe nations, the United States government did not adopt a national sickness insurance program in the late nineteenth century. According to Paul Starr, the United States failed to create a social health insurance plan because American politics and institutions differed.⁵²⁵ From the early 1900s to the 1930s, various reformers including American Association for Labor Legislation members and New Dealers called for a compulsory health plan for at least some portion of the American populations. During this period, a national health insurance plan failed three times because each time physicians and often the leading medical association, the American Medical Association, rallied against a healthcare system that doctors viewed as socialized medicine.⁵²⁶ Furthermore, by the 1940s, American business supported privatized health insurance. For instance, in 1929 and during the 1930s, Blue Cross developed private hospital insurance programs that had six million members by the end of the decade. When the United States entered World War II, private health insurance was already established and some doctors accepted Blue Shield, a medical insurance for physician care. However, the AMA still had qualms with the two separate Blue programs.

American Health Insurance: A History of Industrial Sickness Funds (New Haven: Yale University Press, 2007); Christy Ford Chapin, *Ensuring America's Health: The Public Creation of the Corporate Health Care* (Cambridge: Cambridge University Press, 2015), 10-26; Beatrix Hoffman, *Health Care for Some*.

⁵²⁴ Christy Chapin, *Ensuring America's Health*, 21-22; W. Benbow Thompson, "Emergency Maternity and Infant Care (E.M.I.C.) Program," *California and Western Medicine* 61, no. 2 (August 1944): 75.

⁵²⁵ Paul Starr, *The Social Transformation of American Medicine*, 240.

⁵²⁶ *Ibid.*, 286-287; John Burnham, *Health Care in America*, 250, 257.

Even without the backing of the AMA, most doctors preferred private health care over social insurance.⁵²⁷ In this context, the government launched the EMIC, the largest government health insurance program in the United States at that point.⁵²⁸

The CB had to address the healthcare needs of the servicemen's wives and children. Many infants and children moved throughout the United States when their fathers enlisted in the military. In September 1940, Congress passed the Selective Training and Service Act of 1940, which required men ages twenty-one to thirty-five to register for a draft as a mobilization effort. During the next few months, draft boards conscripted young men throughout the country, who left their hometowns to attend basic training. By the time the Japanese attacked Pearl Harbor, the United States Army had approximately 1.65 million men serving and hundreds of thousands were new recruits or selectees.⁵²⁹ By the end of 1942, the number of soldiers stood at nearly 5.4 million. While many of these young men were single, thousands of them had families or started families during the war.⁵³⁰ According to historian William M. Tuttle, Jr., Congress considered exempting fathers from the draft, but Congress members failed to reach an agreement. Finally in October 1943, the Selective Service "issued a decree abolishing Class III-A" or

⁵²⁷ Paul Starr, *The Social Transformation of American Medicine*, 306-307.

⁵²⁸ John Burnham, *Health Care in America*, 259-261; Beatrix Hoffman, *Health Care for Some*, 47-53; Eden Goldman, "A Right to be Safely Born," 155.

⁵²⁹ Stetson Conn, "Highlights of Mobilization, World War II, 1938-1942," 2-3.7AF.B, Historical Manuscripts Collection, U.S. Army Center of Military History, Department of the Army, Fort Lesley J. McNair, Washington, D.C., accessed October 2016, <http://www.history.army.mil/documents/wwii/ww2mob.htm>.

⁵³⁰ Ibid.

the status that had protected fathers from the draft.⁵³¹ Tuttle further explained that the exact number of fathers serving in the Army and other branches of the military was just an approximation, but he estimated that there were approximately three million Army wives and 1.35 million Navy or Marine wives.⁵³² Millions of these women raised children during the war, and over one million gave birth during the war. These women needed access to medical care for themselves and their newborns.

The mobilization of the armed forces had a substantial effect on the American health care system and American families. Thousands of doctors and nurses left the private sector to serve in the armed forces or volunteer for the Red Cross. During the Second World War, the United States had a medical personnel shortage on the home front. In the spring of 1942, Surgeon General of the United States Army James C. Magee estimated that America had approximately 176,000 doctors, and he knew that “many are overage or have retired from practice.”⁵³³ Of this number the Army eventually met a quota of 45,000 doctors, and the Navy employed over 14,000 physicians by the end of the war.⁵³⁴ Over one-third of American doctors entered the military, which created a need for healthcare providers on the home front. Doctors were not the only medical personnel who resigned from their civilian jobs to put on government uniforms; nurses

⁵³¹William M. Tuttle, Jr. *“Daddy’s Gone to War”: The Second World War in the Lives of America’s Children* (New York: Oxford University Press, 1993), 31.

⁵³² Ibid.

⁵³³Leonard D. Heaton, Surgeon General of the United States Army, *Medical Department, United States Army Personnel in World War II* (Washington, D.C.: Office of the Surgeon General of the United States Army, 1963), 67.

⁵³⁴ Ibid., 67-72; Ross T. McIntire, Surgeon General of the United States Navy, *The History of the Medical Department of the United States Navy in World War II* (Washington, D.C.: United States Government Printing Office, 1953), 1.

and dentists also joined by the thousands. For instance, approximately fifty-eight thousand American nurses left their jobs and joined the Army Nurse Corps to care for servicemen.⁵³⁵ As these nurses, physicians, and dentists joined the military, thousands of soldiers' wives became pregnant and their access to care was often less than it had been before the war.

Even though the Select Service did not typically draft fathers who had children before Pearl Harbor, many fathers enlisted and others quickly became fathers-to-be. Until late 1943, the Selective Service System labeled fathers as Class III-A. A Class III-A status meant that the draftee could defer because of dependents.⁵³⁶ Even so, thousands of fathers enlisted and moved their families with them. Nathan Sinai and Odin Anderson, who published a study of the EMIC in 1948 for the Bureau of Public Health Economics, explained that by late 1941, many wives and children relocated to live close to their soldier's base. Due to the mass population increase around military bases and camps, the infrastructure in surrounding areas could not support this transient population.⁵³⁷ Many pregnant women found themselves without proper obstetric care, and their living conditions were not ideal. At Fort Lewis, Washington, Army medical personnel requested help from the Washington State Department of Health, which relied on maternal and children's health Social Security Title V funds or federal grants for maternal and child

⁵³⁵ Judith A. Bellafaire, *The Army Nurse Corps: A Commemoration of World War II Service* (Ft. McNair: U.S. Army Center of Military History, 2000), 1. Almost 1,000 nurses were already serving when the United States entered the war. Over 59,000 nurses served in the Army Nurse Corps during the Second World War.

⁵³⁶ United States Selective Service Board, *Selective Service Regulations, Volume One: Organization and Administration* (Washington, D.C.: United State Government Printing Office, 1940), 10.

⁵³⁷ Nathan Sinia and Odin Anderson, *Emergency Maternity and Infant Care*, 21.

health. Title V funds were limited and required states to match most of the money. The Washington State Department of Health did not have the funds to provide care for all the wives and infants at Fort Lewis and operate its normal maternal and infant care program.⁵³⁸

Fort Lewis, Washington, an army base located less than ten miles from Tacoma, served as the home or training ground of many infantry divisions during World War II. From 1940 to 1945, the 3rd, 33rd, 40th, 41st, 44th, and 94th Infantry Divisions and 115th Cavalry Regiment were a sometime stationed at the fort. During 1940, the 3rd Infantry Division and IX Army Corps was posted at Fort Lewis and by December 1940, Fort Lewis and the National Guard's Camp Murray were home to 26,000 military men, an exponentially growth from the 1938 population of 5,000. Fort Lewis served as a training ground for Army and Washington National Guardsmen during the remainder of the war. The 1940 infrastructure of Fort Lewis was not large enough to accommodate the influx of soldiers and the following spring, 11,000 more soldiers arrived for training. Soldiers lived in tents in a very muddy environment until new barracks were completed. The hospital at Fort Lewis was too small and remained the same until 1943, when the War Department decided expanded Fort Lewis Hospital to increase hospital access for Army members in the Northwest. The \$3,000,000 addition was not complete until the last year of the war and the new Patrick Madigan Hospital was one of the largest military hospitals

⁵³⁸ Ibid. 21-22; Eden Goldman, “A Right to be Safely Born,” 156-157; Kriste Lindenmeyer, “A Right to Childhood,” 238; Ruth Fairbanks, “A Pregnancy Test,” 74.

in the nation.⁵³⁹ The thousands of soldiers and their dependents needed access to care, but during the war, the health infrastructure was inadequate. In late 1940, Major General Charles Thompson explained that thousands of the soldiers had brought their wives and children to live near Fort Lewis and Camp Murray and often struggled to find adequate housing and amenities for their families. He further noted that Fort Lewis could not provide healthcare for pregnant wives and newborns on base. He turned to the Washington State Department of Health and the CB in late 1940, and by 1941 the CB began a pilot program for maternal and infant healthcare for soldiers' dependents.⁵⁴⁰

During 1941 and 1942, the CB operated the Fort Lewis program and twenty-five other projects that Chief Lenroot and Dr. Eliot used to support a national program for soldiers' wives and newborns.⁵⁴¹ To cope with the lack of funds and facilities, the Washington State Department of Health asked the CB for additional support.⁵⁴² Near Fort Lewis, 677 women "registered for care" under Fund B from Title V of the Social Security Act from August, 1941 until July, 1942.⁵⁴³ However, the issue was much larger than Fort Lewis, and Army medical personnel throughout the country could not provide adequate

⁵³⁹ "World War II, 1939-1949," Lewis Army Museum, accessed March 2018, <https://lewisarmymuseum.com/history-of-the-army-at-camp-lewis-fort-lewis-and-joint-base-lewis-mcchord/world-war-ii-1939-1949/>.

⁵⁴⁰ Martha M. Eliot, "The EMIC Program for Wives and Infants of Enlisted Men," Stamped September 1944, 405, Series: 2012, Box: 8751, Folder: "(E.M.I.C.) Maternity," Mississippi Department of Archives and History, Jackson, Mississippi; Ruth Fairbanks, "The Pregnancy Test," 73-75; Eden Goldman, "'A Right to be Safely Born,'" 155-156; Joan Mulligan, "Three Federal Interventions on Behalf of Childbearing Women," 70; Kriste Lindenmeyer, *A Right to Childhood*, 238-239.

⁵⁴¹ Ibid.

⁵⁴² Nathan Sinia and Odin Anderson, *Emergency Maternity and Infant Care*, 22.

⁵⁴³ Ibid., 18-19, 22; Kriste Lindenmeyer, *A Right to Childhood*, 239.

health care for soldiers' wives and children. According to Sinai and Anderson, by July 1942, thirty-eight states' health departments asked for Fund B Title V appropriations, emergency funds for the maternal and infant healthcare for soldiers' wives and newborns, for states in need, for soldiers' wives and infants, but the CB was only able to award money to twenty-seven states for a total of \$198,000.⁵⁴⁴ By the end of the 1942 and early 1943, the total allotment for these maternal and infant health activities was \$390,177.⁵⁴⁵ CB Chief Katharine Lenroot knew that the CB could not sustain this program without new appropriations. She responded to this critical issue by seeking a specific appropriation for maternity and infant care for soldiers' wives and infants in December 1942.⁵⁴⁶

In early 1943, members of the House of Representatives considered the CB's request. In February 1943, the House Subcommittee of the Committee on Appropriations held a hearing about the First Deficiency Bill of 1943 or a bill to fund items and programs not including in the annual budget. On February 11, 1943, Chief Katharine Lenroot and Dr. Martha Eliot, the Associate Chief of the CB, addressed the Subcommittee and answered questions about the current state of maternal and infant care

⁵⁴⁴ Nathan Sinia and Odin Anderson, *Emergency Maternity and Infant Care*, 23.

⁵⁴⁵ Ibid., 24. According to the Consumer Price Index Inflation Calculator, \$390,177 in January 1943 is equal to \$5,748,553.93 in February 2018.

⁵⁴⁶ Kriste Lindenmeyer, "A Right to Childhood," 240; Eden Goldman, "A Right to be Safely Born," 157; United States Children's Bureau, *The Children's Bureau Legacy: Ensuring the Right to Childhood* (Washington D.C., United States Children's Bureau, 2013), PDF, 70-71. In 1915, Katharine Lenroot began working for the CB in the Social Services Division, where she investigated juvenile court cases and unmarried mothers' conditions. In 1922, Lenroot became the Assistant Chief and by November 1934, she replaced Grace Abbott as the Chief of the CB. During her tenure, the CB managed Title V of the Social Security Act and sponsored the EMIC. During the late 1940s, she was active in creating and serving the United Nations International Children's Emergency Fund (UNICEF). She retired from the CB in 1951.

for soldiers' wives and infants. The baby boom had begun and the CB wanted to provide care for soldiers' wives and newborns.⁵⁴⁷ Chief Lenroot first explained the situation that arose at Fort Lewis in 1941 to highlight the needs of servicemen and their families.

In the first six months of 1943, an estimated 70,000 military men would become fathers. Furthermore, the CB could only afford care for approximately 25,000 wives and newborns in the last half of 1943 with the current budget.⁵⁴⁸ Although soldiers' dependents had received healthcare since the late nineteenth century, the government could not adequately provide health care for the dependents of American soldiers during the early years of Second World War.⁵⁴⁹ In the United States, obstetric care and six months of medical care for an infant cost around eighty to ninety dollars in 1943.⁵⁵⁰ The annual salaries of the lowest four grades ranged from six-hundred dollars to nine-hundred thirty-six, which meant maternal and infant healthcare ranged from nearly ten to fifteen percent of the soldiers' annual income, which would put a strain on the serviceman's household budget.⁵⁵¹ The new EMIC purpose was twofold: "to relieve the servicemen of worry and uncertainty as to the availability of maternity and infant care needed by their

⁵⁴⁷Ruth Fairbanks, "A Pregnancy Test," 72.

⁵⁴⁸ United States Congress, House of Representatives, Subcommittee of the Committee on Appropriations, *First Deficiency Appropriation Bill for 1943*, 319.

⁵⁴⁹ Leland Maassen and David Whipple, "A History of Military Dependent Medical Care Programs," 3-4; Joan Mulligan, "Three Federal Interventions on Behalf of Childbearing Women," 68; Ruth Fairbanks, "A Pregnancy Test," 73.

⁵⁵⁰ United States Congress, House of Representatives, Subcommittee of the Committee on Appropriations, *First Deficiency Appropriation Bill for 1943*, 320, 325-326. In 2016 currency, the 1943 obstetrical and six-month infant care would range from \$1,117.82 to \$1,257.55 based on the Consumer Price Index. To calculate Consumer Price Index, see: http://www.bls.gov/data/inflation_calculator.htm (accessed November 2016).

⁵⁵¹ Ibid.

families...and to assure the servicemen and their wives that all needed care will be provided.”⁵⁵² With the EMIC funds, the CB could raise the morale of soldiers by offering healthcare for their wives and infants.

The CB leaders wanted to ensure that the Bureau received appropriations for the new EMIC program that would provide maternity care and one-year of infant illness care as a benefit to soldiers. According to the Surgeon General of the Navy Ross T. McIntire and the Surgeon General of the Army Norman T. Kirk, the federal government and the CB offered the EMIC program “for the purpose of relieving anxiety among the enlisted men as to how the cost of maternity care for their wives, or the cost of medical care for their infants, will be met in their absence.”⁵⁵³ To guarantee the program, the CB operated the EMIC under Title V of the Social Security Act. Lindenmeyer asserted that CB officials represented the EMIC program as “simply an expansion of existing services available under the Social Security Act.”⁵⁵⁴ Goldman made a similar contention that the CB leaders addressed the EMIC as an expansion of Title V of the Social Security Act, but she also noted that the program was different from public health programs.⁵⁵⁵ Lindenmeyer explained that the program varied from Title V, Part I, because it offered

⁵⁵² Martha M. Eliot, “The EMIC Program for Wives and Infants of Enlisted Men,” 405.

⁵⁵³ Ross T. McIntire and Norman T. Kirk, “A Message from the Surgeons General of the Army and Navy,” *The Child* 8, no. 10 (April 1944): 151.

⁵⁵⁴ Kriste Lindenmeyer, “*A Right to Childhood*,” 237,240, Eden Goldman, ““A Right to be Safely Born,”” 157. Lindenmeyer contended that Title V, Part I of the Social Security Act created a springboard for the EMIC. Goldman also noted that the CB relayed the similarity of the program to EMIC.

⁵⁵⁵ Eden Goldman, ““A Right to be Safely Born,””157; Ruth Fairbanks, “A Pregnancy Test,” 75.

specific medical care.⁵⁵⁶ Chief Lenroot stated that EMIC differed from Title V of the Social Security Act because this program paid for “hospital costs and medical care” rather than “prenatal care and postnatal supervision and nursing care.”⁵⁵⁷ Section I of Title V operated under the public health infrastructure and the new EMIC program utilized both public and private health organization.⁵⁵⁸

The CB would appropriate funds to state boards of health for the maternal care of soldiers’ wives and infant care for their newborns, if the state boards agreed to a few stipulations. The state EMIC programs could not discriminate based on permanent residency. The program also had to include “methods of authorization for medical or hospital care,” a referral system to direct women to the appropriate caregiver, and ensure an adequate standard for cost and quality of care.⁵⁵⁹ The EMIC plan covered the medical cost of wives and infants of the four-lowest pay grade servicemen or up to the Army equivalent of a sergeant.⁵⁶⁰ The government and CB believed that servicemen above the rank of sergeant made enough money to provide obstetric and pediatric care for their

⁵⁵⁶ Kriste Lindenmeyer, ‘A Right to Childhood’, 239-240; Ruth Fairbanks, “A Pregnancy Test,” 75; Beatrix Hoffman, *Health Care for Some*, 48. According to Lindenmeyer, the program did not require states to make appropriation like the Title V, Part I grants.

⁵⁵⁷ United States Congress, House of Representatives, Subcommittee, *First Deficiency Appropriation Bill for 1943*, 327.

⁵⁵⁸ For information on private medicine and the EMIC, view: Goldman, “‘A Right to be Safely Born’,” 155-156. For the rise of hospitals in America, see: Charles E. Rosenberg, *The Care of Strangers: The Rise of America’s Hospital System* (Baltimore: Johns Hopkins University Press, 1995); Paul Starr, *The Social Transformation of American Medicine: The Rise of the Sovereign Profession and the Making of a Vast Industry, Book Two: The Struggle for Medical Care: Doctors, the State, and the Coming of the Corporation*.

⁵⁵⁹ United States Congress, House of Representatives, Subcommittee, *First Deficiency Appropriation Bill for 1943*, 324.

⁵⁶⁰ Ibid.

wives and children.⁵⁶¹ The CB wanted to ensure that military men who could not protect and care for their wives and newborns had access to healthcare in any state in the United States. Although the CB emphasized “war preparedness and the politics of patriotism,” the House denied the CB request for the creation and funding of the EMIC on February 24, 1943.⁵⁶²

Chief Katharine Lenroot and Dr. Martha Eliot had one more chance to save the EMIC because the team could sway the Senate.⁵⁶³ By the time Chief Lenroot presented her case to the Senate in March 1943, twenty-eight states had programs in place for soldiers’ wives and infants. The Bureau believed that soldiers’ wives should have access to care and Lenroot explained that the soldiers in the lowest four grades could not afford medical services for their wives and infants. She noted, “There is very great need for this type of care, because the pay for service men and noncommissioned officers...is not sufficient to enable a wife to build up any reserve to pay for maternity care.”⁵⁶⁴ The

⁵⁶¹ For more information on why the government did not offer healthcare to other wartime workers, see: Ruth Fairbanks, “A Pregnancy Test,” 90-102; Joan Mulligan, “Three Federal Interventions on Behalf of Childbearing Women,” 83-90.

⁵⁶² Eden Goldman, “A Right to be Safely Born,” 156; Kriste Lindenmeyer, “A Right to Childhood,” 240.

⁵⁶³ For more information on Martha May Eliot, see: United States Children’s Bureau, *The Children’s Bureau Legacy*, PDF, 95-96; Ruth Fairbanks, “The Pregnancy Test,” 73, 75; Eden Goldman, “A Right to Be Born,” 1, 218-219; Beatrix Hoffman, *Health Care for Some*, 52-53. From 1924 to 1934, Dr. Martha Eliot served as the Director of the Division of Child and Maternal Health of the CB. In 1934, she assumed the role of Associate Chief of the Children’s Bureau, where she managed children’s health programs for the Bureau and she was instrumental in drafting Title V of the Social Security Act. Eliot traveled to Great Britain and studied the impact of the war on British children’s health. Her experience in Britain informed her opinions on the creation of the EMIC. She also served as the President of the American Public Health Association in 1948. The following year, Eliot left the CB to serve as the Assistant Director General of the World Health Organization. In addition, she worked with UNICEF. In 1951, Eliot returned to the CB as the new chief and her experiences during the 1940s made her well equip to understand children’s health in an international framework.

⁵⁶⁴ United States Congress, Senate, Subcommittee of the Committee on Appropriations, *First Deficiency Appropriation Bill for 1943: Hearings before a Subcommittee of the Committee on Appropriations*, 78th Cong., 1st sess., 1943, 129; Lindenmeyer, “A Right to Childhood,” 238.

military did not want soldiers' wives to receive cash allowances for maternal and infant healthcare because military leaders worried that the wives would not use the money for appropriate medical care.⁵⁶⁵ Without a raise or cash allowance, soldiers turned to maternal and infant health programs operated by the CB. In 1942, the CB exhausted Fund B or appropriations for soldiers' wives and newborns because it allocated money to twenty-eight states for the care of soldiers' wives. The CB only appropriated \$390,000 for the program and state programs quickly exceed the budget. CB could not provide states with more funds and Chief Lenroot asked Congress for help. In March 1943, Chief Lenroot explained to the Senate Subcommittee of the Committee on Appropriation that the CB would not be able to fund the program during the remaining of the 1943 fiscal year without additional funding. She also informed the committee that during the short-history of the program, the Bureau had provided care for approximately 5,000 cases.⁵⁶⁶ The CB asked for appropriations to fund the program in forty-three states and territories for the rest of the fiscal year and estimated that the program would cost \$1,200,000 for three months. Chief Lenroot believed that she could operate the program for a full year for six million dollars.⁵⁶⁷

To persuade the senators, Lenroot offered further evidence about the great need and why the government should pay for G.I. infants. Chief Lenroot strategically presented letters from a hospital association superintendent in New Jersey and a

⁵⁶⁵ Ruth Fairbanks, "A Pregnancy Test," 83.

⁵⁶⁶ United States Congress, Senate, Subcommittee, *First Deficiency Appropriation Bill for 1943*, 130; W. Benbow Thompson, "Emergency Maternity and Infant Care (E.M.I.C.) Program," 70.

⁵⁶⁷ United States Congress, Senate, Subcommittee, *First Deficiency Appropriation Bill for 1943*, 130.

California mother. Victoria Smith, the Superintendent of the Englewood (New Jersey) Hospital Association, wrote to Lenroot because local hospitals in New Jersey and New York were concerned about the growing number of obstetric and pediatric cases the hospitals were handling. Smith had recently read a *New York Times* article that estimated that 70,000 American servicemen would become fathers between January and June 1943. She also pointed to the local issue around Camp Shanks, Orangeburg, New York. Officials from the five hospitals of Bergen County, New Jersey, and Rockland County, New York, met in attempt to standardize care for soldiers' wives and infants, but Smith claimed that they "ran into a mass of misinformation and misunderstanding concerning the problem."⁵⁶⁸ These hospitals argued that they should not bare the sole expense for women who were not from the community, but soldiers' wives felt that they were entitled and deserved free obstetric and pediatric care.⁵⁶⁹ The soldiers and their wives thought that the military would provide care because in the past dependents of soldiers had often received medical care provided by the Army.⁵⁷⁰ During 1942 and 1943, Army hospitals often did not have room to take on obstetric cases.⁵⁷¹ Smith explained to Lenroot that Camp Shanks wives were supposed to receive care at Fort Jay, Brooklyn, New York, but

⁵⁶⁸ Ibid., 131.

⁵⁶⁹ Ibid.

⁵⁷⁰ Leonard D. Heaton, Surgeon General of the United States Army, *Medical Department, United States Army Personnel in World War II* (Washington, D.C.: Office of the Surgeon General of the United States Army, 1963), 2.

⁵⁷¹ United States Congress, Senate, Subcommittee, *First Deficiency Appropriation Bill for 1943*, 132.

the fort only had seven beds for maternity cases. Fort Jay could not accept new patients at the time because it was typically booked at least five months in advance.⁵⁷²

Chief Lenroot also included a letter of support from the wife of a soldier, who benefited from the CB's maternal and infant health program. The young mother-to-be Marguerite Somers, who lived in North Sacramento, California, thanked Chief Lenroot for standing up for the wives and newborns of low-pay grade soldiers. She explained that her husband, a corporal, only made sixty-six dollars a month and that she had no savings. Somers said that the only way she and her husband could afford to have her baby was with government aid.⁵⁷³ These letters helped Lenroot show that the health of the soldiers' wives and infants was an important factor in preparing the home front. Sinai and Anderson succinctly summarized the situation before the EMIC, "The needs were easily definable, the people requiring assistance were easily identified, and the particular geographical areas where the greatest needs existed could be delineated."⁵⁷⁴ EMIC attempted to address these problems and provide care for women and newborns.

EMIC would only offer funds for obstetrical and pediatric care for the wives and infants of the four lowest pay grades because the CB believed that soldiers in the first through third rate could afford maternal and infant care. The program would not require women or soldiers to disclose their incomes or take a means test because the CB determined that these families likely could not afford quality care.⁵⁷⁵ Men above the

⁵⁷² Ibid., 131.

⁵⁷³ Ibid. Based on the Consumer Price Index, her husband's pay approximately \$922.20 in 2016. For Consumer Price Index, see http://www.bls.gov/data/inflation_calculator.htm (accessed November 2016).

⁵⁷⁴ Nathan Sinia and Odin Anderson, *Emergency Maternity and Infant Care*, 21.

⁵⁷⁵ United States Congress, Senate, Subcommittee, *First Deficiency Appropriation Bill for 1943*, 136; Kriste Lindenmeyer, 'A Right to Childhood', 240; Eden Goldman, "'A Right to be Safely Born',"

fourth pay grade were responsible for the medical expenses of their wives and infants. During a hearing before the Senate Subcommittee of the Committee on Appropriations, Senator Carl Hayden, a Democrat from Arizona, asked Chief Katharine Lenroot if a soldier, who was in higher pay grade, could receive EMIC benefits for his wife and infant.⁵⁷⁶ Lenroot explained that soldiers in the lower pay rates only made fifty to seventy-eight dollars a month, while the first through third pay grades received a higher base pay and “an allowance for quarters for dependents,” but the government provided maternity care as a benefit for the enlisted men.⁵⁷⁷ The military did not want to give soldiers case allowances for maternity care because military leaders believed the money would be mismanaged.⁵⁷⁸ Senator Henry Cabot Lodge, Jr., a Republican from Massachusetts, rebutted, “It is not a question of money; the care is just not there.” [Lodge was referring to officers’ or soldiers’ wives giving birth in the woods somewhere.]⁵⁷⁹ Lenroot assured Lodge that the EMIC program would benefit high-ranking officers such as colonels and their wives because the program would ensure that the medical infrastructure was in place. Although a general’s wife would pay for her obstetric care,

162; Ruth Fairbanks, “A Pregnancy Test,” 76; Beatrix Hoffman, *Health Care for Some*, 49.

⁵⁷⁶ United States Congress, Senate, Subcommittee, *First Deficiency Appropriation Bill for 1943*, 136-137; Ruth Fairbanks, “The Pregnancy Test,” 76, 83-84; Eden Goldman, “‘A Right to be Safely Born,’” 162-163; Beatrix Hoffman, *Health Care for Some*, 49; Kriste Lindenmeyer, *A Right to Childhood*, 245.

⁵⁷⁷ United States Congress, Senate, Subcommittee, *First Deficiency Appropriation Bill for 1943*, 136-137. Based on the Consumer Price Index, a 1943 enlisted man in the lower pay rate would earn between \$698.64 and \$1089.88 in 2016 currency per month. For more information on Consumer Price Index calculations, see http://www.bls.gov/data/inflation_calculator.htm (November 2016).

⁵⁷⁸ Ruth Fairbanks, “The Pregnancy Test,” 76, 83-84; Eden Goldman, “‘A Right to be Safely Born,’” 162-163; Beatrix Hoffman, *Health Care for Some*, 49; Kriste Lindenmeyer, *A Right to Childhood*, 245.

⁵⁷⁹ United States Congress, Senate, Subcommittee, *First Deficiency Appropriation Bill for 1943*, 136-137.

she would have assurances that she had access to care near her husband's base.⁵⁸⁰

Lenroot and Eliot persuaded the Senate Committee to support the program by March 12, 1943, and by March 18, 1943, House members also backed the EMIC.⁵⁸¹ Congress embraced the EMIC as a part of the "wartime emergency."⁵⁸² Congress moved the CB further away from public maternity health care because under the EMIC, the CB overwhelmingly paid private physicians to treat mothers and infants.⁵⁸³

Mothers and physicians alike learned more about the new EMIC program in the media. Professional journals and popular newspapers announced and discussed the EMIC program during the last three quarters of 1943. The *American Journal of Nursing* reported, "Uncle Sam Provides Obstetric Care" to military men's wives and infants. The First Deficiency Appropriation Act went into effect on March 18, 1943, and by March 25, 1943, thirty states' plans qualified for the EMIC funds, which was not surprising because twenty-eight states participated in the 1942 program. The funds were only available to the wives of military members and not unmarried mothers. The programs only allowed mothers to seek outside obstetric care if the Army or Navy hospitals did not have room.⁵⁸⁴ To receive free maternal health care, the wife or the soldier had to fill out a form and have it authorized by a physician, who agreed to certain terms including type of

⁵⁸⁰ Ibid.

⁵⁸¹ Kriste Lindenmeyer, "A Right to Childhood," 241.

⁵⁸² Ibid; Beatrix Hoffman, *Health Care for Some*, 48-49.

⁵⁸³ Joan Mulligan, "Three Federal Interventions on Behalf of Childbearing Women," 95.

⁵⁸⁴ "Uncle Sam Provides Obstetric Care: Maternity and Infant Care for Wives and Infants of Men in Military Service," *American Journal of Nursing* 43, no. 5 (May 1943): 470.

care and the price. The professional journal articles often delivered the facts about EMIC or focused on the medical profession and the program.

Popular newspapers also featured articles on the EMIC. The *New York Times* ran an article entitled, “Uncle Sam Looks After Babies” in the Women’s Activities section, in which journalist Beatrice Oppenheim followed the pregnancy of “Mrs. Private Jones.”⁵⁸⁵ Mrs. Jones was the wife of an Army private, who was training approximately “2,000 miles away” from the family’s residence in New York City and who received a “dependency allowance of \$50 a month.”⁵⁸⁶ Oppenheim explained Mrs. Jones’s options after she filed the EMIC application, which ranged from a consultant service to help her find a doctor or hospital to a six-week post-partum check-up.⁵⁸⁷ Other newspaper articles publicized the program and explained the impact EMIC made on maternal and infant health in various states. The *Coronado Eagle and Journal* (California) noted that the California State Department of Health started accepting EMIC cases in July 1943 and had to disband the program temporarily on September 16, 1943, because the state did not have the money to continue the program. By October 7, 1943, the state was waiting for new EMIC funds to uphold its responsibility to servicemen and their families.⁵⁸⁸ While

⁵⁸⁵ Beatrice Oppenheim, “Uncle Sam Looks After Babies,” *The New York Times*, October 3, 1943.

⁵⁸⁶ Ibid.

⁵⁸⁷ Ibid.

⁵⁸⁸ “Emergency Maternity and Infant Care is Resumed by State,” *Coronado Eagle and Journal*, October 7, 1943, 7.

the journals and newspapers publicized the new benefit for servicemen in the four lowest pay grades, the structure of the EMIC was rapidly changing.⁵⁸⁹

In July 1943, Congress extended funding for EMIC to operate during the 1944 fiscal year (July 1, 1943-June 30, 1944). According to a recurring CB article, “Safeguarding the Health of Mothers and Children,” by January 1944, the EMIC had already provided care for 130,000 women and infants.⁵⁹⁰ Some politicians considered expanded the service to even more military wives. Just a few months after the creation of the EMIC, some Congress members wanted to redefine who qualified for benefits under the program. Some wanted all enlisted men to have the ability to apply for maternal and infant care for their wives and infants, but the CB still saw the EMIC as a program with limited scope. In a memorandum to state health agencies, Chief Lenroot explained that the CB “had not requested the inclusion of the first to third pay grade,” which would allow the EMIC program to offer care to all enlisted men and their families.⁵⁹¹ Congress members argued that the CB’s program should help higher ranking enlisted men, whose wives and infants needed care. The CB had to prioritize men in the fourth through seventh pay grade, which comprised “93 percent of enlisted men.”⁵⁹² The CB believed

⁵⁸⁹ For other articles on the EMIC, see: Eleanor Roosevelt, “My Day: Maternity and Infant Care Available to Soldiers’ Families,” *The Washington Daily News*, May 4, 1943.

⁵⁹⁰ “Safeguarding the Health of Mothers and Children,” *The Child* 8, no. 7 (January 1944): 111.

⁵⁹¹ Chief, Children’s Bureau (Katharine Lenroot), memorandum to State Health Agencies, July 20, 1943, Record Group 102: Records of the Children’s Bureau, 1908-1969, Box 216: “Central File, 1941-44, 13-2-2-(0) to 13-2-4-0,” Folder: “13-2-2-1(0) Correspondence Unofficial Agencies to EMIC Program.” The National Archives at College Park.

⁵⁹² *Ibid.*

that men outside of these ranks were capable of paying for maternal and infant health care.

Representative Malcolm C. Tarver, a Democrat from Georgia and a member of the House Subcommittee on Labor Department and Federal Security Appropriations, addressed his concerns with the EMIC program. He explained that “the wives and children of those servicemen in higher grades do not have the family allowances which are given to servicemen of the four lower grades.”⁵⁹³ He further “assumed” that Congress believed that soldiers in the first three pay grades could afford care for their wives and children.⁵⁹⁴ Tarver presented different facts to Chief Lenroot and the entire subcommittee hearing. He briefly commented on the higher ranked enlisted men and their ability to obtain care for their families. Then he turned his attention to the Chief of the Bureau of Naval Personnel’s concerns for a higher paid serviceman, who did not provide for his wife and children.⁵⁹⁵ He hoped that Congress and the CB would consider providing maternal and infant health care services for higher ranking soldiers and seamen.

CB Chief Lenroot said that she “would not object to having the authority broadened.” She thought that the original EMIC program only covered the lowest four pay grades because “it was necessary to draw a line somewhere.”⁵⁹⁶ The 1944 legislation read that grants would be made for the “grants to States for emergency maternity and

⁵⁹³ United States Congress, House of Representatives, Subcommittee of the Committee on Appropriations, *Department of Labor-Federal Security Agency Appropriation Bill for 1944: Hearings before a Subcommittee of the Committee on Appropriations*, 78th Cong., 1st sess., 1943, 243.

⁵⁹⁴ Ibid.

⁵⁹⁵ Ibid.

⁵⁹⁶ Ibid., 243-244.

infant care (national defense)... to provide, in addition to similar services otherwise available, medical, nursing, and hospital maternity and infant care for wives and infants of enlisted men in the armed forces...”⁵⁹⁷ Congress allocated 4.4 million dollars for the EMIC program to provide care for all enlisted men’s wives’ maternal care and illness care for G.I. newborns under one years old.⁵⁹⁸ Sinia and Anderson clarified the CB’s position. They stated that the CB notified states about the change in the law, but noted that the CB would only accept “cases in the first three pay grade,” if a hardship existed.⁵⁹⁹ Although the law simply stated enlisted men, the program continued to only provide the benefit for soldiers in the fourth through seventh pay grades. A few months after the hearing and a couple weeks after the Department of Labor-Federal Security Appropriation Act of 1944 passed, Chief Lenroot wrote that the EMIC program covered men in the lowest four pay grades.⁶⁰⁰ Another CB correspondence claimed that the program would only provide care for top three pay grades soldiers’ wives and infants “when circumstances require.”⁶⁰¹ This created confusion because the program did not

⁵⁹⁷Labor-Federal Security Appropriation Act, 1944, Public Law 78-135, *U.S. Statutes at Large* 57 (1943): 497.

⁵⁹⁸ Ibid.

⁵⁹⁹ Nathan Sinia and Odin Anderson, *Emergency Maternity and Infant Care*, 66.

⁶⁰⁰ Katharine Lenroot, letter to Irene E. Murphy, July 24, 1943, Record Group 102: Records of the Children’s Bureau, 1908-1969, Box 216: “Central File, 1941-44, 13-2-2-(0) to 13-2-4-0,” Folder: “13-2-2-1(0) Correspondence Unofficial Agencies to EMIC Program.” The National Archives at College Park.

⁶⁰¹ Mary Taylor, letter to Ray Torr, July 31, 1943, Record Group 102: Records of the Children’s Bureau, 1908-1969, Box 216: “Central File, 1941-44, 13-2-2-(0) to 13-2-4-0,” Folder: “13-2-2-1(0) Correspondence Unofficial Agencies to EMIC Program.” The National Archives at College Park.

have a means test. Later legislation stated that the benefit was only for men in the lowest four pay grades.⁶⁰²

When Katharine Lenroot addressed the Senate’s Subcommittee of the Committee of Appropriation, she explained that each state or territory would manage their own EMIC program. She stated, “The plan is a state plan, and the state health agencies are responsible for developing the procedures under the plan.”⁶⁰³ Scholar Eden Goldman notes that state officials were concerned about federal control of maternal and infant health care policies and that the CB realized the EMIC had to operate at the “state and local level” because it was “politically essential.”⁶⁰⁴ Each state managed its own EMIC program that highlighted regional differences. For instance, in the South and other regions many hospitals remained segregated.⁶⁰⁵ The number of approved recipients also varied regionally. States with larger populations or many military bases received more funds for the EMIC program simply because the need was larger. The EMIC originally allotted thirty-five dollars for average maternal cases, but the CB raised this to a maximum cost of fifty dollars in December 1943.⁶⁰⁶ While the EMIC was a national maternal and infant health program, regional disparities affected the care that the women and infants received. The CB allowed states to manage the EMIC programs if they met

⁶⁰² Nathan Sinia and Odin Anderson, *Emergency Maternity and Infant Care*, 66.

⁶⁰³ *Ibid.*, 36.

⁶⁰⁴ Eden Goldman, “‘A Right to be Safely Born,’” 165-166.

⁶⁰⁵ For a southern example of an EMIC program, see: Thomas, *Deluxe Jim Crow*, 96-98.

⁶⁰⁶ Nathan Sinia and Odin Anderson, *Emergency Maternity and Infant Care*, 128.

the minimum standards.⁶⁰⁷ California, New York, and Mississippi operated EMIC plans that met the national standards, and each state had to overcome regional obstacles.

In California, the California Medical Association Committee on EMIC managed the program. The Director of the California State Department of Health, Wilton L. Halverson, believed the situation in California was particularly dire. He cited the extreme growth in population and dislocation of many families because of the war efforts.⁶⁰⁸ Many physicians opposed portions of the EMIC program and complained to the California Committee on EMIC. According to Dr. W. Benbow Thompson, the EMIC program managed “one birth in six” in California by August 1944.⁶⁰⁹ California military installations such as Camp Cooke and Camp Irwin made the state the second largest EMIC fund recipient. The doctors in California and other parts of the nation felt that the government was not fairly compensating doctors for their services. Dr. Karl L. Schaupp, the President of the California Medical Association (CMA), and Dr. George Kress, the Secretary of the CMA, warned doctors that if the physician signed Part II of an EMIC application, the doctor must “give the professional services stipulated for the money consideration also outlined.”⁶¹⁰ The most money a doctor could earn was fifty dollars for full maternal care that included antepartum, delivery, and postpartum care. In late 1944,

⁶⁰⁷ For standards, see: Eden Goldman, “A Right to be Born,” 167; Kriste Lindenmeyer, “A Right to Childhood,” 242, Ruth Fairbanks, “A Pregnancy Test,” 77, 79.

⁶⁰⁸ United States Congress, House of Representatives, Subcommittee of the Committee on Appropriations, *Department of Labor-Federal Security Agency Appropriation Bill for 1945: Hearings before a Subcommittee of the Committee on Appropriations*, 78th Cong., 2nd sess., 1944 ,563.

⁶⁰⁹ W. Benbow Thompson, “Emergency Maternity and Infant Care (E.M.I.C.) Program,” 72.

⁶¹⁰ “Item XXXI: Maternity-Pediatric, Important Letter from California Medical Association Council to California Medical Association Members,” *California and Western Medicine* 59, no. 5 (November 1943): 282.

complete maternity care in California averaged forty-three dollars and six cents.⁶¹¹ Although that was the average, many doctors charged more and were upset with the government for setting a ceiling on the fee. Furthermore, some doctors feared that the EMIC program might lead to socialized medicine.⁶¹² For decades, American physicians had fought against socialized medicine because it threatened their professional identity, and because they did not want the government to regulate the medical system.⁶¹³ Although many doctors disagreed with the EMIC program, California doctors cared for the second largest caseload in the country.

Dr. Thompson represented the CMA at a CB conference/meeting to voice discontent about the EMIC program in his state. At the CB meeting at Johns Hopkins Hospital, doctors came to discuss the EMIC programs with CB leaders. Thompson was among eleven other American obstetricians and seven Advisory Committee of the CB members. He reflected on the meeting and posited several criticisms about the EMIC programs. One of the obstetricians, Dr. Brackett, who represented Rhode Island, argued that the fifty-dollar limit for obstetric cases imposed by the CB hindered the quality of care for soldiers' wives and newborns. Brackett explained that the soldier's wife had to choose a doctor who charged fifty-dollars or less, which meant that women often did not

⁶¹¹ Nathan Sinia and Odin Anderson, *Emergency Maternity and Infant Care*, 84, 118.

⁶¹² "Item XXXIV: Maternity-Pediatric, Resolution Adopted by Placer-Nevada-Sierra County Medical Association," *California and Western Medicine* 59, no. 5 (November 1943): 283. The Placer-Nevada-Sierra County Medical Society worried that the EMIC would create socialized medicine in the United States.

⁶¹³ Paul Starr, *The Social Transformation of American Medicine*, 286-287; John Burnham, *Health Care in America*, 250, 257.

receive the best medical care and sometimes they received subpar care.⁶¹⁴ S. A. Cosgrove from New Jersey also had qualms with the fifty-dollar obstetric fee because cost varied due to location, professional level of physician, and “a whole host of other factors.”⁶¹⁵ Throughout the nation physicians criticized the CB and its policies, but the CMA Committee on Maternity-Pediatric Work was particularly adamant and provided an addendum to cite objections to the rate set by the CB.⁶¹⁶ The CMA requested that the CB change EMIC policies. The CMA also wanted patients, who were able, to pay additional fees for care to supplement EMIC payments. The CB disapproved “on the basis of the intent of Congress, availability of funds and impracticability of variations in fees.”⁶¹⁷ The Bureau also refused CMA’s appeal to reduce the minimum five prenatal visits for the fifty-dollar fee and additional fees for Caesarean sections.⁶¹⁸ The CMA made small victories by expanding the definition of consultants and changing wording to “allow any practitioner who does not customarily provide such care to refer the infant to a pediatrician.”⁶¹⁹ The debate in California was not only a local concern, but a national

⁶¹⁴ W. Benbow Thompson, “Emergency Maternity and Infant Care (E.M.I.C.) Program,” 73. For other critiques of the EMIC see: Joan Mulligan, “Three Federal Interventions on Behalf of Childbearing Women,” 75-80.

⁶¹⁵ W. Benbow Thompson, “Emergency Maternity and Infant Care (E.M.I.C.) Program,” 73.

⁶¹⁶ “Addendum,” *California and Western Medicine* 61, no. 3 (September 1944): 160-161. For more information on the national response from the American Academy of Pediatrics (AAP) to the EMIC, see: Lindenmeyer, ‘*A Right to Childhood*’, 244; Hoffman, *Health Care for Some*, 51.

⁶¹⁷ “Maternity-Pediatric-Item LVII, County Society Maternity-Pediatric Committees, Recent Rulings on E.M.I.C. on C.M.A. Suggestions,” *California and Western Medicine* 61, no. 3 (September 1944): 161.

⁶¹⁸ *Ibid.*, 160-161; Goldman, “A Right to be Born,” 168. At the national level many doctors criticized the “cased-based system” because they preferred “fee-for-service.”

⁶¹⁹ “Maternity-Pediatric-Item LVII, County Society Maternity-Pediatric Committees, Recent Rulings on E.M.I.C. on C.M.A. Suggestions,” 161.

concern of some physicians, who were accustomed to collecting more than fifty dollars for maternal care. The American Academy of Pediatric Committee on the EMIC Program argued that the Bureau was using “the guise of war effort or necessity arbitrarily [to] control medical practice, and which are in reality plans for the control of postwar medical practice.”⁶²⁰ Many physicians worried about the scope of the EMIC projects, but other doctors and public health personnel took advantage of the program.

When establishing a state EMIC program, states had to consider federal regulations. Congress claimed to guarantee three regulations for the EMIC program. First, the EMIC was to provide medical, hospital, and nursing care to the wives and infants of soldiers in the four lowest pay grades. The CB was not to give cash allowances for maternity and infant care cases because the individuals may not have used the money for its intended purpose. Secondly, Congress voted on a program that did not require a financial means test. This stipulation meant that all women of soldiers in the lowest four grades should qualify for the program. Lastly, the patient had “free choice of their physicians.”⁶²¹ Dr. Martha Eliot, the Associate Chief of the CB, explained that the Bureau established additional standards for EMIC to maintain a consistent national program. The CB determined that the Bureau would send appropriations to state and territorial public health agencies, which would pay hospitals and doctors for services and accommodations.⁶²² The doctor and the hospital that the woman chose had to meet the

⁶²⁰ Robert H. Bremner, ed., *Children and Youth in America*, 1260.

⁶²¹ Martha M. Eliot, “The EMIC Program for Wives and Infants of Enlisted Men,” 405.

⁶²² Ibid.

CB's qualifications and accept the set payment because patients were not allowed to pay for any service.⁶²³ The mother-to-be would forfeit her right to physician care under the EMIC, if she or someone else paid for her hospital care and vice versa.⁶²⁴ For instance, a woman's family may have wanted to pay for a private hospital room, but they could not because it would void her medical care. The program attempted to standardize care, and the guidelines were in place to avoid discrepancies. The care also included recommendations for public health nursing service and programs for "special needs of individual mothers and infants" such as care for mothers-to-be with comorbid conditions.⁶²⁵ When states applied for EMIC funds, the states had to abide by these standards set by Congress and the CB. Yet, in some states not all of these standards were met. For instance, in southern states African American women could not receive care in certain hospitals. The state public health agencies and states could set up additional regulations, but the states' programs had to meet Congress's and the CB's minimum standards.

After Congress passed the First Deficiency Appropriation Act of 1943, personnel in the Mississippi State Board of Health (MSBH) worked quickly to meet standards for the EMIC program. On April 3, 1943, State Board of Health Officer Felix J. Underwood wrote each doctor explaining the new program. Mississippi would receive its Fund E or the EMIC allotment in April 1943, and then the program would officially start in the

⁶²³ Ibid.

⁶²⁴ Ibid.

⁶²⁵ Ibid, 405-406.

state. Underwood knew that Mississippi's medical infrastructure could not initially support a statewide EMIC program. "The direction in which the program will be extended first, depends upon the areas in which need is greatest, therefore, we request you contact the Maternal and Child Health Director at once if your community presents a definite need for this assistance."⁶²⁶ He continued to outline the plan in Mississippi by noting that the program must follow federal regulations to guarantee EMIC appropriations.

The MSBH wanted the program to operate smoothly; therefore, the Board placed the EMIC administrative program under the Maternal and Child Health Division.⁶²⁷ A state, such as Mississippi, was only financially responsible for administrative cost of its EMIC program.⁶²⁸ A wife's application had to include her "husband's serial number," so the division could verify her husband's status and approve the patient's application. If approved she could receive care by a Mississippi-licensed physician.⁶²⁹ Once the division approved the application, the division reserved funds for full maternal care for that patient. Underwood made sure that doctors understood that they would only receive payment of thirty-five dollars for complete obstetric care, which included five prenatal exams, delivery, and post-natal care, if the Maternal and Child Health Division approved the application. The patient could only receive maternal or infant care in a hospital that

⁶²⁶ Felix J. Underwood, letter to each physician in Mississippi, April 3, 1943, 1-3, Series: 2012, Box: 8751, Folder: "(E.M.I.C.) Maternity," Mississippi Department of Archives and History.

⁶²⁷ *Ibid.*, 3.

⁶²⁸ Kriste Lindenmeyer, *"A Right to Childhood,"* 158.

⁶²⁹ Felix J. Underwood, letter to each physician in Mississippi, April 3, 1943, 2.

the State Board of Health determined met obstetric and infant care standards set by the federal government. If a hospital had prior approval by the American College of Surgeons, it met standards and the State Board did not need to reevaluate it.⁶³⁰ While the federal program allocated up to four dollars and a quarter a day for hospital care, a Mississippi hospital could only charge \$2.50 per day and an additional dollar per day per infant because of state legislation. Eventually, Mississippi hospitals received three dollars for maternity patients.⁶³¹ Underwood knew that the State Board of Health could not “directly furnish care” and relied heavily on local county health departments and Mississippi physicians to provide medical care for the wives and newborns of soldiers. He vowed that the Maternal and Child Health Division was only operating as an administrator of the EMIC program.⁶³²

At the same time that the EMIC program started, Mississippi’s population was in flux. Beginning three years before the EMIC passed, thousands of Mississippians registered for the draft and thousands more enlisted. From 1940 to 1946, approximately 267,000 of nearly 2,200,000 Mississippians joined a branch of the American military, including the National Guard, a division of the United States Army since 1933.⁶³³ The EMIC program started in 1943, and men in the lowest four grades qualified for EMIC for their partner and infant, if they were still enlisted. Most of the men who enlisted in the military were young single men ranging in age from eighteen to their mid-thirties. They

⁶³⁰ Ibid., 1-2.

⁶³¹ Nathan Sinia and Odin Anderson, *Emergency Maternity and Infant Care*, 141-142.

⁶³² Felix J. Underwood, letter to each physician in Mississippi, April 3, 1943, 1-2.

⁶³³ Westley Busbee, Jr. *Mississippi: A History* (Wheeling, Illinois: Harlan Davidson, Inc., 2005), 261.

primarily enlisted in a division of the Army. Of the approximately 234,836 Mississippians who joined the Army, 4,042 did not qualify for the EMIC benefits because they enlisted in the top three pay grades ranging from staff sergeant to master sergeant.⁶³⁴ Another 2,231 did not qualify because of their gender.⁶³⁵ Thousands of men would move up in the ranks, but the clear majority of men could still provide EMIC benefits for their pregnant wives. Unwed mothers did not qualify for maternity care, but the soldiers' newborns could receive care, if the soldier acknowledged the infant.⁶³⁶ The majority of the men who were likely to use this service were married men. In Mississippi approximately 37,375 white enlisted men in the lowest four pay grades and 24,327 "negro" enlisted men in the lowest four pay grades in a division of the Army and National Guard qualified for this care.⁶³⁷ While nearly 62,000 men could provide this benefit for their wives, thousands of the men's wives would not use the program for a number of reasons ranging from wartime service location of their husbands which made pregnancy unlikely for a couple or the couple did not want more children. Some

⁶³⁴ These statistics are from a database, the "Electronic Army Serial Number Merged File, ca. 1938-1946" based on information in Record Group 64: Records of the National Archives and Records Administration. To calculate soldiers from Mississippi and different pay grades at enlist, you must do an advance search with keywords such as "Mississippi" and "master sergeant." To view the database, see: "Electronic Army Serial Number Merged File, ca. 1938-1946," The National Archives, accessed November 2016, <https://aad.archives.gov/aad/fielded-search.jsp?dt=893&tf=F&cat=WR26&bc=,sl>.

⁶³⁵ Ibid.; Eden Goldman, "A Right to be Safely Born," 163-164, 166-167. 4,042 women from Mississippi served in the Army during the World War II era. Only five were in the top three pay grades. They are also included in the previous number of soldiers that did not qualify because of their rank. Pregnancy in the military was discouraged because it would lead to discharge. Goldman reported that women did not qualify for the EMIC program and the program upheld traditional gender norms.

⁶³⁶ Eden Goldman, "A Right to be Safely Born," 163. For more information on unwed mothers and the EMIC, see: Regina Markell Morantz, Cynthia Stodola Promerleau, and Carol Hansen Fenichel, eds., *In Her Own Words: Oral Histories of Women Physicians* (Westport: Greenwood Press, 1982), 110.

⁶³⁷ "Electronic Army Serial Number Merged Files, ca. 1938-1946."

Mississippi women would also apply for EMIC care in a different state because they travelled with their husband. Some transient wives from Mississippi still applied for EMIC care in their home state.⁶³⁸ From 1943 to 1946, Mississippi's EMIC program was responsible for the care of over 22,333 patients.⁶³⁹ The overwhelming majority of the patients received maternal care.

Some of the maternity patients from Mississippi's EMIC program were women from other states. The state was home to Camp Shelby, which at its World War II peak had 75,000 military personnel living and serving in Forrest and Perry Counties. Keesler Field, an airfield for the Army Air Force located in Harrison County near Biloxi, hosted approximately 69,000 military members.⁶⁴⁰ The Mississippi EMIC program personnel reported that from April 1943 to October 1, 1943, the Division of Maternal and Child Health received fifty-nine applications from the Camp Shelby area and sixty-one EMIC requests in Harrison County. The county with the most applications was Lauderdale County, with 135 requests for care. Meridian, the county's seat, was home to Key Field, an airfield, and historically was a critical junction in Mississippi's railroad system.⁶⁴¹

⁶³⁸ "Mississippi Emergency in Maternal and Infant Care Program, Applications as of July 15, 1944," Series: 2012, Box: 8751, Folder: "(E.M.I.C.) Maternity," Mississippi Department of Archives and History. This map list out of state applications for care.

⁶³⁹ Martha Eliot and Lillian Freedman, "Four Years of the EMIC Program," 629. As of November 30, 1946, the Mississippi EMIC program managed 23,333 cases.

⁶⁴⁰ Westley Busbee, *Mississippi*, 261.

⁶⁴¹ Dennis H. Mitchell, *Mississippi: A New History* (Oxford: University of Mississippi Press, 2014), 237-238, 358. During the last half of the nineteenth century, Meridian's railroad infrastructure grew and the city remained a hub for the state into the twentieth century. During the war Meridian was the states' "largest urban center."

By the end of 1943 and 1944, the Division of Maternal and Child Health standardized its EMIC program. The CB had informed the Mississippi State Board of Health that EMIC services for “crippled” infants should remain under the Mississippi’s Crippled Children’s Service.⁶⁴² In addition, the State Board of Health sponsored a Maternal and Child Health Education Orientation Course from June 5, 1944, to June 17, 1944, that included lectures about how to approach patients when discussing pregnancy and children’s health. Dr. Underwood explained current issues in Mississippi maternal health while Dr. Virginia Howard, the Director of the Division of Maternal and Child Health, and other public health officials discussed the importance of maternal and infant health conferences.⁶⁴³ During the same year, State Board of Health personnel decided which hospitals were suitable to provide EMIC maternal and pediatric care. The American College of Surgeons or the Mississippi State Hospital Association approved hospitals for the EMIC program.⁶⁴⁴ An inspector determined if the hospital had a window in maternity wards, rooms, and nursery. The hospital had to have adequate heating, and the evaluator determined whether maternal and pediatric patients were “separated from the wards or rooms in which patients with communicable disease or septic conditions”

⁶⁴² “Budget Bureau No. 44-4348,” November 12, 1943, Series: 2012, Box: 8751, Folder: “(E.M.I.C.) Maternity,” Mississippi Department of Archives and History.

⁶⁴³ “Maternal and Child Health Education Orientation Course, Mississippi State Board of Health,” June 5-17, 1944, 1-6, Series: 2012, Box: 8751, Folder: “(E.M.I.C.) Maternity,” Mississippi Department of Archives and History. For EMIC and training, see: Sinia and Anderson, *Emergency Maternity and Infant Care*, 100, 138.

⁶⁴⁴ “Medical and Hospital Obstetric and Pediatric Care for Wives and Infants of Men in Military Service,” 3, Series: 2012, Box: 8751, Folder: “(E.M.I.C.) Maternity,” Mississippi Department of Archives and History.

were housed.⁶⁴⁵ Wards were also to have at least sixty to eighty square feet of space per patient. Furthermore, the inspector evaluated water availability, delivery rooms, laboratory technologies, and administrative capabilities for recording births.⁶⁴⁶ If a hospital had “separate maternity services for white and Negro patients” the inspector would assess each ward separately. Hospitals in Mississippi were still able to operate in a segregated capacity, but they had to meet the national standards, such as a bassinet for each baby.⁶⁴⁷ By September 13, 1944, one-hundred and one Mississippi hospitals met the CB and state standards and participated in the EMIC program. Some hospitals, like two Greenville hospitals, the Colored King’s Daughters Hospital and Dr. Willis Walley’s Hospital, only treated African American patients. Others, such as King’s Daughters Hospital in Greenville, only cared for white patients. A third type of hospital treated both white and African American patients in segregated facilities. The Camp Shelby Station Hospital, which treated patients according to Mississippi’s custom, segregated them.⁶⁴⁸ In 1944, Mississippi’s EMIC program operated at full capacity by approving maternity cases in every county.⁶⁴⁹

⁶⁴⁵ “Check List for Use in Giving Provisional Approval to Hospitals for Maternity Care,” MCH 21-1 to MCH 21-5, Series: 2012, Box: 8751, Folder: “(E.M.I.C.) Maternity,” Mississippi Department of Archives and History.

⁶⁴⁶ Ibid.

⁶⁴⁷ For more on national standards see, Goldman, “‘A Right to be Safely Born’,” 167.

⁶⁴⁸ “Hospitals Participating in Mississippi Emergency Maternity and Infant Care Program, September 13, 1944,” Series: 2012, Box: 8751, Folder: “(E.M.I.C.) Maternity,” Mississippi Department of Archives and History; Sanders Marble, “‘Separate, But Almost Equal’: The Army’s Negro Medical Field Units in World War II,” *Journal of the National Medical Association* 104, no. 1&2 (January/February 2012): 97.

⁶⁴⁹ “Mississippi Emergency in Maternal and Infant Care Program, Applications as of July 15, 1944,” Series: 2012, Box: 8751, Folder: “(E.M.I.C.) Maternity,” Mississippi Department of Archives and History.

HOSPITALS PARTICIPATING IN MISSISSIPPI EMERGENCY
MATERNITY AND INFANT CARE PROGRAM, SEPTEMBER 13, 1944

NORTHEAST

Aberdeen Hospital, Aberdeen
 Baldwin Hospital, Baldwin
 Bramlett Hospital, Oxford
 Calhoun County Hospital, Erwin
 City Hospital, Okolona
 Columbus Hospital, Columbus
 Corinth Hospital, Corinth
 Foster Hospital, Columbus
 Flowers Hospital, West Point
 Gilmore Sanitarium, Amory
 Houston Hospital, Houston
 Louisville Hospital, Louisville
 McKee Hospital, Corinth
 Mason Hospital, Mason
 Mayer Hospital, New Albany
 Mansford Jones Memorial Hospital,
 Hattiesburg
 New Albany Hospital, New Albany
 North East Miss. Hospital, Hoozerville
 North Miss. Community Hospital, Tupelo
 Oxford Hospital, Oxford
 Pearson & Wilson Clinic, Louisville
 Philadelphia Hospital, Inc.,
 Philadelphia
 Pentateo Clinic, Pentateo
 Tate's Clinic, Ripley
 Water Valley Hospital, Water Valley
 Winona Infirmary, Winona
 W. D. Franklin's Clinic, Walnut Grove
 Yates Hospital, Philadelphia

SOUTHWEST

Dr. Deuchman's Clinic, Magnolia
 Brandon Hospital, Brandon
 Catching's Clinic, Woodville
 Columbia Clinic Hospital, Columbia
 Galy Hospital, Columbia
 Field Memorial Hospital, Centerville
 Foster General Hospital, Jackson
 King's Daughters Hospital, Brookhaven
 McComb City Hospital, McComb
 Magee General Hospital, Magee
 Marlan Butler Memorial Clinic, Liberty
 Mercy Hospital, Street Memorial,
 Vicksburg
 Miss. State Sanatorium, Somborium
 Natchez Charity Hospital, Natchez
 Natchez Sanatorium, Natchez
 Mrs. A. S. Horton's Maternity Home
 Natchez
 Pincus's Emergency Hospital (col.),
 Vicksburg
 Sallie Harris Clinic, Jackson
 Tylertown Hospital, Tylertown
 Vicksburg Hospital, Vicksburg
 Vicksburg Infirmary, Vicksburg
 Dr. Willie Walker's Hospital (col.) Jackson
 Whitall Hospital, Tylertown

NORTHWEST

Altoona Hospital, Yazoo City
 W. H. Brock's Clinic, Sardis
 City Hospital, Cleveland
 Clarkedale Hospital, Clarkedale
 Colored King's Daughters Hospital, Green-
 vills
 Greenwood Colored Hospital, Greenwood
 Greenwood Leflore Hospital, Greenwood
 Granada General Hospital, Granada
 Holmes County Community Hospital, Lexington
 King's Daughters Hospital, Greenville
 King's Daughters Hospital, Canton
 King's Daughters Hospital, Indianola
 King's Daughters Hospital, Yazoo City
 Lambert Hospital, Lambert
 Marie Hospital, Marks
 Pamela Clinic, Panama
 Dr. W. C. Fack's Clinic, Cary
 Rosedale Bolivar County Hospital, Rosedale
 Sarah Williams Nursing Home, Greenville
 Tabernah Hospital (col.), Mount Bayou
 Tallahatchie Hospital, Charleston
 Yazoo Clinic & Hospital, (col.) Yazoo City

SOUTHEAST

Anderson Infirmary, Meridian
 Army Air Force Regional Hospital, Biloxi
 Dr. Snak's Clinic, Ellisville
 Seagr Clinic, Laurel
 City Hospital, Lumberton
 City and County Hospital, Gulfport
 Gulfport General Hospital, Gulfport
 Jackson County Hospital, Pascagoula
 King's Daughters & Sons Hospital, Bay
 St. Louis
 Laird Hospital, Union
 Lewis Hospital, Meridian
 McIlwain Clinic, Wagnersboro
 Martin Sanatorium, Piquette
 Meridian Sanatorium, Meridian
 New Biloxi Hospital, Biloxi
 Newton Infirmary, Newton
 Oatis Clinic, Laurel
 Folk's Clinic, Purvis
 Poplarville Hospital, Poplarville
 Fisher's Clinic, Sosa
 Rush's Infirmary, Meridian
 Scott County Hospital, Hattiesburg
 South Miss. Charity Hospital, Laurel
 South Miss. Infirmary, Hattiesburg
 Stanton Hospital, Corp Shelby
 Statum Hospital, Gulfport Field
 Watkins Memorial Hospital, Quitman
 Wagnersboro Clinic, Wagnersboro

Figure 5.1 The MSBH approved these hospitals for the EMIC program. Some of the hospitals were completely segregated.

“Hospitals Participating in Mississippi Emergency Maternity and Infant Care Program, September 13, 1944,” Series: 2012, Box: 8751, Folder: “(E.M.I.C.) Maternity,” Mississippi Department of Archives and History.

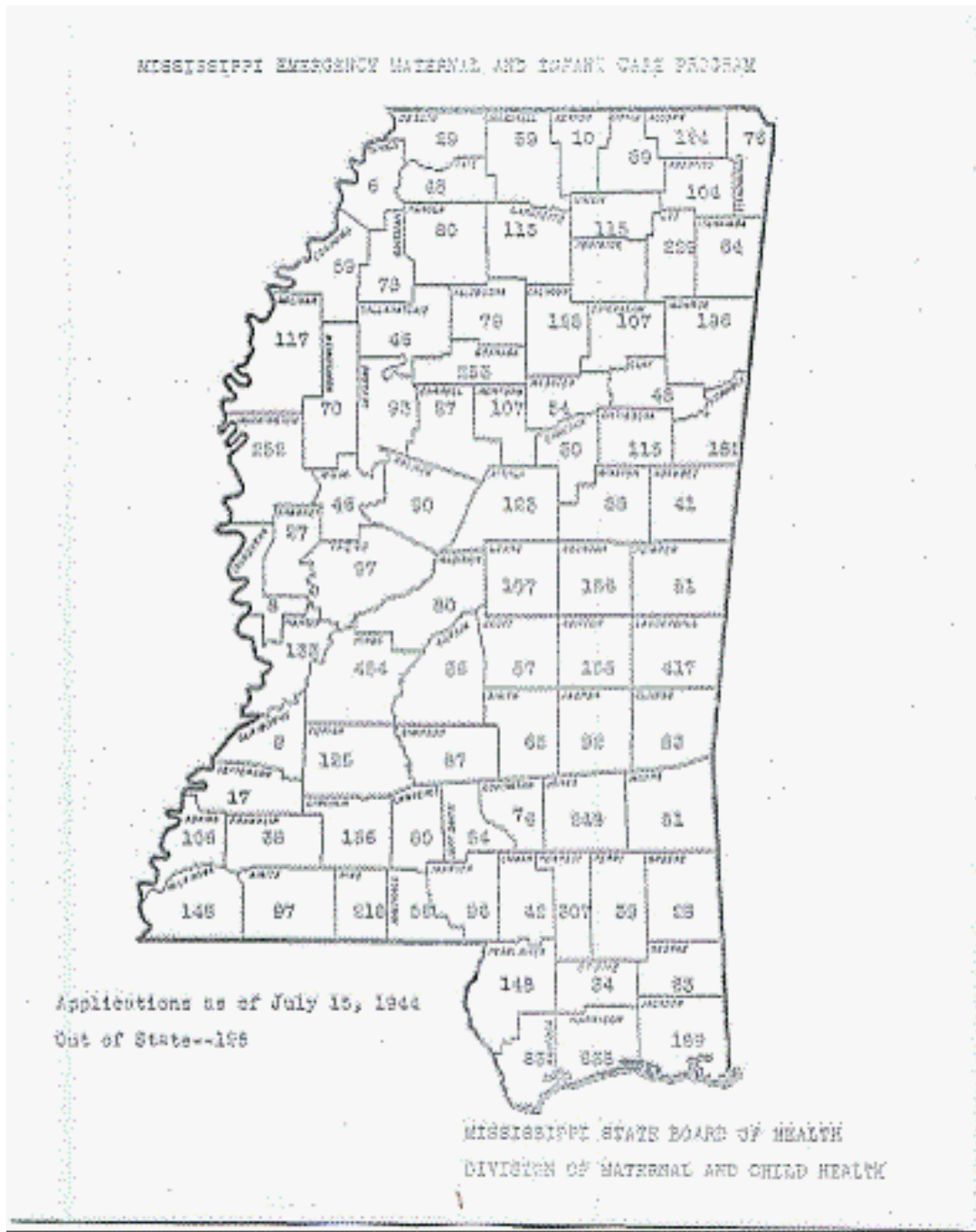


Figure 5.2 This map tracked the number of EMIC applications per Mississippi county as of July 15, 1944.

“Mississippi Emergency in Maternal and Infant Care Program, Applications as of July 15, 1944,” Series: 2012, Box: 8751, Folder: “(E.M.I.C.) Maternity,” Mississippi Department of Archives and History.

To better understand the effectiveness of the EMIC on maternity care in Mississippi, public health officials produced a statistical study of 5,516 EMIC births from 1944.⁶⁵⁰ During 1944, 58,861 deliveries occurred in Mississippi with a total of 56,899 live births. The EMIC program was responsible for a little less than ten percent, or 5,351 total births with 5,259 live births, which was slightly lower than the national rate. Dr. Underwood stated that most Mississippi births occurred at home and that over 23,000 women gave birth with the assistance of a midwife. He further noted, “Under the Emergency Maternity and Infant Care Program hospital deliveries occurred in 72.2 per cent of births, whereas in Mississippi the percent of hospital births was 32.5 percent.”⁶⁵¹ While these statistics attest to the shift toward hospital birth at the national level, Mississippi remained far below the national average.⁶⁵² Even so, it was the highest rate of Mississippi hospital births to date.

⁶⁵⁰ “Mississippi Emergency Maternal & Infant Care Program: A Statistical Study of 5516 Deliveries,” Series: 2012, Box: 8751, Folder: “(E.M.I.C.) Maternity,” Mississippi Department of Archives and History. “Approximately 8,000 wives applied for care, but only 5,516 delivered under the EMIC.

⁶⁵¹ Ibid.

⁶⁵² For a comparison of all states and territories participating in the EMIC, see: Martha Eliot and Lillian Freedman, “Four Years of the EMIC Program,” 627.

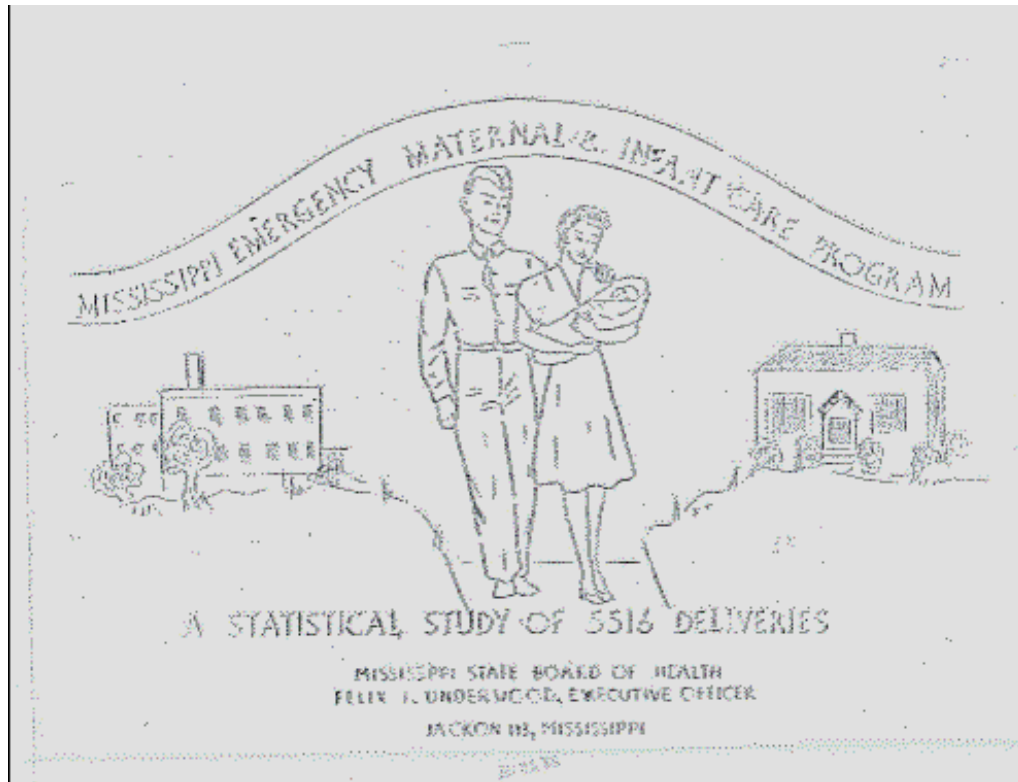


Figure 5.3 The MSBH studied the EMIC program in an attempt to improve maternal and infant healthcare throughout the state.

“Mississippi Emergency Maternal & Infant Care Program: A Statistical Study of 5516 Deliveries,” Series: 2012, Box: 8751, Folder: “(E.M.I.C.) Maternity,” Mississippi Department of Archives and History.

The “average” Mississippi EMIC patient was a white woman who lived in a rural community with less than 2500 people. She was between twenty and twenty-four years

old and pregnant with her first child.⁶⁵³ Her husband was serving in a branch of the United States armed forces, and he was in the lowest four pay grades. Her husband learned about the EMIC program when he received his pay envelope, which included an EMIC flyer. The program gave him the ability to provide for his wife and infant when he was serving his country.⁶⁵⁴ When his wife found out she was pregnant she could apply for the EMIC at her local health department or obtain the paperwork from her physician.⁶⁵⁵ She most likely applied for the EMIC program before the end of her fourth month in order to receive prenatal care.⁶⁵⁶ Most white rural women received four to more than eight doctor visits during the antepartum period. Doctors attended forty percent of these women more than eight times.⁶⁵⁷ During these visits, while she had a syphilis blood test, urinalyses, and blood pressure readings, she was less likely than her non-white

⁶⁵³ The Mississippi State Board of Health divided the Area into four categories: Urban Cities of 25,000 to 100,000 (314 deliveries), Urban Cities of 10,000 to 25,000 (920 deliveries), Urban Cities of 2,500 to 10,000 (843 deliveries), and Rural Areas with less than 2,500 (2053 deliveries). Overall, all urban areas totaled 2,077 births compared to 2,053 deliveries in rural areas. Yet, this analysis will reconstruct a patient's experience of a rural Mississippi EMIC patient because more births occurred in this fourth category. This evaluation is based on statistical data and does not represent one patient's exact experience. "Mississippi Emergency Maternal & Infant Care Program: A Statistical Study of 5516 Deliveries," Table 1. Deliveries by Person in Attendance, by Race, Urban and Rural, Table 2. Deliveries by Age of Mother, by Race, and by Outcome of Gestation; Urban and Rural, Series: 2012, Box: 8751, Folder: "(E.M.I.C.) Maternity," Mississippi Department of Archives and History.

⁶⁵⁴ "First Lady Points to Maternity Care," *The New York Times*, May 16, 1944; Lindenmeyer, 'A Right to Childhood,' 241-242; Fairbanks, "The Pregnancy Test," 76, 81; Hoffman, *Health Care for Some*, 50. The first EMIC payday flyer appeared in August 1943 pay envelopes.

⁶⁵⁵ "Medical and Hospital Obstetric and Pediatric Care for Wives and Infants of Men in Military Service," 3.

⁶⁵⁶ "Mississippi Emergency Maternal & Infant Care Program: A Statistical Study of 5516 Deliveries," Table 11. Maternity Cased by Month of Pregnancy in which Application for Care was made; by Race; Urban and Rural, Series: 2012, Box: 8751, Folder: "(E.M.I.C.) Maternity," Mississippi Department of Archives and History.

⁶⁵⁷ "Mississippi Emergency Maternal & Infant Care Program: A Statistical Study of 5516 Deliveries," Table 13. Maternity Cases by Physician's Antepartum and Postpartum Visits, by Race; Urban and Rural.

counterpart to receive a syphilis test.⁶⁵⁸ The local health department invited her to a hygiene or a wellness clinic. For instance, in Harrison County, the county health department invited EMIC patients to attend maternity classes that were taught by two nurses.⁶⁵⁹ EMIC patients attended these conferences and received antepartum care to prepare for delivery and motherhood.

When Mrs. G.I. Joe reached full term in her pregnancy, she would go into labor. Unlike the majority of Mississippi mothers-to-be, she would travel to a local hospital to deliver her baby under a physician's care.⁶⁶⁰ Most EMIC women of this age throughout the state had spontaneous births, but a high number of women had "other operative" deliveries, which were not forceps or caesarean delivery.⁶⁶¹ The other procedure could suggest an episiotomy. Mrs. G.I. Joe likely had no complications at all and less than ten percent of white women of this age had any medical difficulty.⁶⁶² She had a single birth, and there was almost a fifty percent chance on the gender. The reports showed that rural women gave birth slightly more often to males than females.⁶⁶³ G.I. Joe, Jr. was healthy

⁶⁵⁸ Ibid., Table 14. Maternity Causes by Physician's Antepartum Examinations (Tests), by Race: Urban and Rural.

⁶⁵⁹ "Harrison-Survey of Harrison County Health Department, 1945," 49, Series: 1863, Box: 8405, Folder: "(County Files: Harrison-Survey of Harrison County Health Department, 1945," Mississippi Department of Archives and History.

⁶⁶⁰ "Mississippi Emergency Maternal & Infant Care Program: A Statistical Study of 5516 Deliveries."

⁶⁶¹ Ibid., Table 3. Deliveries by Age of Mother, by Race, and by Type of Delivery.

⁶⁶² Ibid., Table 3, Table 4. Deliveries by Age of Mother, by Race, and by Complications of Pregnancy, Childbirth and Puerperium. The status of 371 deliveries were not reported, so percentage of complications could be slightly higher or lower.

⁶⁶³ Ibid., Table 7. Stillbirths by Sex of Child, Age of Mother, and Race; Urban and Rural.

and weighed between seven and nine pounds.⁶⁶⁴ The mother recuperated in the hospital in a semi-private room at a segregated hospital for approximately eight or nine days.⁶⁶⁵ The vast majority of mothers recovered at the hospital between five and fourteen days.⁶⁶⁶ After she left the hospital, the doctor would follow-up the delivery with postpartum care. Approximately 3,289 white EMIC women received postpartum care for six weeks.⁶⁶⁷ A doctor would only receive the full thirty-five-dollar obstetric set Mississippi fee, if he completed “at least five prenatal examinations; delivery and care through the puerperium (including care of the newborn), and postpartum care for six weeks.”⁶⁶⁸ After postpartum care was complete, a woman’s EMIC care was complete, but her newborn could receive care until he or she reached one-year-old.

In Mississippi, “non-white” EMIC patients experienced similarities and differences in care. “Non-white” women, mostly African American, accounted for 1,385, or approximately twenty-five percent, of Mississippi EMIC births.⁶⁶⁹ The average African American EMIC patient also lived in a rural setting and was twenty to twenty-

⁶⁶⁴ Ibid., Table 8. Births by Condition of Child at Birth, Age of Mother, and Race, Table 10. Live Births by Weight at Birth, Order of Birth, and Race.

⁶⁶⁵ Ibid., 1.

⁶⁶⁶ Ibid., Table 12. Maternity Cases by Number of Hospital Days, by Race; Urban or Rural.

⁶⁶⁷ Ibid., Table 13.

⁶⁶⁸ “Medical and Hospital Obstetric and Pediatric Care for Wives and Infants of Men in Military Service,” 4.

⁶⁶⁹ “Mississippi Emergency Maternal & Infant Care Program: A Statistical Study of 5516 Deliveries,” Table 1; Mississippi State Department of Health, “Mississippi Vital Statistics,” PDF, 161, accessed November 2016, http://msdh.ms.gov/msdhsite/_static/resources/3010.pdf. In 1944, 56,586 live births occurred in Mississippi. Non-white births account for 30,939 or nearly fifty-five percent of 1944 Mississippi births. This highlights that the MS EMIC program was skewed toward white patients.

four years old when she had a spontaneous delivery.⁶⁷⁰ Instead of waiting, she applied for care before the end of her first trimester, which was a month quicker than her average white counterpart. Over half of non-white EMIC patients applied for care by the end of the third month of pregnancy.⁶⁷¹ During antepartum care, the African American mother-to-be was tested for syphilis, a disease that had racial connotations at the time.⁶⁷² Yet, her hemoglobin was not tested; therefore, she did not know if she suffered from anemia.⁶⁷³ When she delivered, she frequently did not have complications, but at least 61 of 591 non-white twenty to twenty-four year old women experienced complications ranging from toxemias to hemorrhages.⁶⁷⁴ Unlike white EMIC patients, she gave birth at home or at a relative's house. Only 547 non-white EMIC patients of the 1,385 received care in a hospital. Even so, this rate of thirty-two and a half percent non-white hospital births was higher than non-white non-EMIC births.⁶⁷⁵ Physicians treated EMIC patients rather than midwives, which was another significant difference in care.⁶⁷⁶ Black patients were at

⁶⁷⁰ Ibid, Table 1, Table 2, Table 3. 591 non-white women were age twenty to twenty-four.

⁶⁷¹ Ibid., Table 11.

⁶⁷² For more on African Americans and syphilis, see: James Jones, *Bad Blood: The Tuskegee Syphilis Experiment* (New York: The Free Press, 1993); Susan Reverby, *Examining Tuskegee: The Infamous Syphilis Study and Its Legacy* (Chapel Hill: The University of North Carolina Press, 2009).

⁶⁷³ "Mississippi Emergency Maternal & Infant Care Program: A Statistical Study of 5516 Deliveries," Table 14.

⁶⁷⁴ Ibid., Table 4.

⁶⁷⁵ Ibid., Table 1.

⁶⁷⁶ "Mississippi Emergency Maternal & Infant Care Program: A Statistical Study of 5516 Deliveries;" Eden Goldman, "'A Right to be Born,'" 172. Goldman claimed that the EMIC did not "compensate midwife-supervised home deliveries, though it did pay for doctor-attended home-births in communities where no EMIC-approved or EMIC-accepting hospitals existed." Yet, in Mississippi midwives attended thirty-nine EMIC cases in 1944. Some women also chose home births even in areas near hospitals.

higher risk of stillbirths, which accounted for about thirty-five percent or thirty-six stillborn of 102 total stillbirths. This rate was high considering African American women only represented twenty-five percent of the patients.⁶⁷⁷ After she recovered, a physician made a postpartum visit. Over 1,270 non-whites had postpartum visits to check both the mothers' and the newborns' health.⁶⁷⁸ These women's infants also had access to care for one year under the EMIC.



Figure 5.4 African American enlisted man with wife and newborn, who benefited from the EMIC program.

Photo accessed from the Administration for Children and Families of the United States Department of Health and Human Services, accessed 2017, https://cb100.acf.hhs.gov/cb_eBrochure_EmergencyCare; original photo available at National Archives and Records Administration.

⁶⁷⁷ "Mississippi Emergency Maternal & Infant Care Program: A Statistical Study of 5516," Table 8.

⁶⁷⁸ Ibid., Table 13.

Mississippi EMIC provided care for newborns who needed medical attention, but at a much lower rate than maternal care. Dr. Virginia Howard explained that the EMIC would not provide “routine well-baby care and immunizations.”⁶⁷⁹ Mississippi counties’ departments of health already hosted well-baby and vaccination clinics throughout the year. A press release from the State Board of Health explained that in some cases both mothers and infants were rejected because “these cases are cared for by various other agencies, such as the American Red Cross, the Army Emergency Relief, Navy Relief, Family Service, Department of Public Welfare, Crippled Children’s Service, the USO, YWCA, Travelers’ Aid, and many others too numerous to mention.”⁶⁸⁰ By September 1944, the CB determined that newborns should receive care “for their first year of life instead of a new authorization every three weeks...” This would include illness care and immunizations.⁶⁸¹ The Mississippi EMIC program would pay for “sick-baby care,” if a private physician filed an application.⁶⁸² Mississippi EMIC paid doctors two dollars to treat sick infants before November 1944 and two dollars and fifty cents thereafter.⁶⁸³

⁶⁷⁹ Dr. Virginia Howard, letter to Miss Williams, September 15, 1944, Series: 2012, Box: 8751, Folder: “(E.M.I.C.) Maternity,” Mississippi Department of Archives and History.

⁶⁸⁰ “For Immediate Release,” July 29, 1944 Series: 2012, Box: 8751, Folder: “(E.M.I.C.) Maternity,” Mississippi Department of Archives and History.

⁶⁸¹ Nathan Sinia and Odin Anderson, *Emergency Maternity and Infant Care*, 71.

⁶⁸² Dr. Virginia Howard, letter to Miss Williams, September 15, 1944.

⁶⁸³ Dr. Virginia Howard, letter to Doctor, Subject: Increases in Rates of Payment under the Mississippi Emergency Maternity and Infant Care Program, October 1944, Series: 2012, Box: 8751, Folder: “(E.M.I.C.) Maternity,” Mississippi Department of Archives and History.

Infants received treatment for a range of issues from communicable disease care to surgeries. On the national level, approximately fifteen percent of cases were related to infant healthcare.⁶⁸⁴ The vast majority of EMIC cases in Mississippi were maternity cases, but the records were skewed. The statistical data produced by the Division of Maternal and Child Health focused on the mother and not the child.

According to the State Board of Health, the end of the war led to “some reduction” in the EMIC program.⁶⁸⁵ In 1946, “only 2,956 deliveries were authorized at the request of private physicians.”⁶⁸⁶ The program operated in a smaller capacity than it had in 1944 and 1945. On May 21, 1947, Dr. Lucille J. Marsh, the Regional Medical Director of the Social Security Administration, wrote to Dr. Underwood and Dr. Howard to discuss the program’s end. Although Congress had not officially ended the program, she noted that the EMIC was “drawing to a close.”⁶⁸⁷ After the program ended, soldiers’ wives and infants could no longer choose private physicians. They would have to rely on Navy and Army hospitals. Naval hospitals provided care when possible and charged

⁶⁸⁴Martha Eliot and Lillian Freedman, “Four Years of the EMIC Program,” 629.

⁶⁸⁵ “Mississippi State Board of Health Report of Activities, June 19, 1946, Series: 2080, Box: 8708, Folder: “Report of Activities State Board of Health, June 19, 1946,” Mississippi Department of Archives and History.

⁶⁸⁶ “Mississippi State Board of Health Report of Activities, June 25, 1947, Series: 2080, Box: 8708, Folder: “Report of Activities State Board of Health, June 25, 1947,” Mississippi Department of Archives and History.

⁶⁸⁷ Dr. Lucille J. Marsh, to Dr. Felix J. Underwood, May 21, 1947, Series: 2012, Box: 8751, Folder: “(E.M.I.C.) Maternity,” Mississippi Department of Archives and History. See: United States Congress, Senate, Subcommittee of the Committee on Appropriations, *Labor-Federal Security Appropriation Bill for 1947: Hearings before a Subcommittee of the Committee on Appropriations*, 79th Cong., 2nd sess., 1946, 60-62. The EMIC was to remain a program until the wartime emergency was over. The CB also requested funds for studying the program.

approximately one dollar and seventy-five cents a day for maternal care. Army hospitals, on the other hand, would only take “a specified number per month” for approximately one dollar and thirty-five cents.⁶⁸⁸ The government would not care for soldiers’ wives in civilian hospitals.⁶⁸⁹ EMIC programs stopped approving maternity cases on June 30, 1947, but the EMIC program continued to operate until June 30, 1949. This allowed for maternity care and a full year of infant care.⁶⁹⁰ Although the program closed throughout the United States, many states like Mississippi saw positive improvements in maternal and infant health that lasted after EMIC shut its doors.

By July 1, 1947, Mississippi EMIC managed 25,200 maternity and infant cases.⁶⁹¹ Mississippi’s EMIC program was middle of the range in terms of patient acceptance. Despite its positive contribution to the overall health of military personnel dependents, its influence on maternal health care did not go unchallenged.⁶⁹² Dr. Martha Eliot and Lillian Freedman noted, “In Mississippi we have a striking example of the effect of the program in raising the number of hospital deliveries; in 1944 in the State approximately 30 per cent of the total births took place in hospitals, and almost 70 per cent at home.”⁶⁹³ The

⁶⁸⁸ Ibid.

⁶⁸⁹ Ibid.

⁶⁹⁰ “Part 204- Emergency Maternity and Infant Care Service,” *The Code of Federal Regulations of the United States of America*, title 42 (Washington, D.C.: United States Government Printing Office, 1949), 270.

⁶⁹¹ Felix Joel Underwood and Richard Noble Whitfield, *Public Health and Medical Licensure in the State of Mississippi, 1939-1947, Volume II* (Jackson: Mississippi State Board of Health, 1950), 305. For information on other EMIC program caseloads, see: Eliot and Freedman, “Four Years of the EMIC Program,”⁶²⁹.

⁶⁹² Martha Eliot and Lillian Freedman, “Four Years of the EMIC Program,”⁶²⁹.

⁶⁹³ Ibid., 626.

CB officials continued, “Under the EMIC program the situation was reversed.”⁶⁹⁴ The program moved Mississippi toward the national trend of hospital births. The State Board of Health recognized Mississippi’s need for more hospitals with higher standards. According to the State Board of Health’s bi-annual report, the Division of Maternal and Child Health personnel argued that if the Hill-Burton Bill passed, the Division would have to plan for maternity, newborn, and pediatric facilities and care in the new hospitals built from the Hill-Burton appropriations.⁶⁹⁵ The Division wanted to produce “ideal plans” for these new hospitals.⁶⁹⁶ In addition, beginning in the post-EMIC period, the Mississippi State Legislature required an inspection program for all hospitals that received state funding.⁶⁹⁷ Inspections were a part of the EMIC that carried over into the post-war. The State Board of Health praised the program as the “most accurate study of rural obstetric available in recent years.”⁶⁹⁸ Finally, the Board attributed low mortality rates to the EMIC program.⁶⁹⁹ In 1940, the Mississippi maternal death rate was approximately six and a quarter deaths per 1,000 live births.⁷⁰⁰ The 1944 Mississippi

⁶⁹⁴ Ibid.

⁶⁹⁵ “Mississippi State Board of Health Report of Activities, June 19, 1946, Series: 2080, Box: 8708, Folder: “Report of Activities State Board of Health, June 19, 1946,” Mississippi Department of Archives and History. The Hill Burton Act or the Hospital Survey and Construction Act did pass, which provide appropriation for the construction of new hospitals. For more information on the Hill-Burton Act, see: Thomas, *Deluxe Jim Crow*, 157-207.

⁶⁹⁶ Ibid.

⁶⁹⁷ Ibid.

⁶⁹⁸ “Mississippi State Board of Health Report, December 12, 1946,” 47, Series: 2080, Box: 8708, Folder: “Mississippi State Board of Health Report, December 12, 1946,” Mississippi Department of Archives and History.

⁶⁹⁹ Felix Joel Underwood and Richard Noble Whitfield, *Public Health and Medical Licensure in the State of Mississippi, 1939-1947, Volume II* (Jackson: Mississippi State Board of Health, 1950), 304-305.

⁷⁰⁰ Mississippi State Department of Health, “Mississippi Vital Statistics,” PDF, 165-166.

maternal death rate was four deaths per 1,000 live births, while the EMIC maternal death rate was one and a half deaths per 1,000 live births.⁷⁰¹ Other southern states also saw lower maternity mortality rates. For instance, between 1944 and 1946, Alabama's maternal death rate was three and one-fifth deaths per 1,000 live births.⁷⁰² Historian Ruth Fairbanks agreed that the EMIC lowered maternal mortality rates, but explained that rates were already declining because of the use of sulfa drugs.⁷⁰³ By 1952, the maternal death rate dipped below two deaths per 1,000 live births.⁷⁰⁴ The rates have remained below two deaths per 1,000 since the early 1950s and steadily decreased over the last half of the twentieth century as deliveries shifted to hospitals.

States that already relied on hospital maternity care also participated in the EMIC program. In New York, the EMIC program helped improve maternal care in urban and in rural areas. By April 1944, approximately 12,000 New York City women and infants received care under the EMIC program and a report indicated that ten percent of New York City births were covered by the CB's program.⁷⁰⁵ In New York City, nearly one hundred health organizations from hospitals to New York City Health Department clinics offered care to servicemen's wives and infants. The conditions in New York City were

⁷⁰¹ "Mississippi Emergency Maternal & Infant Care Program: A Statistical Study of 5516 Deliveries."

⁷⁰² T.M. Boulware, "Maternal and Infant Welfare," *Transitions of the Medical Association of the State of Alabama* (1948):6, Reynolds-Finley Historical Library, The University of Alabama at Birmingham, Birmingham, Alabama.

⁷⁰³ Ruth Fairbanks, "The Pregnancy Test," 82.

⁷⁰⁴ Mississippi State Department of Health, "Mississippi Vital Statistics," PDF, 165-166.

⁷⁰⁵ "Wives of Troops Helped," *The New York Times*, April 12, 1944.

unique because the city did not have a critical shortage of doctors or hospital beds.⁷⁰⁶ Shortly after the EMIC program ended, Vivian Pessin, Dr. Helen Wallace, and Dr. Leona Baumgartner, New York City Department of Health officials, examined medical care for EMIC patients from 1943 to 1949 in New York City. The team determined that although women could choose which physician provided care, their choice was not that simple. The fee for obstetric care in New York was higher than the fifty dollars allotted by the CB and in some instances, doctors advised the woman to choose another physician.⁷⁰⁷ Even though the typical fee was higher, in general New York City physicians accepted EMIC patients.⁷⁰⁸

Rural New York, like many rural areas in the United States, struggled to meet the needs of the EMIC program. The state health department personnel were still concerned about access to care. According to a “Special to *The New York Times*,” Dr. Edward S. Rogers, an assistant commissioner for the New York State Department of Health, noted that during the first year of EMIC, major cities had the infrastructure to accept the EMIC cases. Rogers believed that during the 1945 fiscal year EMIC would expand into rural areas and small cities in New York.⁷⁰⁹ This program’s growth improved access to maternal and infant health care in hospitals and medical clinics.⁷¹⁰ By the end of the

⁷⁰⁶ Vivian Pessin, Helen M. Wallace, and Leona Baumgartner, “Medical Care of Maternity Patients Under the Emergency Maternity and Infant Care Program in New York City,” *American Journal of Public Health* 41, no. 4 (April 1951), 402.

⁷⁰⁷ *Ibid.*, 402-403.

⁷⁰⁸ *Ibid.*, 403.

⁷⁰⁹ “Rural Areas in State to Gain,” *The New York Times*, September 29, 1944.

⁷¹⁰ *Ibid.*

program, service members' wives in rural areas of New York had access to quality medical care. In both rural and urban areas, the New York State Department of Health ran its EMIC program "as liberally as possible since its inception."⁷¹¹ The New York State Department of Health continued to accept cases until July 1947 and even retroactively granted wives, who were pregnant before July 1947, access to care. Since no new pregnancy cases were accepted after the nine-month grace period of retroactive approval, the program reduced its activities in late 1947 and 1948.⁷¹² By the summer of 1949, when the EMIC program ceased. New York State operated the largest EMIC program in the nation and territories. New York treated over 28,200 infant cases and over 100,000 maternity cases.⁷¹³ Almost all the deliveries occurred in a hospital and followed the medical standards established by the CB.

At the national level, EMIC was both praised and criticized. Many doctors worried that after the war, the CB would create a permanent socialized medical system.⁷¹⁴ In October 1944, Dr. Eliot vowed that the EMIC program was a "wartime measure" and that the program would "automatically come to an end six months after the war..."⁷¹⁵

⁷¹¹ Ibid.

⁷¹² *Public Health in New York State 1947: Sixty-Eighth Annual Report of the State Department of Health* (Albany: New York State Department of Health, 1948), 25-26.

⁷¹³ Nathan Sinia and Odin Anderson, *Emergency Maternity and Infant Care*, 83, 87; Martha Eliot and Lillian Freedman, "Four Years of the EMIC Program," 629.

⁷¹⁴ Kriste Lindenmeyer, *"A Right to Childhood"*, 243; Beatrix Hoffman, *Health Care for Some*, 51. Lindenmeyer asserted that the American Medical Association (AMA) only supported EMIC as a wartime measure because the organization was against socialized medicine. Hoffman noted that the AMA members did not agree with the fifty-dollar set fee.

⁷¹⁵ Martha M. Eliot, "EMIC Program: The Children's Bureau, EMIC and Postwar Planning for Child Health," *The Journal of Pediatrics* 25, no. 4 (October 1944): 351-367.

Some scholars assert that Eliot wanted to extend the program to a peacetime program for all American mother and infants.⁷¹⁶ Sources support these scholars' claims, but Eliot and the CB were realistic and recognized the limitations of the programs and did not push for care for soldiers above the fourth pay grade. The CB understood that the American health care system included both public and private health organizations.

Congress's final appropriation for the EMIC was on July 20, 1946, for the 1947 fiscal year, and EMIC programs approved maternity cases until June 30, 1947.⁷¹⁷ The EMIC caseload decreased so much after the war that Chief Lenroot returned a portion of the allocated appropriations to Congress.⁷¹⁸ The program continued until June 1949 or for approximately four years after the war ended.⁷¹⁹ An anonymous author in the *American Journal of Public Health* quoted statistics that "at its height, this program covered one out of seven of all births taking place in the United States."⁷²⁰ The author further praised the program's administrative feat of every state health department operating an EMIC program.⁷²¹ Throughout the United States and territories, the EMIC was responsible for the maternal care for over one million mothers and the birth of over one million

⁷¹⁶ Eden Goldman, "A Right to be Safely Born," 175-176; Kriste Lindenmeyer, "A Right to Childhood," 240,243, 245; Ruth Fairbanks, "The Pregnancy Test," 86-87. Lindenmeyer said that the CB only asked for funding for the lowest four pay grades in the hearings because the CB wanted Congress to back the program. Yet, the Senate hearing suggested some Congressmen were willing to expand the program. According to Fairbanks, the limited scope of the EMIC hindered the CB's ability to create a full maternity program.

⁷¹⁷ Kriste Lindenmeyer, "A Right to Childhood," 242.

⁷¹⁸ Nathan Sinia and Odin Anderson, 47-48; Eden Goldman, "A Right to be Safely Born," 161.

⁷¹⁹ Kriste Lindenmeyer, "A Right to Childhood," 242.

⁷²⁰ Robert H. Bremner, *Children and Youth in America*, 1262.

⁷²¹ *Ibid.*, 1263.

Americans. The government had paid over \$127 million dollars caring for American mothers and newborns.⁷²² EMIC was one factor that helped move childbirth into hospitals.⁷²³ At the national level, hospital births rose from 72.1% in 1943 to 84.8% in 1947.⁷²⁴ In the South, the EMIC played an even more significant role in moving childbirth into the hospital.⁷²⁵ The program also offered lessons on how to provide better children's health care as these young Americans grew older. Dr. Eliot argued that it was the CB's duty to make suggestion for postwar planning for children and their health, and she suggested an expansion of maternal, pediatric, and adolescent care.⁷²⁶

In the late 1940s, the CB and other federal and state agencies grew more concerned with the postwar international climate and its relation to children's health. James A. Gillespie notes that the early Cold War and the end of the EMIC led Dr. Eliot to focus on international activities and children's health.⁷²⁷ Eliot used her experiences with the EMIC to promote maternal and child health internationally.⁷²⁸ Back in the United States, the CB had undergone significant changes shortly after the war ended. In

⁷²² Ibid.; Kriste Lindenmeyer, "A Right to Childhood," 242. "Close of the EMIC Program" estimated the EMIC cost around \$127 million, while Lindenmeyer cited \$130,500,000 as the total cost.

⁷²³ Ruth Fairbanks, "The Pregnancy Test," 77-78; Eden Goldman, "A Right to be Safely Born," 172-174; Joan Mulligan, "Three Federal Interventions on Behalf of Childbearing Women," 81.

⁷²⁴ Eden Goldman, "A Right to be Safely Born," 173.

⁷²⁵ For Mississippi's example see: Eliot and Freedman, "Four Years of the EMIC Program," 626. Also see: Karen Kruse Thomas, *Deluxe Jim Crow*, 97.

⁷²⁶ Martha Eliot, "EMIC Program: The Children's Bureau, EMIC and Postwar Planning for Child Health," 366-367.

⁷²⁷ James A. Gillespie, "International Organization and the Problem of Child Health, 1945-1960," *Dynamis: Acta Hispanica ad Medicinam Scientiarumque Historiam Illustrandam* 23 (2003): 137.

⁷²⁸ Ibid., 125.

December 1945, President Harry Truman moved to transition the CB from the Labor Department to the Federal Security Agency. He was successful in moving the Bureau into the FSA under the umbrella of the Social Security Administration by mid-1946.⁷²⁹ By 1948, the CB began planning the Midcentury White House Conference on Children and Youth that attempted to ensure that American children had healthy personalities. The conference delegates, including CB personnel and international representatives, considered tensions with the Soviet Union as they developed the scaffolding to create happy and emotionally healthy American children.

⁷²⁹ United States Children's Bureau, *The Children's Bureau Legacy*, 95-96. When the Social Security Act of 1935 passed, the CB fought to retain control of Title V, within a decade the whole Bureau was under the Social Security Administration.

CHAPTER VI

“FOR EVERY CHILD A HEALTHY PERSONALITY”: JUVENILE MENTAL HEALTH AND COLD WAR CONFORMITY IN THE EARLY 1950S⁷³⁰

On the morning of December 5, 1950, President Harry Truman traveled to the National Guard Armory in Washington, DC. Communism threatened American democracy and freedom, and as the Commander-in-Chief, Harry Truman felt pressure to protect American values as the Cold War heated up. At 10:15 a.m., Truman addressed a group of experts on youth and thousands of Americans tuned in at home. He first explained that “the serious crisis in world affairs overshadows all that we do.”⁷³¹ Truman was concerned with the situation in Korea and feared the spread of communism at large. He explained that the goal of the Midcentury White House Conference on Children and Youth (MWHCCY) was to “help our children and young people become mentally and morally stronger, and to make them better citizens.” The focus of Truman’s speech was the effects of communism on Americans, especially the youth. He explained the importance of the conference in training American children to protect America ideals:

⁷³⁰ *For Every Child a Healthy Personality: A Digest of the Fact-Finding Report to the Midcentury White House Conference on Children and Youth* (Washington, D.C.: Midcentury White House Conference on Children and Youth, Inc., 1950).

⁷³¹ Harry S. Truman, “Address Before the Midcentury White House Conference on Children and Youth,” December 5, 1950, The American Presidency Project, accessed December 2016, <http://www.presidency.ucsb.edu/ws/?pid=13677>.

No matter how the immediate situation may develop, we must remember that the fighting in Korea is but one part of the tremendous struggle of our time--the struggle between freedom and Communist slavery. This struggle engages all our national life, all our institutions, and all our resources. For the effort of the evil forces of communism to reach out and dominate the world confronts our Nation and I believe the single most important thing our young people will need to meet this critical challenge in the years ahead is moral strength--and strength of character. I know that the work of this conference will be of tremendous assistance in the urgent task of helping our young people achieve the strength of character they will need.

If we are to give our children the training that will enable them to hold fast to the right course in these dangerous times, we must clearly understand the nature of the crisis. We must understand the nature of the threat created by international communism.⁷³²

Truman knew that communism posed a “military threat” that would affect the lives of the American youth.⁷³³ These young Americans would contribute to and “build a world order based on freedom and justice.”⁷³⁴ These early Cold War events factored into the topic of the 1950 White House Conference on Children and Youth series. The MWHCCY was the fifth White House Conference on Children, which began in 1909, and child welfare advocates met approximately every ten years to address issues American children faced. The goal of this midcentury meeting was to help all American children develop a healthy personality to combat communism. Truman summarized how the conference would help children uphold American values: “We must teach them why we must fight, when necessary, to defend our democratic institutions, our belief in the rights of the individual, and our fundamental belief in God.”⁷³⁵ Through this conference,

⁷³² Ibid.

⁷³³ Ibid.

⁷³⁴ Ibid.

⁷³⁵ Ibid.

the United Public Health Service (USPHS), the Children’s Bureau (CB), and other government agencies produced literature and programs that were sent to schools and parents to teach children how to become the ideal American child. Government officials and child welfare advocates believed that this child would be happy with good emotional health, Judeo-Christian, and an embodiment of democratic values. The MWHCCY laid the foundation for implementing Cold War conformity among America’s midcentury children.⁷³⁶

To reach these goals of stable emotional health in the early 1950s, state delegates adopted “The Pledge to Children,” which promised to improve education and expanded mental and emotional health programs. At the same time, the Pledge reinforcing democratic values and the children’s duty to their country. This chapter contends that the Midcentury White House Conference on Children and Youth (MWHCCY) served as a platform for new theories on childhood personality, where the delegates constructed and propagated specific qualities that defined a happy American child with a well-adjusted personality. The chapter also provides two examples of state follow-up work, where local child welfare advocates attempted to guarantee happy children by improving education and mental healthcare. In Mississippi, the Mississippi Children’s Code Commission (MCCC) addressed inequalities in Mississippi’s education system, but the legislature attempted to veil these disparities with a new educational program. In addition, the

⁷³⁶ For more on conformity in the Cold War see: Elaine Tyler May, *Homeward Bound: American Families in the Cold War Era* (New York: Basic Books, 1988); Laura McEnaney, *Civil Defense Begins at Home: Militarization Meets Everyday Life in the Fifties* (Princeton: Princeton University Press, 2000); Andrew Harlman, *Education and the Cold War: The Battle for the American School* (New York: Palgrave Macmillan, 2008).

MCCC worked to improve mental healthcare for children by expanding child guidance clinics. The MCCC failed to meet all the promises of the pledge, but made some advancements. On the other hand, New York created a successful mental health service network that included school interventions, child guidance clinics, and religious instruction. With the joint help of professionals and public, the New York State Committee of One Hundred on Children and Youth (NYCOHCY) provided anxious children with outlets to address their issues. Although not all MWHCCY follow-up state committees upheld all the platform ideals, the conference made a direct impact on mental health services through education, health care, and religious institutions in the 1950s.

In late 1949, fifty-two child health and welfare advocates from the CB and other agencies determined that the conference should focus on the mental and emotional wellbeing of American children, and asserted that the mental and spiritual health of American children were vital components to producing conforming democratic-minded citizens. The delegates considered social, economic, political, and religious factors that affected American children to establish the conference theme. Recent events, including the United States entering the Korean War, fostered anxiety, and the delegates worried about the effects these events would have on children's development. The delegates determined that the conference should focus on the mental and emotional wellbeing of American children, and asserted that the mental and spiritual health of American children were vital components to producing democratic-minded citizens. The Fact-Finding Committee (FFC) based "its concern for children on the primacy of spiritual values, democratic purpose of the Conference shall be to consider how we can develop in

children the mental, emotional, and spiritual qualities essential to individual social conditions...”⁷³⁷ To prepare for the upcoming conference, the FFC had to collect data on American children and the services that they needed.

In 1949 and 1950, the FFC gathered information on the status of American children. The Committee’s purpose was to supply delegates with statistics and observations that would be helpful during working group sessions.⁷³⁸ The FFC published a small digest of its findings to distribute to Conference delegates, who needed more background information on the conference topic, American children and their personalities. In *For Every Child a Healthy Personality*, the Committee explained that it became “increasingly apparent that all who have to do with serving children must work in a way that takes children’s feelings into account if they are fully to accomplish their purposes.”⁷³⁹ The midcentury child was in an uncertain world, and new theories about children and emotional health helped delegates address create an environment for American children to develop healthy personalities.⁷⁴⁰

The FFC understood that American children were individuals who had different backgrounds, but they still tried to gather statistical data to understand how most American children lived. The committee considered the baby boom when assessing the status of children and noted that 1947 was the largest birth year in recent American

⁷³⁷ *For Every Child a Healthy Personality*, 2.

⁷³⁸ *Ibid.*, 1.

⁷³⁹ *Ibid.*

⁷⁴⁰ *Ibid.*, 6-7. The delegates specially looked to the theories of Erik Erikson.

history with approximately four million Americans born.⁷⁴¹ With the large baby boom after World War II, government officials had to consider the growing population of youth in the 1950s. By the beginning of the decade, only twenty percent of children lived on farms, while nearly eighty percent or forty million young people lived in urban or suburban areas.⁷⁴² Many families were moving to cities or suburbs during this time and children were changing “friends, school, and other surroundings.”⁷⁴³ These changes often threatened a child’s stability and ability to have a happy personality. The committee charted the distribution of children and what type of education, healthcare, and living conditions these children had in various regions of the United States. The North and the Pacific West Coast had the largest youth populations, but the committee assured delegates that each region had more children “than ever before.”⁷⁴⁴ Along with the baby boom, better maternal and infant hygiene in the previous decades had reduced infant mortality rates. Even so, the committee recommended continuing improvements in the areas of “obstetrical care, special hospital facilities, and pediatricians and nurses with training in the care of premature babies.”⁷⁴⁵ The committee cited death in the first week

⁷⁴¹ Midcentury White House Conference on Children and Youth Fact Finding Committee, *Children and Youth at the Midcentury: A Chart Book* (Washington, D.C.: National Printing Company, 1950), Introduction to Chart I. Folder: “Midcentury White House Conference on Children and Youth—Conference Publications,” Box: “8” Series II: “Records of the Midcentury White House Conference on Children and Youth,” Record Group: “85-14: White House Conference on Children and Youth, 1930-1970,” Dwight D. Eisenhower Presidential Library and Museum, Abilene, Kansas.

⁷⁴² *Ibid.*, Introduction to Chart 3.

⁷⁴³ *Ibid.*, Introduction to Chart 4.

⁷⁴⁴ *Ibid.*, Introduction to Chart 5.

⁷⁴⁵ *Ibid.*, Introduction to Chart 34. The committee reported 39,000 premature infant deaths in 1948.

of the infant's life as the biggest threat to infant mortality at midcentury.⁷⁴⁶ Maternal death rates were lower than before because "infection, toxemia, and hemorrhage" occurrences decreased due to medical advancements such as the availability of penicillin. African American mothers, other minority mothers, and mothers in the country still needed greater attention.⁷⁴⁷ In the early 1950s, more births were taking place in hospitals rather than home deliveries by midwives or nurses.⁷⁴⁸ The committee calculated "progress in hospitalizing Negro births—10 years behind white births."⁷⁴⁹ Minority and impoverished mothers often were not allowed in segregated hospitals or lacked the means to gain access to the modern hospital system to ensure to physical health for their infants.⁷⁵⁰

Children's emotional health was linked to their physical health. The Fact-Finding Committee stated the obvious that children in the Northeast and Central United States had the best access to medical and dental care.⁷⁵¹ These areas had older and better-established public health organizations and were home to more modern hospitals.⁷⁵²

⁷⁴⁶ Ibid.

⁷⁴⁷ Ibid., Introduction to Chart 35.

⁷⁴⁸ Ibid., Introduction to Chart 36.

⁷⁴⁹ Ibid.

⁷⁵⁰ Keith Wailoo, *Dying in the City of the Blues: Sickle Cell Anemia and the Politics of Race and Health* (Chapel Hill: The University of North Carolina Press, 2001), 29,33, 84-85.

⁷⁵¹ Midcentury White House Conference on Children and Youth Fact Finding Committee, *Children and Youth at the Midcentury: A Chart Book*, Introduction to Chart 42.

⁷⁵² For the history in the American hospital and hospital maternity care see: Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (Baltimore: Johns Hopkins University, 1995); Richard and Dorothy Wertz, *Lying-in: A History of Childbirth in America* (New Haven: Yale University Press); Judith Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750 to 1950* (Oxford: Oxford University Press, 1988).

Regardless of region, some children simply could not afford physician care because of their household income.⁷⁵³ The committee members argued that more public health nurses would improve health care for both American mothers and children.⁷⁵⁴ Physical health had remained a major concern for decades, but in the 1950s, health care professionals and social workers became very interested in emotional health. Social scientists were currently debating about how adolescents developed personalities. The Fact-Finding Committee worried because in “no State is there adequate psychiatric service for children.”⁷⁵⁵ This was a major concern because the delegates wanted to ensure American children had stable emotional health. They believed more psychiatric “preventive service and treatment can help many children to develop a healthy and happy personality.”⁷⁵⁶

The delegates defined personality as “the thinking, feeling, acting human being, who, for the most part, conceives of himself as an individual separate from other individuals and objects. This human being does not *have* a personality; he *is* a personality.”⁷⁵⁷ At midcentury, scholars in the social sciences were debating the theory behind personality, and the MWHCCY allowed these professionals to discuss the importance of personality development during childhood. The primary focus of the

⁷⁵³ Midcentury White House Conference on Children and Youth Fact Finding Committee, *Children and Youth at the Midcentury: A Chart Book*, Introduction to Chart 43.

⁷⁵⁴ *Ibid.*, Introduction to Chart 45.

⁷⁵⁵ *Ibid.*, Introduction to Chart 46.

⁷⁵⁶ *Ibid.*

⁷⁵⁷ *For Every Child a Health Personality*, 3.

meeting was to guarantee “a healthy personality for every child.” Factors such as socio-economic status, access to health care, and racial discrimination were detrimental to children and opposed the democratic ideals.⁷⁵⁸ The delegates sought to address the issues and make improvements to stabilize adolescent mental health. At midcentury, the fields of “psychology, sociology, and physiology” were adding to the understanding of personality, especially for children.⁷⁵⁹ To understand emotional health, the conference planners studied various aspects of children’s lives including family life, education, religion, health care, and child welfare. They began planning months before all delegates would meet to establish standards for child care during the 1950s.

On September 8th and 9th, 1949, these conference planners came together to piece together their ideas about the condition of American children. They quickly decided that the official conference would take place during the first week of December 1950. To plan for this formal meeting, the planners decided to meet “three to four times” to establish the program of work.⁷⁶⁰ President Truman expressed that he wanted the conference to focus on “the mental attitude of young people” and he hoped that the conference would “outline a program for this future generation that is coming into control in this country and world.”⁷⁶¹ The committee had to agree on a conference theme that incorporated Truman’s

⁷⁵⁸ Ibid., i,1.

⁷⁵⁹ Ibid., 2.

⁷⁶⁰ Oscar R. Ewing, Presiding, “Minutes of Meeting of the National Committee Midcentury White House Conference on Children and Youth,” September 8, 1949, 13, Folder: “National Committee for the Midcentury Conference on Children and Youth—Transcript of Proceedings, Sept. 8, 1949 [pp. 1-105],” Box: “16,” Series II: “Records of the Midcentury White House Conference on Children and Youth,” Record Group: “85-14: White House Conference on Children and Youth, 1930-1970.”

⁷⁶¹ Ibid., 1.

wishes. After some consideration, the Ad Hoc Committee on Proposed Conference Focus members agreed that the conference should deliberate “how we can develop in children the mental, emotional, and spiritual qualities essential to individual happiness and to responsible citizenship.”⁷⁶² To achieve these goals, the working committees needed information the FCC had gathered to accomplish these goals. The experts and general citizens would study: how children developed; how did environments effect the way American children live and develop; how did various institutions and organizations influence and serve children; how to develop a proposal to guarantee happy personalities; how to disseminate the proposal and with the help of experts and ordinary citizens to make the proposal a reality throughout the country.⁷⁶³

Over 4,600 delegates including CB employees, physicians, psychologists, sociologists, religious leaders, teachers, social workers, parents, and children traveled from throughout the United States, joined by nearly 1,300 international participants, who met together to discuss American children and plan programs for child emotional development.⁷⁶⁴ When the delegates arrived at the Midcentury Conference in early December 1950, the participants received a welcoming memo from President Harry Truman. He admired that fact that Americans were focusing on children during the Korean War. He praised the meeting, “In this unique demonstration of our democracy’s concern for its children, there is proof again that our American tradition of free exchange

⁷⁶² Ibid., 8.

⁷⁶³ Ibid., 8-9.

⁷⁶⁴ Edward A. Richards, ed. *Proceedings of the Midcentury White House Conference on Children and Youth: Report of Conference Sessions Washington, D.C., December 3-7, 1950* (Raleigh: Health Publications Institute, Inc. 1951),23.

of fact and opinion is a living, working force.”⁷⁶⁵ The conference was taking place in the early backdrop of the Cold War.⁷⁶⁶ Many of the delegates focused on preparing the new generation of Americans from the formable communist threat.

Many of the delegates gave addresses on their concern about American children and the effect of a changing world. One of the delegates, Reverend George A. Buttrick, D.D., the Pastor of New York City’s Madison Avenue Presbyterian Church, spoke on the importance of God for children at the midcentury. He questioned, “How else can our democracy endure?”⁷⁶⁷ Without God, he did not believe America could uphold its standards. Buttrick felt that by turning to God and faith American families would find guidance. Many of the delegates believed that children needed religion to ensure their sanity and emotional health.

With the escalation of the early Cold War, many Americans were anxious and wanted to protect American children from communist ideology. At the MWHCCY, attendees also worried about how world affairs and national conflicts affected children. Dr. Benjamin Spock of the Rochester Child Health Institute and the leading child-care expert that millions of American mothers turned to for advice addressed the delegates. He noted that American society had “too much cruelty and hatred and suspicion and fear.”⁷⁶⁸

⁷⁶⁵ Ibid.,2.

⁷⁶⁶ For more information on the early Cold War see: John Lewis Gaddis, *The United States and the Origins of the Cold War, 1941-1947* (New York: Columbia University Press, 1972); John Lewis Gaddis, *The Cold War: A New History* (New York: Penguin Books, 2005); Melvyn Leffler and David Painter, *Origins of the Cold War: An International History, Second Edition* (New York: Routledge, 2005).

⁷⁶⁷ Edward A. Richards, ed. *Proceedings of the Midcentury White House Conference on Children and Youth*, 54-57.

⁷⁶⁸ Ibid., 61. In Post-War America, Dr. Spock was the leading child-care expert. Mothers turned to his book, *The Common Sense Book of Baby and Child Care* for the latest scientific advice for childrearing. He first published his book in 1946.

These characteristics hindered children from developing the happy personalities. Spock was apprehensive about “the inability of the world to achieve peace keeps us all anxious and suspicious. In the United States, we have yet succeeded in stabilizing and integrating our spiritual ideals.”⁷⁶⁹ Although these were not the only factors that led to unstable mental health, Spock believed the circumstances played a major factor in the development of America’s future generation. He suggested more investigation on how children’s personalities developed. He explained that “one of the investigations will be to see what educational methods...can do to keep alive the delight in children...?”⁷⁷⁰ The delegates debated the various components that affect children’s personality. For instance, notable anthropologist and child welfare advocate, Margaret Mead lamented that Americans were raising “unknown children for an unknown world.”⁷⁷¹ Since Mead was a cultural anthropologist, she believed that culture played a vital role in determining children’s personalities. She challenged children’s advocates to used “the new sciences of human behavior.”⁷⁷² She turned to her colleagues, Erik Erikson, a physiologist and the creator of Erikson’s Stages of Personality Development, and David Reisman, a sociologist who studied American conformity. With the help of these renowned scholars, delegates like Mead studied the state of American children’s personalities. Mead believed the use of social science would allow child welfare activist to create an environment that

⁷⁶⁹ Ibid., 68.

⁷⁷⁰ Ibid., 69.

⁷⁷¹ Ibid., 84. For more information on famous anthropologist Margaret Mead see: Nancy C. Lutkehaus, *Margaret Mead: The Making of an American Icon* (Princeton: Princeton University Press, 2008).

⁷⁷² Ibid., 85-86.

would prevent loneliness.⁷⁷³ The conference allowed a dialogue for scholars working to theorize about child's personality development, and allowed them to inform the lay delegates about new ideas developing in the social sciences during the general and group sessions.

The future of American democracy hinged on children's happiness and personalities. Delegate Allison Davis focused on other aspects that can influence a child's happiness. Davis, a Professor of Education at the University of Chicago, presented a paper to the participants that on the relationship between social and economic influences on youth education. She reminded everyone that now and in the future that the United States needed able-bodied and able-minded citizens.⁷⁷⁴ Davis worried that disconnect between teachers and students would deprive students of the educations that they needed. The teachers were often of different social backgrounds than the "slum children" and the teachers sometime viewed their behaviors as apathy towards learning.⁷⁷⁵ The delegates worried about these children and explained that to understand "the socialization of slum children, one must first view the slum adult-world."⁷⁷⁶ The children's parents cursed, fought, and "consider[ed] school unimportant in their future."⁷⁷⁷ The delegates believed that people living in urban lower-socio economic areas or even sharecroppers were

⁷⁷³ Ibid., 86.

⁷⁷⁴ Ibid., 77.

⁷⁷⁵ Ibid., 78.

⁷⁷⁶ Ibid., 79.

⁷⁷⁷ Ibid., 78.

concerned with meeting their basic needs.⁷⁷⁸ When these adults and children had anxieties about food, shelter, and other necessities, their priorities were not always education. She also argued that these children had lower I.Q. scores. In addition, she noted regional and racial differences in I.Q. scores. Fears, culture, and environment factored into building happy personalities. She feared that if Americans did not “find, and train effectively, more of these children with quick minds (good native ability) in the vast lower socio-economic groups in America, we shall be very seriously challenged by the tremendous populations of Asia and East Europe.”⁷⁷⁹ The focus on education was a common strategy on preparing American youth to defeat communism. American schools began emphasizing science and mathematics because the military-industrial complex would need competent workers.⁷⁸⁰ American children represented the next generation of Americans, who would have to defend American values, fight American wars, and support the American economy.

At the gathering, delegates including four hundred children broke into working groups to discuss various factors of a child’s life including family, community, religion, education, healthcare, and welfare. The Midcentury Conference was the first White

⁷⁷⁸ Ibid., 78-80.

⁷⁷⁹ Ibid., 83. To learn more about intelligence quotient and testing see: Daniel J. Kevles, *In the Name of Eugenics: Genetics and the Uses of Human Heredity* (Berkeley: University of California Press, 1985); Michael Wertheimer, *A Brief History of Psychology, Fifth Edition* (New York: Psychology Press of Taylor & Francis Group, 2012), 102, 121, 153, 156-157, 205, 251, 273; Alexandra Minna Stern, *Eugenic Nation: Faults and Frontiers of Better Breeding in Modern America* (Oakland: University of California Press, 2016), 7, 10, 16, 18-19, 50-51, 91-100, 109-129, 141, 196, 209-212, 214, 226, 237, 279; Lelia Zenderland, *Measuring Minds: Henry Herbert Goddard and the Origins of American Intelligence Testing* (Cambridge: Cambridge University Press, 1998).

⁷⁸⁰ For information on Cold War education consult: Andrew Hartman, *Education and the Cold War: The Battle for the American School* (New York: Palgrave Macmillan, 2008).

House Conference on Children and Youth to allow children, mostly teenagers, to participate and represent various youth organizations.⁷⁸¹ The groups discussed the status of children at the midcentury and aimed to plan for better conditions during the decade. At the same time, the attendees could not deny the growing issues of civil rights at home and the Cold War internationally. Amidst these situations, the delegates produced a platform that intended to defend and improve American democracy. Katharine F. Lenroot, the Chief of the CB, explained to the delegates the promises that the platform offered American children. She worried about the current climate, but knew that the MWHCCY would make a difference in thousands of children's lives like the previous conference. She stated, "Amid the harsh anxieties of the moment, the Conference has dared to adopt a platform and a pledge which sum up in words of eloquence and idealism the aspirations of previous Conferences and the imperatives drawn out of scientific study and practical experience."⁷⁸² The platform was more inclusive of the whole child and his or her life. It also reinforced American values including freedom, religion, and democracy. Lenroot explained that American children should "have clear ideas of freedom, the worth of each individual and man's relation to God, than that they understand atomic fission."⁷⁸³ These ideas were an important factor of conforming to Cold War expectations. With these goals in mind, the delegates made a promise to millions of American youth.

⁷⁸¹ Dean W. Roberts, "Highlights of the Midcentury White House Conference on Children and Youth," *American Journal of Public Health Nations Health* 41, no. 1 (January 1951): 96.

⁷⁸² Edward A. Richards, ed. *Proceedings of the Midcentury White House Conference on Children and Youth*, 93-94.

⁷⁸³ *Ibid.*, 96.



Figure 6.1 Juvenile delegates pictured with CB Chief Katharine Lenroot. The MWHCCY was the first White House Conference on Children and Youth were youth served as delegates.

Original photo located at National Archives and Records Administration, College Park, Maryland. Also see: “Five Hundred Youth...” Children’s Bureau 100th Anniversary, accessed March 2018, https://cb100.acf.hhs.gov/cb_eBrochure_ConferencesOnChildren.

MWHCCY delegates made a pledge to American children to provide them with a better life, but also to guarantee the children would be better citizens in the future. In “The Pledge to Children,” the delegates promised to love children, value their worth, help them find belonging, and offer them respect. The delegates also wanted to foster

children’s imagination and curiosity. Recreation was a large part of developing this imagination and add to learning, social experiences, and happiness.⁷⁸⁴ In addition, the child welfare advocates promised to be moral examples for the children and guide children to develop their “own faith in God.”⁷⁸⁵ American children would have an opportunity to enjoy the arts and a good education.⁷⁸⁶ The delegates wanted to ensure that America was a safe place for all Americans, and to do this they argued that American society needed to “work to rid ourselves of prejudice and discrimination, so that together we may achieve a truly democratic society.”⁷⁸⁷ Ending prejudice and discrimination was an ideal for most delegates as it made the United States look like it was more progressive than communist states. State follow-up work revealed that this goal was difficult to achieve with culture and laws that denied equality for all citizens. As scholar Keith Wailoo suggested, healthcare is affected by local customs, laws, and institution.⁷⁸⁸ In many states, segregation influenced the follow-up workers and the goals of their post-conference planning. With the promises of the Pledge, the delegates believed that children would have a better standard of living than their parents and they would “grow from child to youth to adult, establishing a family life of your own and accepting larger social responsibilities” or being civic-minded Americans who valued a “world society

⁷⁸⁴ Midcentury White House Conference on Children and Youth, Inc., *Platform Recommendations and Pledge to Children* (Raleigh: Health Publications Institute, 1950), iii.

⁷⁸⁵ Ibid.

⁷⁸⁶ Ibid., iii, iv.

⁷⁸⁷ Ibid., iv.

⁷⁸⁸ Keith Wailoo, *Dying in the City of the Blues: Sickle Cell Anemia and the Politics of Race and Health* (Chapel Hill: The University of North Carolina Press, 2001), 29,33, 84-85.

based on freedom, justice, and mutual respect.”⁷⁸⁹ This “Pledge to Children” was idealistic, and state governments planned various ways to implement these goals. The state delegates and other planners considered their states’ economic and social climates to realistically change education, health care, and child welfare throughout the United States.

Many states formed committees or organizations to investigate the status of children before and after the MWHCCY; in the early 1950s, these committees helped follow-up to improve services to children. Some states had many of the services needed to advance children’s lifestyles, but these states still needed to expand these programs. Other states created new divisions or the state legislature enacted new laws related to children. While “The Pledge to Children” offered the ideals, each state had its own agenda for children based on factors ranging from culture to finances. This limited the ability of the delegates to achieve the full goal of the conference, but state committees still pushed for children to maintain a healthy personality by advancing mental health services through education, healthcare, and religious institutions.

In Mississippi, the state legislature organized the Mississippi Children’s Code Commission in 1946 to study and address problems that Mississippi juveniles encountered. The governor appointed members to the commission, which consisted of a nine-person board. After the MWHCCY, the MCCC board members reorganized the structure by creating two auxiliary groups, a forty-two member advisory committee, and an additional one hundred and eighty child welfare advocates throughout the state as

⁷⁸⁹ Midcentury White House Conference on Children and Youth, Inc., *Platform Recommendations and Pledge to Children*, iv.

members of the State Committee on Children and Youth.⁷⁹⁰ The original outline for the MCCC required the board members to be parents. One document noted, “Provided, however, that no person shall be eligible to membership on said commission unless such person shall be at the time of appointment the natural parent of one or more children.”⁷⁹¹ According to CB Field Representative Dwight Ferguson, the State Committee on Children and Youth members gathered information on the status of children and youth at the midcentury.⁷⁹² The MCCC and its partner State Committee on Children and Youth gathered information on the children and wrote a report entitled “Mississippi Report on Services to Children and Youth, 1940-1950.” At the state level, seven fact-finding committees gathered information on children’s health, troubles, education, family, home, recreation, and church. In addition, child welfare supporters met at “nine (9) district meetings..., approximately sixty (60) county meetings and 500 county sub-committee meetings” to better understand Mississippi’s children.⁷⁹³ These activists not only gathered important statistics, but they also educated parents and community leaders about the needs of children in specific communities.

⁷⁹⁰ Dwight H. Ferguson, Children’s Bureau Field Representative, “Mississippi Field Report,” November 1-2, 1951, 1-2, Folder: “Mississippi,” Box: “4,” Series II: “Records of the Midcentury White House Conference on Children and Youth,” Record Group: “85-14: White House Conference on Children and Youth, 1930-1970,” Dwight D. Eisenhower Presidential Library and Museum.

⁷⁹¹ “Creation of the Children’s Code Commission,” Folder: “Mississippi.” The regulation that members of the MCCC must be parents, restricted its membership. Many educators and public health nurses were single. These citizens had a vested interest in child, but they could not serve on the nine-member committee.

⁷⁹² Dwight H. Ferguson, “Mississippi Field Report,” 2.

⁷⁹³ Mississippi Children’s Code Commission, “Biennial Report Children’s Code Commission, January 1, 1950-December 31, 1951,” 4, Folder: “Mississippi.”

Forty-six Mississippians attended the MWHCCY and brought the ideas and platforms adopted back to Mississippi. These delegates were “legislators, judges, lawyers, educators, social workers, doctors, youth representatives, and representatives of organizations interested in children.”⁷⁹⁴ The Code’s Biennial Report explained that over half the delegates were not from professional backgrounds. Most of the delegates were white, but a few African American leaders attended the conference. For instance, Dorothy Gordon, a black home economist and leader in the Negro Home Economics Association, represented Alcorn A&M College.⁷⁹⁵ These delegates participated in various general meetings and others attended sub-committee meetings with topics ranging from education to emotional health. They returned with the MWHCCY’s platform and the promise of “The Pledge to Children.”

The MCCC agreed that the adopted platforms were ideal. The Commission members knew that implementing such an ambitious plan would pose a challenge because Mississippi lacked funding for an adequate education system or child welfare program. Many Mississippians, who worked in the fields of education, health, government, and child welfare, had great intentions to expand services to children. The Commission expressed interest in the MWHCCY’s suggestions, but knew that it would require “considerable work and will tax the imagination and resourcefulness of us all,” especially since the commission did not receive state appropriations.⁷⁹⁶ Even without funds, MCCC members could make recommendations for service for children.

⁷⁹⁴ Ibid.

⁷⁹⁵ Ibid., 16.

⁷⁹⁶ Ibid., 4,6.

With the new advisory committee to the Children’s Code Commission and the State Committee on Children and Youth, the MCCC decided that its efforts should focus on six areas in 1951 and throughout the decade: “children in trouble[delinquents or emotionally and mentally disturbed young people], health, education, social services, community planning and development, and spiritual values.”⁷⁹⁷ The commission members felt that MWHCCY created new momentum for their organization.⁷⁹⁸ The committee hoped that by 1954 the state legislature would make major adjustments such as passing a new adoption bill, establishing mental and emotional health facilities, and new accommodations for dependent mothers and children.⁷⁹⁹ In addition, the commission wanted to advance Mississippi’s education system.⁸⁰⁰

After the conference, the Children’s Code Commission worked to carry out the mission of the conference. In 1951, these MCCC members worked to improve education, children’s welfare, spiritual values, health, and adoption.⁸⁰¹ For instance, the MWHCCY platform encouraged Americans “to rid ourselves of prejudice and discrimination, so that together we may achieve a truly democratic society” and to provide children with “rewarding educational opportunities.”⁸⁰² In 1950, Mississippi’s schools were segregated

⁷⁹⁷ Ibid., 5.

⁷⁹⁸ Ibid.

⁷⁹⁹ Ibid., 6.

⁸⁰⁰ Ibid., 6-7.

⁸⁰¹ Ibid., 5.

⁸⁰² Midcentury White House Conference on Children and Youth, Inc., *Platform Recommendations and Pledge to Children*, iv.

and thousands of Mississippi's youth did not finish their primary or secondary education. Ferguson noted that "one of the controversial issues" the state legislature concerned changes to the education system's budget.⁸⁰³ At the national level, the federal court system was reviewing and beginning to rule on civil rights cases including those related to education. Under pressure from the federal government, the Mississippi State Department of Education proposed a new budget that would increase funding for African American schools. Presumably equal schools would make seem the educational system more democratic.⁸⁰⁴ However, the state did not have the funds to accept the entire budget. While the Children's Code Advisory Committee examined the proposed budget, and suggested that the Commission recommend the bill. The MCCC decided that Mississippi's education system needed to further study the situation.⁸⁰⁵ The Advisory Committee suggestions followed the "strategy of educational equalization," or equal funding and quality education for black and white schools that Mississippi leaders began utilizing in the 1940s to maintain a segregated system.⁸⁰⁶ Mississippi continued to use this strategy to improve African American schools in order to slow down desegregation, but the school system had additional flaws.

⁸⁰³ Dwight H. Ferguson, "Mississippi Field Report," 2.

⁸⁰⁴ Mary Dudziak, *Cold War Civil Rights: Race and the Image of American Democracy* (Princeton: Princeton University, 2000,2011),49-53.

⁸⁰⁵ Ibid.

⁸⁰⁶ For more information on "Mississippi's School Equalization Program," see: Charles C. Bolton, "Mississippi's School Equalization Program, 1945-1954: A Last Gasp to Try to Maintain a Segregated Educational System," *The Journal of Southern History* 66, no. 4 (November 2000), 781-814.

In 1951, the MCCC determined that the education system lacked many standards. Based on studies and interests in education, the MCCC requested five changes to Mississippi's education system. To adhere to "A Pledge to Children," the Commission wanted the legislature to require compulsory education. In addition, children, who lived further than two miles from a school should have access to a bus with an appropriate driver. According to the recommendations, African American and white schools should have classrooms that were "well lighted, heated, ventilated, properly equipped and not overcrowded."⁸⁰⁷ Mississippi "still had over fourteen hundred one-room schools, almost all of which were for blacks."⁸⁰⁸ The MCCC advocated for trained teachers, who would receive adequate pay and a pension after ample service. A better salary and security for retirement would allow the state to recruit better teachers. Yet, the state paid black teachers nearly fifty percent less than their white counterparts.⁸⁰⁹ Finally, the Commission explored educational opportunities for "exceptional children who do not fit into the regular school program."⁸¹⁰ The MWHCCY proposed that a good education helped children have a more stable emotional health and an ability to achieve happiness. These five requests were often repeated by the MCCC in the 1950s and the Commission tasked the legislature with changing education for Mississippi's children.

⁸⁰⁷ Mississippi Children's Code Commission, "Biennial Report Children's Code Commission, January 1, 1950-December 31, 1951," 7.

⁸⁰⁸ Charles C. Bolton, "Mississippi's School Equalization Program," 804.

⁸⁰⁹ Ibid.

⁸¹⁰ Mississippi Children's Code Commission, "Biennial Report Children's Code Commission, January 1, 1950-December 31, 1951," 7.

The MCCC reported many changes to the education system in the 1950s. Mississippi Board of Education wanted to have schools that met “national trends as far as possible within the frame work of our economy.”⁸¹¹ The Code realized that the school laws were very confusing by 1950 and that they need revising. By 1951, a Citizens" Council on Education, an organization supported by the State Department of Education and Mississippi Parent-Teachers Organizations, studied the educational situation and made suggestions. The following year the Legislative Recess Education Committee produced another study on the status of education.⁸¹² These studies corroborated information that the MCCC suspected. By 1953, Governor Hugh White requested a new education law featuring the suggestions by the Citizens Council on Education, the Legislative Recess Education Committee, and the MCCC.⁸¹³ The legislature passed a law that created the Minimum Foundation Educational Program (MFEP) and repealed many of the old education laws.⁸¹⁴

Under the law the MFEP was to “equalize educational opportunities for all the children of the people of the state, irrespective of places of birth, of race, color or creed.”⁸¹⁵ The MCCC boasted that the state poured millions of dollars into constructing and improving African American schools to appease the federal government. At the same

⁸¹¹ The Mississippi Children’s Code Commission, *Mississippi Report on Services to Children and Youth* (Jackson: The Mississippi Children’s Code, 1956), 80, Mississippi Department of Archives and History, Jackson, Mississippi.

⁸¹² Ibid.

⁸¹³ Ibid.

⁸¹⁴ Ibid., 81.

⁸¹⁵ Ibid.

time, the MCCC noted that the state spent nearly fifty million dollars on the white school infrastructure and only twenty and a half million on black schools.⁸¹⁶ The program sought to end the practice of labeling African American schools as colored schools or white schools as white schools. Instead, the legislature wanted all schools to be Mississippi schools, not distinguished by race. Teachers should not be addressed by their race either. While this may seem like a move toward equality, the schools were still segregated by race and African American teachers did not receive the same pay.⁸¹⁷ The new plan paid lip service to MCCC recommendations for better pay and training for African American teachers, while maintaining the status quo.

The Mississippi Legislature called for schools to be redistricted modeled on South Carolina school districting. By 1957, the Board of Education classified districts in three categories: municipal separate, county, and large consolidated (city and county schools). By recreating school districts, a rural county that used to have a school board for both white and black schools, would only have one county district, with five elected school board members.⁸¹⁸ Inevitably, many African Americans lost positions on school boards throughout the state. This façade of equalization meant African American students continued to suffer and white board members underfunded segregated schools. In August 1957, McComb Superintendent R.S. Simpson announced that the new plan would be in effect for the fall semester, but continued to address black and white students separately.

⁸¹⁶ Ibid., 84.

⁸¹⁷ Charles C. Bolton, "Mississippi's School Equalization Program," 804.

⁸¹⁸ The Mississippi Children's Code Commission, *Mississippi Report on Services to Children and Youth*, 82-83.

The *Enterprise-Journal* relayed these plans to the citizens of McComb Municipal Separate School District, and just like the previous years, the schools remained segregated. Black high school students attended Burglund School and white students attended at McComb High School. Referring to residence, Simpson stated, “Under the assignment law, a student may be sent where it is most convenient and feasible to educate the child.”⁸¹⁹ The new plan did not solve the inequalities in education and caused distress to African American students and parents. In *Brown v. Board*, Thurgood Marshall argued that segregation affected children and their emotional happiness.⁸²⁰ Marshall turned Dr. Kenneth Clark, a psychologist that focused on racial disparities, who conducted a study concerning how African American children viewed themselves. Kenneth and Mamie Clark, psychologists, conducted a study that asked children if the children preferred a white or an African American doll. The majority of the African American children questioned in Clarendon County, South Carolina believed that the white doll was good and the black doll was bad. Clark determined that segregation had “definitely harmed in the development of their personalities.”⁸²¹ Mississippi had modeled its new program after South Carolina’s educational system. The equalization process was to prolong

⁸¹⁹ “Opening Plans Disclosed for New District Schools,” *Enterprise-Journal*, August 14, 1957, 1.

⁸²⁰ James T. Patterson, *Brown V. Board of Education: A Civil Rights Milestone and Its Troubled Legacy* (Oxford: Oxford University Press, 2001), 42.

⁸²¹ *Ibid.*, 43-44; Kenneth B. Clark and Mamie P. Clark, “Emotional Factors in Racial Identification and Preference in Negro Children,” *The Journal of Negro Education* 19, no. 3 (Summer 1950): 341-350; Kenneth B. Clark, “Effect of Prejudice and Discrimination on Personality Development.” The Clarks questioned sixteen children in Clarendon County, South Carolina using two dolls with different skin tones. In addition, Kenneth Clark spoke at the MWHCCY about the negatively shaped minority children. Also see: Anne C. Dailey, “Developing Citizens,” *Iowa Law Review* 91 (2006): 446-447.

segregation in school, which harmed students. The new system did not uphold the ideals of “A Pledge to the Children.”

The equalization plan or the MFEP created as it suggested minimum standards for educational standards. The new law accepted the MCCC suggestions for transportation for students, who lived two miles away from the school. This helped students access an education, especially when their designated school was on the other side of town or the county. The program continued to sponsor vocational high schools to better train students for the industrializing economy, but most vocational high schools were white-only by a margin of nearly three to one.⁸²² The availability of space for African American students was disproportionate to the number of schools. African Americans totaled over two-fifths of the total state population.⁸²³ The MCCC believed that school guidance workers should place students into a vocational or educational program that fit a student’s individual needs.⁸²⁴ Many students did not have access to guidance counselors because only forty-five worked in the state and the MCCC advocated for more funds to expand guidance programs.⁸²⁵ Finally, the new program addressed education for “exceptional children programs” for “any child of educable mind, between the ages of six and twenty-one years, except a child for who institutional care and training are already available in the state, who is retarded in the in the regular public school activities...”⁸²⁶ These children

⁸²²The Mississippi Children’s Code Commission, *Mississippi Report on Services to Children and Youth*, 84.

⁸²³Westley F. Busbee, Jr. *Mississippi: A History* (Wheeling, Illinois: Harlan Davidson, Inc., 2005), 297.

⁸²⁴ The Mississippi Children’s Code Commission, *Mississippi Report on Services to Children and Youth*, 95.

⁸²⁵ *Ibid.*, 96.

⁸²⁶ *Ibid.*,90.

could have cognitive disorders, physically handicapped, hearing, speech, or vision impairments.⁸²⁷

In the early 1950s, the exceptional children program was just beginning and by 1951, only twenty-one of the eighty-two counties had established programs.⁸²⁸ The program was growing quickly and opening educational opportunities to children that may have been excluded from developing cognitive skills in the general classroom. One issue that the new program faced in Mississippi was special education training for teachers. The programs were only available at the University of Mississippi and Mississippi Southern College, all white schools in the mid-1950s. The state recognized the limitation, but believed that the programs would continue to grow and reach more students in the future.⁸²⁹ The MCCC believed that the education program for exceptional children would “do its part toward building a happy and useful citizenry if proper financial and administrative provision is made for it.”⁸³⁰ The MCCC was hopeful for education improvement to create happy and emotionally stable children in the mid-1950s, but Mississippi’s educational system still needed to develop better curriculum, construct more facilities, provide better training for teachers, and truly work toward providing equal access to education in desegregated schools.

⁸²⁷ Ibid. House Bill 51 outlined which children qualified for special education courses.

⁸²⁸ Ibid., 90-91.

⁸²⁹ Ibid.

⁸³⁰ Ibid., 91.

Although the legislature allocated funds for “equalizing” segregated schools in the early 1950s, in the mid-1950s the MCCC attempted to persuade the legislature to make significant changes to the education. However, the MCCC did not request for desegregation, which influenced how African American students felt about their educational opportunities. Some advancements in education did occur for all Mississippi students during the 1950s. By 1954 and 1955, the MCCC made a number of recommendations for the upcoming legislature in 1958 to consider bills that would address the importance of an education for later employment in industry and school certification for working children.⁸³¹ The Code Commission made many of these recommendations because Mississippi high school students dropped out at a higher rate than their national counterparts. For school-aged youth, the MCCC studied the dropout problem in the state. According to the *Enterprise-Journal*, one of the MCCC dropout studies revealed that only thirty-six and a half percent of students graduated high school.⁸³² On the same page of the *Enterprise-Journal*, the editorial article explained that the “Soviets [were] outclassing us in education.”⁸³³ Presumably the status of American education caused some anxiety about the state of American education. The MCCC continued to request the state legislature to address the issue. Over thirty years after the MWHCCY, the Mississippi Legislature passed the Educational Reform Act, which enforced compulsory education for students age six to fourteen. The Act was the largest

⁸³¹ Mississippi Children’s Code Commission, “Biennial Report of the Children’s Code Commission, January 1, 1954-December 31, 1955,” 12- 13, Mississippi Department of Archives and History.

⁸³² “Too Many School “Drop Outs in Mississippi,” *Enterprise-Journal*, December 3, 1957, 2.

⁸³³ Ibid.

overhaul of education in Mississippi and it achieved much more than what the MCCC members wanted thirty years earlier. The bill created school accreditation, increased the number of teachers, and created kindergartens.⁸³⁴ The happiness and emotional health of Mississippi children was an ideal in 1950s rather than a reality. Other states also tried to address the happiness and emotional health of their children. These states considered education along with other services for children such as mental health care.

In the 1950s, New York attempted to improve children's mental health by improving education and expanding mental hygiene services for children. In New York, four million children resided in the state at midcentury. The state had nearly twice as many children as Mississippi's entire population. New York's larger population required more logistical planning in order to meet the needs of both rural and urban New York juveniles. Governor Thomas Dewey appointed members to an advisory committee about children and youth on March 3, 1950. This group included politicians and appointed officials ranging from the State Commissioner of Health to the Director of the State Youth Commission. The goal of this organization was to draw public attention to issues surrounding children and to create a sense of responsibility to improve conditions for New York's youth.⁸³⁵ Shortly thereafter, one hundred New Yorkers representing various

⁸³⁴ "Senator Lancaster says...Special Legislative Session Called for some 'Agonizing' Votes," *The Winona Times*, December 20, 1982, 5.

⁸³⁵ Samuel R. Millbank, "'The Four Million' in New York," *State Government* (1952): 12, Folder: "New York," Box: "4," Series II: "Records of the Midcentury White House Conference on Children and Youth," Record Group: "85-14: White House Conference on Children and Youth, 1930-1970," Dwight D. Eisenhower Presidential Library and Museum; Samuel Milbank, Chair, *The Four Million: Report of the New York State Citizens' Committee of One Hundred for Children and Youth, 1951* (Albany: New York State Citizen's Committee of One Hundred for Children and Youth, 1951), preface. Approximately seven hundred people served in some capacity on NYCOHCY's different committees. Governor Thomas Dewey appointed one-hundred official members in March 1950. In addition, the Commissioners of Health, Mental Hygiene, Labor, Agriculture and Markets, Social Welfare, Correction, Education, the Chairman of

religious, political, and professional backgrounds joined the newly created New York State Citizens' Committee of One Hundred for Children and Youth or the NYCOHCY. To achieve these goals, the committee broke into smaller groups like Mississippi's subcommittees. These groups studied "child care, child health, mental health, education, youth services, rural youth, industrial youth, and protective and correctional care" respectively.⁸³⁶ The scope of New York's investigation on children was wider because the state had larger populations of both urban and rural children. Samuel Milbank, the Chairman of the Committee of One Hundred for Children and Youth and the Vice-President of the Milbank Memorial Fund, explained that the smaller groups also included other members from the general public and government that totaled over six hundred participants. The data these advocates collected stemmed from fact-finding for the MWHCCY, but it continued its work into 1951. In *The Four Million*, the NYCOHCY reported its findings on children and their relationships to family, child care, education, physical and mental health, physical disabilities, mental disabilities, delinquency, work, and community.

In New York, the MWHCCY's goals encouraged the NYCOHCY to reevaluate the state's education system. With the help of Lewis A. Wilson, the New York State Commissioner of Education, the NYCOHCY's Education Section (ES) accessed and made recommendations to help New York's education system meet the goals of MWHCCY. The ES members knew that the school as an organization reached almost all

the State Parole Board and the Executive Director of the State Youth Commission served on an Advisory Committee.

⁸³⁶ Ibid.

children.⁸³⁷ According to the ES, the school with other organizations like the church needed to cooperate to reach “the common goal of developing good citizens, happy and well-adjusted adults, ethically, morally, and spiritually sound men and women.”⁸³⁸

Because of the baby boom, midcentury New York schools often had overcrowded classes and a shortage of teachers.⁸³⁹ In addition, some teachers did not have adequate training in their subject field or in current teaching methodologies. For instance, New York City would need about 5,000 additional elementary teachers by mid-1950.⁸⁴⁰ With these deficiencies in mind, the ES members addressed issues and made recommendations regarding kindergarten, elementary, and secondary schools. The state legislature had already passed a 1947 law to raise teachers’ salaries, which made teaching a more appealing profession. The ES delegates also recommended teachers scouting out potential students who had the personality and aptitude for teaching. According to the ES’s report, “All applicants for teacher training should be carefully screen in terms of their personality characteristics as well as their intellectual abilities.”⁸⁴¹ The education representatives feared that teachers, who suffered from mental illness or lacked sensitivity towards children, could harm the development of New York students.⁸⁴² If

⁸³⁷ Samuel Milbank, Chair, *The Four Million: Report of the New York State Citizens’ Committee of One Hundred for Children and Youth, 1951*, 35.

⁸³⁸ *Ibid.*, 36.

⁸³⁹ *Ibid.*

⁸⁴⁰ *Ibid.*, 41.

⁸⁴¹ *Ibid.*

⁸⁴² *Ibid.*, 42.

teachers were to teach American children to have a desirable personality, the members thought that the teachers needed to have similar personality characteristics.

In New York, the ES members wanted teachers to encourage students to have happy personalities and emotional health, but to still be an individual.⁸⁴³ To accomplish these goals, the ES's report offered suggestions on elementary curriculum. During the 1950s, New York schools needed to improve by developing a "child development curriculum" or a curriculum that incorporated new social science theories about child development.⁸⁴⁴ The ES representatives argued that the "most important outcomes of education are the attitudes children develop."⁸⁴⁵ The teachers were responsible for finding students, who needed additional help, so that they could individually grow into a well-adjusted adult. The curriculum the teachers taught was one way to encourage responsibility, but providing guidance was another important aspect.

The ES believed that the school served as an organization that could provide guidance to children. The Section's report noted that "guidance is still of central importance to each of the White House Conference objectives."⁸⁴⁶ New York did not have many guidance programs in elementary schools to provide students with "special needs" regarding "their social, mental, and emotional development."⁸⁴⁷ The ES members believed that in many cases the programs that existed were inadequate and more

⁸⁴³ Ibid.

⁸⁴⁴ Ibid., 43.

⁸⁴⁵ Ibid.

⁸⁴⁶ Ibid., 57.

⁸⁴⁷ Ibid.

programs needed to be established throughout the state. Guidance counselors, instead of teachers, were ideal for providing student with the services the children needed. At the high school level, the ES wanted all high schools to have guidance programs with trained counselors and recommended that smaller schools at least have trained staff members, who can help guide students. Although it was ideal for these professionals to care for no more than three hundred students, their caseloads were often much higher. Guidance counselors or teachers advised high school students on which course of study fit their needs.⁸⁴⁸ The ES asked schools to provide guidance services that were “directed toward the vocational, social, and emotional needs of youth, rather than too exclusively to the educational problems of young people.”⁸⁴⁹

Guidance would ensure that students received individualized curriculum and still conformed to a happy personality. If a student displayed signs of “social maladjustment,” the guidance counselor, teachers, or school administrators could suggest special programs, but the state lacked enough programs for these students. The ES reported that many school staff members wanted more training in understanding children with mental or emotional illnesses. At the midcentury, many schools were attempting to create programs “to take care of the aggressive, disturbed, withdrawn, or emotionally upset children.”⁸⁵⁰ The school systems could not receive financial help for these programs because the state only provided aid for legally delinquent children, who had committed

⁸⁴⁸ Ibid.

⁸⁴⁹ Ibid., 60.

⁸⁵⁰ Ibid., 55.

crimes.⁸⁵¹ The ES proposed that future planning address the lack of funding for social maladjustment programs and believed more of these programs should exist. New York City served as an example because it had six-hundred schools for certain groups of socially maladjusted pupils.”⁸⁵² Many of these programs offered remedial course work and cooperated with community services and social workers to improve pupils’ personalities.⁸⁵³ Although the state did not have many of these programs in the early 1950s, the state’s education system was moving towards incorporating these programs to ensure that children would become emotionally stable adults.

Schools attempted to address the issues of children’s overall health. The ES members explained that children needed access to health care diagnoses for physical and mental illnesses at school. The school medical professionals, mostly nurses, often reached out to parents to inform them of the child’s condition and how to correct or treat the illness.⁸⁵⁴ In addition, the ES advocated for health education classes for students. Many New York schools already had health services and health classes, but rural schools throughout the states would expand in school healthcare during the 1950s. The Section also advocated for more psychological health services that provided treatment for children including counseling. By promoting children’s physical and mental health, the school could help in maintaining the health of America’s future generation.

⁸⁵¹ Ibid.

⁸⁵² Ibid.

⁸⁵³ Ibid., 55-56.

⁸⁵⁴ Ibid., 45.

The ES recommended that school systems improve their school census procedure. If the school officials knew exactly how many children from birth to eighteen lived in the district, the school administration could better monitor school attendance. According to the ES delegates, the school censuses were often incomplete, especially for young children under five, those age seventeen or older, and those with “mentally and physically handicapped children.”⁸⁵⁵ Better school censuses would lead to better attendance because attendance monitors could investigate the issue behind absenteeism. When more children attended class, teachers had more opportunities to teach children how to behave.

At New York schools, teachers taught citizenship training about the privileges and “the responsibilities of citizens in a democracy.”⁸⁵⁶ Citizenship training often consisted of social studies lessons and opportunities for children to participate in community or school projects.⁸⁵⁷ The goals of such lessons and projects were to teach students responsibility and prepare students to be active citizens. Many schools implemented or continued citizenship training for students. In 1954 in Newark, New York, a small town near Rochester, elementary teachers organized to revise the current citizenship training program. By 1955, the Newark teachers created a new citizenship training program that focused on the “changing times and the changing concepts of citizenship education.”⁸⁵⁸ Students were encouraged to take on more responsibility in

⁸⁵⁵ Ibid., 48.

⁸⁵⁶ Ibid., 62.

⁸⁵⁷ Ibid.

⁸⁵⁸ “School Citizenship Unit to Meet in Newark Today,” *Democrat and Chronicle*, January 20, 1955, 33.

their community including being active in social and civic organizations.⁸⁵⁹ The New York Education Section strove to meet the goals of the MWHCCY by implementing programs that promoted better emotional health, attempted to reach students, who displayed undesirable personalities, and trained students to be productive citizens in the future.

In addition, ES members valued the “spiritual foundation” of education and the importance of religious education despite separation of church and state.⁸⁶⁰ In conjunction with the NYCOHCY Youth Services Study Section, the ES that “further study and experimentation with both released time and dismissed time programs” was needed. These programs allowed children to leave school to go to church or receive religious instructions at their own home. At the midcentury, over one hundred thousand students participated in these programs.⁸⁶¹ The ES believed that “the home, school, church, and community” had a duty to develop “ideals in children and youth.”⁸⁶² The ES’s report specifically noted that the church should play a role in a child’s education, which suggests that the members believed that Christianity was an ideal characteristic for citizens. The Youth Services Section concurred and specifically encouraged “churches and synagogues,” to improve recreation services provided for children, which helped in character development.⁸⁶³ The MWHCCY promoted children’s relationship to God and

⁸⁵⁹ Samuel Milbank, Chair, *The Four Million: Report of the New York State Citizens’ Committee of One Hundred for Children and Youth, 1951*, 62.

⁸⁶⁰ *Ibid.*, 37, 65.

⁸⁶¹ *Ibid.*, 65.

⁸⁶² *Ibid.*, 37.

⁸⁶³ *Ibid.*, 193.

the NYCOHCY followed the example and incorporated Judeo-Christian ideas throughout their recommendations.

Mississippi and New York responded to the call to improve education in ways that benefited each respective state. Both states needed more classrooms and school facilities because the schools were overcrowded. These schools were also understaffed or staffed with undereducated teachers. The two committees addressing education in these states called for better pay for teachers, more training for teachers, and more classrooms. Local factors including customs and economy influenced the MCCC and the NYCOHCY's ES education plan. In Mississippi, the Commission focused on an "equalization" program in an attempt to maintain segregation in schools. The plan did invest more money in both white and black schools, but overwhelmingly provided more money for white schools and students. The MCCC recommended requiring compulsory education and offering transportation to students, who lived outside of walking distance. On the other hand, New York's ES members called for better school censuses to determine how many children should be in school. Both Mississippi's and New York's measures encouraged better attendance, which exposed children to teachers, who taught children responsibility and values. In New York, the ES took teaching values further by incorporating citizenship training into the curriculum. The ES also recommended moving towards a child-development curriculum, so teachers could identify individuals, who had different educational needs to become well-adjusted adults. When students became adults, they needed a place in society. Both the Mississippi and New York programs saw a future in guidance counseling for students and provided more vocational education

programs. However, Mississippi did not have the trained personnel or money to provide the same level of guidance counseling as New York. Another discrepancy between the two states' educational system was special education. Mississippi needed to expand services with children with learning disabilities. New York had some educational options for children with learning disabilities, but the ES wanted to offer schools for socially maladjusted students. The MWHCCY led both states to reconsider education and how it played a role in shaping children's personalities.

The MWHCCY delegates emphasized the importance of mental health services for developing and maintaining healthy personalities. Along with readdressing the education systems, Mississippi and New York studied the children's mental health system in their states. The MCCC and the NYCOHCY members focused on offering child guidance clinics and caring for emotionally distressed children. The two state committees wanted to create or expand programs that helped promoted the goal of the MWHCCY. Some of the recommendations came to fruition, while local factors made some programs develop slowly. Child emotional healthcare became a significant portion of juvenile public health during the 1950s.

Since World War II, the MSBH "operated Child Guidance Centers for children having emotional and adjustment problems and the adults who are responsible for and concerned about them."⁸⁶⁴ The child guidance programs were clinical and educational.⁸⁶⁵ According to the MCCC, different areas had more access to the child guidance programs

⁸⁶⁴The Mississippi Children's Code Commission, *Mississippi Report on Services to Children and Youth*, 172.

⁸⁶⁵ Ibid.

than others, and areas with service often had to prioritize which children received care. For this reason, the MCCC recommended that local areas should create their own mental health services. To accomplish this goal, MCCC published a plan for expanding juvenile mental health in Mississippi in September 1955. Under the new plan, the MSBH would monitor three mental health regions: the northern region's center would be located at Leflore County Health Department in Greenwood; a central region with the State Board of Health in Jackson would serve as a center; and in Hattiesburg, the Forrest County Health Department would provide services for the southern region. Patients seeking care had go to the center in their district. The MCCC noted that these regional mental health centers would have at least a clinical psychologist and a psychiatric social worker. In addition, the centers would staff part-time psychiatrist and a part-time special clinician.⁸⁶⁶ The centers would hold a three-day psychiatric clinic each month and children with appointments could receive care at their regional centers.

The MSBH's mental health clinic staff members traveled upon request to other counties to provided mental health education or consultation.⁸⁶⁷ The plan encouraged local demonstrations about the services the mental health clinics offered, so more counties would prioritize mental health services. According to the MCC's report, the demonstrations took place in communities that the health officials had an interest and funds to host a local clinic. In Natchez, Dr. Estelle Mageria, a MSBH psychologist for child guidance, spoke to the Carpenter No. 1 Parent-Teacher Association about the

⁸⁶⁶ Ibid., 173.

⁸⁶⁷ Ibid.

importance of “child psychology and the school.”⁸⁶⁸ Outreach helped garner interest for child guidance clinics in more counties. These county or district that hosted the local clinic had to provide a work-space for the visiting clinical psychiatrist and psychiatric social workers. The goal was to help local clinics to move towards a locally staffed mental health program within five years. To ensure this plan, each county or district was fiscally responsible for a portion of the clinic cost.⁸⁶⁹ Under the plan, the MSBH could contract clinics in four counties or districts in each region. In the future, the MSBH hoped the clinics could expand its services. Current mental health professionals felt that the services needed to vary because child with emotional or behavioral problems needed different treatments. With the new plan, the staff would offer consultations, diagnosis, and treated children. First, the professionals would study “the child and his family” and then, the clinicians formulated “a plan that may be carried out by the staff and by other agencies in the community.”⁸⁷⁰ MSBH slowly began improving their child mental health services.

By 1957, Greenville leaders launched a campaign for a child guidance clinic. During National Mental Health Week, Reverend Russell Nunan led a week-long drive throughout Washington County to collect funds for the cause. According to State Senator Hayden Campbell. Greenville’s drive was the first attempt to expand child guidance clinics to a county in Mississippi.⁸⁷¹ The committee hoped to use the funds to provide

⁸⁶⁸ “Dr. Mageria Talks to Natchez PTA,” *The Clarion-Ledger*, 15, November 16, 1956.

⁸⁶⁹The Mississippi Children’s Code Commission, *Mississippi Report on Services to Children and Youth*, 174.

⁸⁷⁰ *Ibid.*, 174-175.

⁸⁷¹ “Child Guidance Clinic Goal of Mental Health Fund,” *The Delta Democrat-Times*, 1, April 30, 1957.

scholarships to local youth to study either psychiatry or psychiatric nursing. When the students finished their studies, the community would have locally trained personnel that could staff a child guidance clinic.⁸⁷² By the late 1960s, Washington County finally established a Child Guidance Clinic to serve the needs of children.⁸⁷³ Some children needed more than outpatient care and received in-residence treatment.

The Midcentury Conference prompted the MCCC to reevaluate mental health facilities for children. The MCCC members reported that “Mississippi is sadly lacking in adequate facilities to care for children who are acutely in need of continuing or prolonged psychiatric treatment.”⁸⁷⁴ By the 1950s, Mississippi had two institutions where long-term care was offered to children in Whitfield and Ellisville. The MCCC’s report mainly focused on Whitfield or Mississippi State Hospital, the state’s mental health hospital that followed the cottage model and in the early 1950s had a capacity of 4,810 patients.⁸⁷⁵ At the time, the hospital was meant for adult patients and discouraged admitting children.⁸⁷⁶

⁸⁷² Ibid.

⁸⁷³ Juanita Crespino, “JA Projects Benefit Area Children,” November 2, 1969, 8.

⁸⁷⁴The Mississippi Children’s Code Commission, *Mississippi Report on Services to Children and Youth*, 172.

⁸⁷⁵ Ibid., 178. For more information on the cottage plan see: Justin Martin, *Genius of Place: The Life of Frederick Law Olmsted, Abolitionist, Conservationist, and Designer of Central Park* (Cambridge: Da Capo Press, 2011), 311; James Trent, *Inventing the Feeble Mind: A History of Intellectual Disability in the United States* (Oxford: Oxford University Press, 1995), 61, 72-74, 83-89, 95-96; Mary de Young, *Madness: An American History of Mental Illness and Its Treatment* (Jefferson, North Carolina: McFarland Publishing, Inc., 2010), 96; Gerald N. Grob, *The Mad Among Us: A History of the Care of America’s Mentally Ill* (New York: The Free Press, 1994), 112, 115, 123.

⁸⁷⁶ The Mississippi Children’s Code Commission, *Mississippi Report on Services to Children and Youth*, 178.

However, a chancery clerk and two doctors could sign orders to admit teenagers over fifteen. For children under fifteen, a chancery Judge had to order admission.⁸⁷⁷

From March 1952 to October 1955, one hundred and forty-one children or teenagers under sixteen lived at the hospital for some time. African American patients made up ninety-four of the one hundred and forty-one. In the 1950s, the hospital was segregated and the children were separated by their race. An eight-year-old African American male and a nine-year-old African American male were the youngest patients.⁸⁷⁸ These young patients were incorporated into the general population.⁸⁷⁹ During the 1950s, the MCCC recommended that Whitfield officials should organize a children's unit for long-term care because the hospital received inquiries at least twenty-times a month about children's care. Whitfield psychiatric staff and other employees cited a "definite and urgent need for some facilities for emotionally disturbed children."⁸⁸⁰ The staff also argued that "it was not in the best interest of an emotionally disturbed children or a psychotic child" to place children in an environment with adult patients. The staff advocated for a children's unit and the MCCC concurred by recommending that Mississippi open a children's unit. By 1964, Whitfield still did not have a children's unit and the director, Dr. W.L. Jaquith, warned that his institution was "no place for a child." He cited the need for facilities to treat Mississippi children with emotional or mental illnesses. The hospital staff was "constantly bombarded by teachers, agencies, and

⁸⁷⁷ Ibid., 179-180.

⁸⁷⁸ Ibid, 180.

⁸⁷⁹ Ibid.

⁸⁸⁰ Ibid., 179.

communities to treat and process children.”⁸⁸¹ Unfortunately, the Mississippi State Hospital did not follow through with the plan for a separate unit for children until 1993, forty-three years after the call for better mental health services for American children.⁸⁸²

Since the Mississippi State Hospital did not have a juvenile unit, the Whitfield staff transferred fifteen of the one hundred and forty-one young patients to the Ellisville State School (Ellisville). The school opened as the Mississippi School and Colony for the Feebleminded in 1921 and offered in-resident training for mentally disabled patients. Some of the residents learned how to farm, while others learned how to tend house.⁸⁸³ It is likely that gender roles, race, and class dictated which skill a child learned. From 1950 to 1955, the state helped expanded Ellisville by increasing residency capacity from 350 to 857.⁸⁸⁴ The school also almost doubled its staff by reaching 113 employees by 1955.⁸⁸⁵ The MCCC’s report did not provide specific recommendations for Ellisville, but the institution was already transforming to help mentally disabled children become productive citizens. Yet, the state did not have a school for children in emotional distress.

In New York, juvenile mental healthcare had a better foundation. The NYCOHCY’s subsections on Child Health and Mental Health compiled a guide that

⁸⁸¹ “No Place for a Child,” *Hattiesburg American*, May 12, 1964, 6.

⁸⁸² “MSH to Mark Anniversary of Center,” *Rankin Ledger*, April 26, 2016.

⁸⁸³ The Mississippi Children’s Code Commission, *Mississippi Report on Services to Children and Youth*, 53.

⁸⁸⁴ *Ibid.*

⁸⁸⁵ *Ibid.*

incorporated the recommendations of the MWHCCY.⁸⁸⁶ New York had one of the country's top state public health infrastructures and invested millions of dollars into the State Department of Health and the State Department of Mental Hygiene each year. For instance, in 1950, New York allocated one hundred million dollars to the State Department of Mental Hygiene and with some of these funds, the department ran one hundred forty-nine of the one hundred eighty-three child guidance clinics throughout the state.⁸⁸⁷ The clinics were only the beginning phase for improving mental health among both adult and child populations. The state also began adding new units to state hospitals that specifically treated mentally "defective" patients and in the long-term, planned to add at least three hundred beds for mentally "disturbed children."⁸⁸⁸ The Child Health and Mental Health subsections wanted to promote an interest in children's health. To create public action, these advocates decided that they needed to define the specific goals for providing services for children to grow and maintain a healthy personality and physical body.

The Child Health and Mental Health groups gathered together to define what New York, as a state, should provide to its minors. The Child Health members gathered nine Heads of the Departments of Pediatrics from New York to outline standards of care from birth to teenage years. According to the group, the MWHCCY "with its emphasis upon 'the mental, emotional, and spiritual qualities essential to individual happiness and

⁸⁸⁶ Samuel Milbank, Chair, *The Four Million: Report of the New York State Citizens' Committee of One Hundred for Children and Youth, 1951*, 70. According to Consumer Price Index Calculator, one-hundred million dollars in January 1950 is equivalent to \$147.5 million dollars in 2018 currency.

⁸⁸⁷ *Ibid.*, 69.

⁸⁸⁸ *Ibid.*

responsible citizenship,' provide an opportunity in New York State to present more clearly the objectives of total health supervision of the presumably normal child...”⁸⁸⁹ New York’s standards sought to provide the level of care to maintain children’s health based on the World Health Organization’s (WHO) definition of health. The WHO, a post-war branch of the United Nations, incorporated “physical, mental and social well-being.”⁸⁹⁰ The WHO definition of health was like the MWHCC’s idea of health, but the MWHCC delegates also focused on spiritual health. The New York organizers believed that the state could provide total healthcare from infancy to adulthood. The panel argued that the state was responsible for four areas of supervised health care: regular medical examinations, nutritional services, vaccinations, and dental care.⁸⁹¹ Public health officials and physicians should not only focus on physical, but emotional health. These health care professionals had a duty to prepare “parents in advance for the successive stages of normal emotional and social development of their children, so as to allow fullest development of the child’s personality...”⁸⁹² The overall program required health professionals to engage with the public and parents about children’s health. They guided and taught these parents at various functions such as health clinics or Parent-Teacher Association meetings.⁸⁹³ The proposed plan for New York’s four million children reified the goal set forth by the MWHCCY. For instance, the committee related adequate

⁸⁸⁹ Ibid., 71.

⁸⁹⁰ Ibid.

⁸⁹¹ Ibid., 73-74.

⁸⁹² Ibid., 73.

⁸⁹³ Ibid., 74.

nutrition and emotional stability: children who had access to nutritious foods were less likely to be anxious regarding eating. Emotional and mental health would be a staple in public health programs for New York children for the second half of the twentieth century.

The mental health care structure at midcentury was beginning to grow.⁸⁹⁴ In 1949, the New York State Mental Health Commission began studying the status of mental health throughout the state. The commission was tasked with creating and organizing mental health care in the Empire State, and to accomplish this goal, the Commission cooperated with various state agencies including the New York Department of Mental Hygiene, which formed in 1926, and the Department of Health.⁸⁹⁵ Although these state agencies existed, the state could not currently provide its citizens with proper mental health care because it did not enough facilities or providers. This could have factored into the commission's decision to focus on "preventive programs."⁸⁹⁶ When considering children's mental health, the commission asserted that the personnel and laypeople needed training in the mental and emotional health of children.⁸⁹⁷ "Spiritual leaders, teachers, social workers, health educators, nursery school teachers, and many other types of personnel in specialized fields, all must play their part in community programs for fostering mental and emotional health."⁸⁹⁸ Since these adults had so much influence on

⁸⁹⁴ Gerald Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill* (New York: Free Press, 1994), 223-248.

⁸⁹⁵ Samuel Milbank, Chair, *The Four Million*, 74-75.

⁸⁹⁶ *Ibid.*, 75.

⁸⁹⁷ *Ibid.*, 76.

⁸⁹⁸ *Ibid.*

children, they needed to study child development. College students training to become teachers had an obligation to learn about children growth, development, and behavior.⁸⁹⁹ In some counties, public health personnel taught teachers about child development. In 1952, Yates County teachers attended a viewing of “Preface to Life,” a film on child development, hosted by Mrs. Kenneth Eaton, a school nurse.⁹⁰⁰ Teachers could identify children who seemed deviant in behavior or did not meet growth milestones. The educators were often the first responders to improve students’ conduct or offer remedial coursework to help students reach their educational goals. Furthermore, teachers could refer students with mental or physical illness to public health clinics or suggest that the parents’ follow-up with their family physician.

The Commission encouraged public health personnel to focus on emotional health and personality even before an infant was born. In 1950, most New York births occurred in hospitals, but some still occurred at home or maternity clinics. The state was still experiencing the baby boom and approximately 300,000 births occurred that year. By 1960, the boom peaked at over 350,000 births.⁹⁰¹ The population growth of young children during the 1950s exerted more pressure on the state’s health and mental health infrastructure. Throughout the state, public health nurses continued hosting baby wellness clinics and child health conferences. At these events, nurses and other health personnel educated mothers about the importance of regular preventive and wellness health

⁸⁹⁹ Ibid., 77.

⁹⁰⁰ “Rural Teachers See Mental Health Film for Children,” *Chronicle-Express*, October 30, 1952, 19.

⁹⁰¹ New York State Department of Health Division of Information, *Annual Report of Vital Statistics: New York State 2013* (Albany: New York State Department of Health, 2015), 9.

visits.⁹⁰² The health supervision program that the NYCOHCY plan included attempted to provide both infants and preschool children medical attention just like school-aged children. Preventive services for young children would ensure that most children entered school “in as nearly perfect a state of health-mental, emotional, and physical---as it is possible to achieve...”⁹⁰³ This required parents to cooperate with health officials and child welfare personnel.

For all New York children, the Committee’s subgroup on health and mental health wanted parents to be responsible, both providing health care to their child and paying for said services. These groups knew that New York could not expect each New York child to receive every service that the state offered. Some rural communities did not offer specific health services and only had part-time health departments. This made it difficult for all New York children to have access to more specialized public health services such as mental health sessions. The health and mental health believed that more children could receive health supervision by “cooperation” and “coordination.”⁹⁰⁴ With these plans the NYCOHCY helped New York by building New York’s health service, especially emotional health service, and making it available to children through the state.

Some children in emotional distress attended child guidance clinics. However, the Child Care Section of the NYCOHCY explained that most rural areas did not have enough “child guidance clinic service.”⁹⁰⁵ The scarcity of these clinics meant that the

⁹⁰² Samuel Milbank, Chair, *Report of the New York State Citizens’ Committee of One Hundred for Children and Youth, 1951*, 81-82.

⁹⁰³ *Ibid.*, 82.

⁹⁰⁴ *Ibid.*, 76.

⁹⁰⁵ *Ibid.*, 87.

staff placed children on waitlists, and disturbed adolescents did not begin treatment in a timely matter, which sometimes exacerbated the problem. Urban areas also needed more child guidance clinics. These clinics provided basic psychiatric care and provided limited treatments or corrections.⁹⁰⁶ For more serious mental disorders, children were placed in child psychiatric wards at the Rockland State Hospital, King's Park State Hospital, and New York State Psychiatric Institute. These wards did not have space for all the children that needed treatment, so many were left to attending child guidance clinics at irregular intervals.⁹⁰⁷ The NYCOHCY Mental Health Section stated that the current facilities could not provide care for all referred children. The Mental Health Section recommended that a child mental health unit should be established, especially in upstate.⁹⁰⁸ By early 1963, the State Mental Hygiene Department devoted two million dollars to improve current structures at the Fairmount Division of the Syracuse State School. The Fairmount Division would serve as a center for emotionally disturbed children in the upstate area. After more than a decade of work, the state met one of the goals to improve institutional care of children.

Other parents turned to religion to help their children through difficult times. The delegates at the MWHCCY believed that Judeo-Christian values improved children's spirituality, personalities, and emotional health.⁹⁰⁹ Similarly, New Yorkers saw that

⁹⁰⁶Ibid., 87-88.

⁹⁰⁷ Ibid., 88-89.

⁹⁰⁸ Ibid., 89.

⁹⁰⁹ Midcentury White House Conference on Children and Youth, Inc., *Platform Recommendations and Pledge to Children*, iii-iv.

religion played an important role in “the development and synthesis of mental and moral health in many ways thoroughly germane to the human personality.”⁹¹⁰ Nearly half of all New Yorkers or approximately seven million people held membership at Christian churches or Jewish synagogues.⁹¹¹ A few million more also attended these religious centers throughout the year for guidance and spiritual growth. These religious institutions provided children with recreational opportunities and character building exercises.⁹¹² Religion was a medium to prevent and improve juvenile delinquency. The Youth Sub-Committee explained that “there is no ideal conceived by natural ethics that can offer a child as compelling a concept for better behavior as the truth taught by religion that he is a child of God.”⁹¹³ During the Cold War, the spirituality of American children was a vital part of proving that American values were better than communist values. Shortly after the MWHCCY, a group of Catholic leaders met in Albany to discuss the importance of religious education for children. One nun, Sister Mary St. Mark of the Immaculate Conception School (Rochester) explained, “We must plant the seeds that will be reaped in a harvest of happy homes for the next generation.”⁹¹⁴ At the midcentury, spirituality was tied to emotional well-being.

⁹¹⁰ Samuel Milbank, Chair, *Report of the New York State Citizens’ Committee of One Hundred for Children and Youth, 1951*, 91.

⁹¹¹ *Ibid.*, 192.

⁹¹² *Ibid.*, 192-193.

⁹¹³ *Ibid.*, 192.

⁹¹⁴ “Catholic Group Holds Regional Parley at Albany,” *The Times Record*, October 26, 1951, 18.

With the cooperation and coordination between religious institutions, schools, volunteer organizations, and health services, the NYCOHCY members believed that New York children had a better chance at having healthier bodies and personalities. By the late 1950s, New York had created a thriving mental hygiene program that incorporated professionals and members of the general public to help children achieve healthy personalities. The Committee of One Hundred and various state organizations realized that it could not fund an entire public mental hygiene program, but by suggesting private care for children whose parents could afford treatment, and public or community sponsored programs including counseling. The four million New York children were growing up in a cold international and national climate and many were anxious. By the end of the decade, they had a variety of outlets to restore emotional stability.

The MWHCCY delegates wanted American children to have equal access to quality education. The 1950s follow-up work in Mississippi and New York made improvements in education, but inequalities still existed in both states' educational systems. In New York, rural areas did not always have the same programs or facilities as urban schools. For instance, in New York City, students who experienced emotional distress had better access to specific schools that aimed to improve the student's personalities. In Mississippi, race remained a contentious issue in the education system for decades. Equalization did not provide African American students with the same quality of education and black students did not have the same access to vocational courses as white students. These aspects represent shortcomings in America's education system, but it reflected each state's local context. Both state committees attempted to advance education and help children develop happy personalities.

The MWHCCY delegates believed that children's mental health was important to child development. Mississippi and New York assess and expand mental health programs for children. New York entered the 1950s with one of the United States' best public health programs because it had the infrastructure, trained public health personnel, and funding. On the other hand, Mississippi's program was below average, albeit Mississippi's public health program was advancing by encouraging better training and expanding programs. Both states had child guidance clinics to treat children with emotional or personality disorders and help parents. The guidance clinics cooperated with the parents, schools, and other community organizations. In New York, the NYCOHCY encouraged religious leaders and organizations to foster children's mental health. This contrasted with Mississippi's mental health expansion plan. MCCC members followed the recommendation of the state's mental hospital staff and encouraged the creation of an in-residence program for children. The MCCC failed to accomplish this goal in a reasonable timeframe. New York, which already had child psychiatric programs, encouraged a new institution upstate and planning began for a children's unit at Fairmount. Considering New York's resources and existing infrastructure for public health, it is not surprising that the state made more headway than Mississippi. Both states adjusted their mental health programs to focus on more modern mental health programs that incorporated children's psychiatric care, but to varying degrees. The MWHCCY directly led to improvement in juvenile mental healthcare in the states.

The MWHCCY did not take place in a vacuum; international and national current events affected the topic and outcome of the conference. At the conference, the delegates worried that children were growing up during anxious times and they needed better

education opportunities, health care, and spirituality. The delegates debated the meaning of childhood personality and defined specific qualities for American children. The attendees also encouraged states to follow-up on the conference. States utilized the studies that state committees produced on the status of children to address issues facing the youth in each state. Mississippi and New York are two examples of states using national programs to improve the education and health of American children. The theme for the MWHCCY, emotional and mental health, created a higher standard for public and private healthcare during the decade. Doctors and nurses considered not only the physical health of the child, but also the emotional. Better-trained teachers could also point out discrepancies with developmental growth and attempt to correct the issue. By the end of the 1950s and with the help of court cases and new legislation, child welfare advocates were moving closer to their goals for American children. *Brown v. Board* started the process of desegregation of public schools, but many states like Mississippi continued to practice “school equalization” to delay integrating public schools and damaged children’s self-esteem.⁹¹⁵ Public health was at a high point in the 1950s as states expanded child healthcare and welfare programs, as well as new programs focused on mental health and protecting children from situations that caused anxieties. When child welfare advocates began reevaluating at the end of the decade, they began planning the Golden White House Conference on Children and Youth. The conference’s theme was “to promote opportunities for children and youth to realize their full potential for a creative life in

⁹¹⁵ Charles C. Bolton, “Mississippi’s School Equalization Program,” 813-814.

freedom and dignity.”⁹¹⁶ The new conference focused on opportunity and creativity, while previous conferences seemed to be addressing specific problems children and youth faced.

⁹¹⁶ *Conference Proceedings: Golden Anniversary White House Conference on Children and Youth: March 27-April 2, 1960, Washington, D.C.* (Washington, D.C.: Golden Anniversary White House Conference on Children and Youth, Inc., 1960), 6.

CHAPTER VII

EPILOGUE: A PROGRESSING “FRONTIER” FOR MATERNAL AND CHILDREN’S HEALTH⁹¹⁷

On February 5, 1963, John F. Kennedy addressed both houses of the United States Congress about “the nation’s most urgent needs in the area of health improvements.”⁹¹⁸ President Kennedy argued that the nation faced the “twin problems” of “mental illness and mental retardation.”⁹¹⁹ The President’s own sister Rosemary Kennedy had an intellectual disability and was further incapacitated from lobotomy, which was supposed to treat her. Rosemary Kennedy’s disability influenced President Kennedy’s mental health policies.⁹²⁰ Kennedy proposed launching a “national program to combat mental retardation” because “it strikes our most precious asset—our children.”⁹²¹ Debilitating

⁹¹⁷ John F. Kennedy, “A New Frontier,” July 15, 1960, Democratic National Convention, Los Angeles, California, John F. Kennedy Presidential Library and Museum, accessed January 2018, <https://www.jfklibrary.org/Asset-Viewer/Archives/JFKSEN-0910-015.aspx>. In “A New Frontier,” John F. Kennedy asked Americans to avoid complacency and fight for advancements in all field for American society. Kennedy argued that Americans had to protect America’s system of governance and prove it was stronger than communism. Americans need to strive for “national greatness” rather than “national decline.”

⁹¹⁸ John F. Kennedy, “Special Message to the Congress on Mental Illness and Mental Retardation,” February 5, 1963, The American Presidency Project, accessed January 2018, <http://www.presidency.ucsb.edu/ws/?pid=9546>.

⁹¹⁹ Ibid.

⁹²⁰ E. Fuller Torrey, *American Psychosis: How the Federal Government Destroyed the Mental Illness Treatment System* (Oxford: Oxford University Press, 2014), 33-35.

⁹²¹ John F. Kennedy, “Special Message to the Congress on Mental Illness and Mental Retardation.”

intellectual disabilities plagued nearly 400,000 children, who required round-the-clock supervision. These 400,000 of 68.4 million American children only made up one-half of a percent of the total youth population. Kennedy lamented that until the 1950s, no state department of health had a program for intellectual disabilities. Although this was not factually correct, the United States did not provide adequate public health care programs for people with intellectual disabilities, especially children.⁹²² He worried that if more attention was not given to these disabilities that “a major national health, social and economic problem” would develop.⁹²³ Unfortunately, infants and children from lower socio-economic backgrounds developed “mental retardation” at higher rates.⁹²⁴ For this reason, child welfare advocates and politicians focused on improving healthcare for mentally disabled children and encouraged the government to invest in family planning services for poor families. Federal, state, and local governments invested nearly 600 million dollars each year to study, treat, and educate the intellectually disabled.⁹²⁵ By the early 1960s, child welfare advocates including President Kennedy began fostering public health initiatives that concentrated on this subgroup of American children, rather than preventative medicine for all American children because these programs were by this point well established.

⁹²² Many states developed institutions and schools for intellectually disabled Americans in the nineteenth century. See: Gerald Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill* (New York: Free Press, 1994).

⁹²³ John F. Kennedy, “Special Message to the Congress on Mental Illness and Mental Retardation.”

⁹²⁴ Ibid.

⁹²⁵ Ibid.

The child welfare activists of 1960s were turning their attention away from their early twentieth century health campaigns because of high vaccination rates and the low occurrence rates of childhood disease like diphtheria. During the first half of the twentieth century, delegates initially focused on preventive medicine for all mothers and young children. The Sheppard-Towner Act increased efforts in maternal and infant health, which led to a decrease in maternal and infant mortality. Although the Children's Bureau lobbied for the continuation of the Sheppard-Towner program, Congress did not renew it in 1929. Members of the Children's Bureau (CB) and other child welfare activists quickly addressed the lack of funds at the 1930 White House Conference on Child Health and Protection. Using the insecurities of the Great Depression, the CB pushed for Title V of the Social Security Act of 1935 to ensure public maternal and child health for mothers and children throughout the United States. Title V helped build the maternal and infant health care system that was vital during World War II.

The CB used the influx of soldiers' expectant wives to broaden their control of federal maternal and infant hygiene programs. These early programs centered on improving maternal and infant hygiene and providing preventative care for children. Child welfare activists knew that American children would soon become American adults, who physically defended the nation and socially upheld American democratic ideology. The ideal function of these programs was to provide access to healthcare to all mothers and children. From 1918 to 1950, these maternal and child health programs reached millions of Americans. Most of these services focused on the physical health of the mother and child. By 1950, preventative medicine for physical ailments was established and child welfare advocates shifted their attention to better understanding the

emotional and mental health of American children. Within the decade, state public health officials expanded mental health programs for their state's children. Medical historian Paul Starr explained that during the 1940s and 1950s, a shift occurred in American health care that "may be described as a change from mass exclusion to minority exclusion from medical care."⁹²⁶ To Starr, poor Americans did not have adequate medical care.⁹²⁷ When examining children's health, impoverished children also needed better access to health services. Therefore, with the preventative infrastructure for both physical and mental children's health care established by the 1960s, child welfare advocates turned their focus to specific groups of children, particularly those with intellectual disabilities or those who could not afford the increasingly expensive private health care system. The activists also pushed for federally funded family planning counseling for mothers.

During the early 1960s, health care was changing for American mothers and children. At the Golden Anniversary White House Conference on Children and Youth (1960), for the sixth time, delegates gathered data on the status of America's youth. The United States Interdepartmental Committee on Children and Youth noted that all states and territories received accepted "federal funds to extend and improve services for the health of mothers and child under the maternal and child health program established by the Social Security Act of 1935 and administered by the Children's Bureau."⁹²⁸ The

⁹²⁶ Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982), 373.

⁹²⁷ Ibid.

⁹²⁸ United States Interdepartmental Committee on Children and Youth, *Children in a Changing World: A Book of Charts* (Washington, D.C.: Golden Anniversary White House Conference on Children and Youth, 1960), 60.

Maternal and Child Health nursing service cared for 554,000 mothers (1958), while over four million mothers were treated by physicians in hospitals during some point of their pregnancy.⁹²⁹ The way American mothers received maternal care had changed by 1960. The shift towards hospital births began two decades earlier and has remained the trend to the present-day.⁹³⁰ American mothers' infants and children also received public and private health care. By the 1960s, child health programs reached three million children, but many parents were taking their children to private physicians. Schools and public health clinics had become the standard, but "constant vigilance must be maintained and each generation must be immunized anew."⁹³¹ Even though private physicians vaccinated millions of children, the importance of vaccinations remained. The state-sponsored public health programs still offered vaccinations to all children, practically those who could not afford visiting a private physician.⁹³² In the late 1950s and early 1960s, the federal government made small appropriations under "maternal and child health services" for "services for mentally retarded children."⁹³³

By the late 1950s, approximately two-thirds of Americans had hospital insurance.⁹³⁴ Starr notes, "Prosperity gave Americans the opportunity to worry about

⁹²⁹ National Office of Vital Statistics of the United States Department of Health, Education, and Welfare, *Vital Statistics of the United States, 1958: Volume I* (Washington, D.C.: United States Government Printing Office, 1960), 115.

⁹³⁰ For information on the history of American childbirth in hospitals see: Richard and Dorothy Wertz, *Lying-in: A History of Childbirth in America* (New Haven: Yale University Press); Judith Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750 to 1950* (Oxford: Oxford University Press, 1988).

⁹³¹ United States Interdepartmental Committee on Children and Youth, *Children in a Changing World*, 61.

⁹³² Ibid.

⁹³³ Ibid., 63.

⁹³⁴ Starr, *The Social Transformation of American Medicine*, 334.

their health, and it also changed the health problems they worried about.” When President Kennedy addressed Congress in 1963, he called for improvements in services for mental health and intellectual disabilities. Kennedy’s request is a prime example of Starr’s observation. With preventative medicine in place to prevent contagious diseases, public health officials could address non-life-threatening illnesses. For instance, Kennedy signed into law the Maternal and Child Health and Mental Retardation Planning Amendments of 1963, which amended Title V of the original Social Security Act.⁹³⁵ The program assisted “States and communities in preventing and combating mental retardation through expansion and improvement of the maternal and child health and crippled children’s programs.”⁹³⁶ This expansion of maternal and children’s health reflects the shift in the type of services offered by public health organizations. Child welfare advocates were not arguing that children with mental disabilities would be future citizens, who would serve the country and protect American values. Instead, many of the advocates and President Kennedy believed that children who had mental disabilities would put a strain on the public health infrastructure and the economy.⁹³⁷ To solve these problems, these child

⁹³⁵ For more information regarding maternal and child health of the 1963 Social Security Amendments see: Joan Mulligan, “Three Federal Interventions on Behalf of Childbearing Women: The Sheppard-Towner Act, Emergency Maternity and Infant Care, and the Maternal and Child Health and Mental Retardation Planning Amendments of 1963,” (PhD diss., University of Michigan, 1976).

⁹³⁶ United States Congress, “Maternal and Child Health and Mental Retardation Planning Amendments of 1963,” October 24, 1963, National Archives and Records Administration, accessed January 2018, <https://www.archives.gov/research/americans-with-disabilities/transcriptions/naid-6050326-offprint-of-public-law-88-156.html>.

⁹³⁷ John F. Kennedy, “Special Message to the Congress on Mental Illness and Mental Retardation;” “Maternal and Child Health and Mental Retardation Planning Amendments of 1963,” Discussion of the Amendments on August 27, 1963, HR 7544, 88th Cong., 1st sess., *Congressional Record* 109, pt. 12, 15996-16013.

welfare advocates and politicians invested more money in mental health programs for intellectually disabled children and family planning.

The liberal reform of American medicine continued throughout the 1960s.⁹³⁸ Lyndon B. Johnson carried on the legacy of his predecessor. In 1964 and 1965, Johnson promoted the Great Society, which focused on ending poverty and promoting civil rights. One component of Johnson's Great Society was the Social Security Amendments of 1965, which not only provided insurance for elderly Americans, but also updated the maternal and children health service and the child welfare program. First, the law increased funding for all three programs: maternal health, children's health, and child welfare. Secondly, it authorized "special project grants to provide comprehensive health care for children of low-income families."⁹³⁹ This legislation represented the emphasis on health care for low-income children in the 1960s. Congress appropriated one hundred and eighty million dollars for a five-year health care program for impoverished children. States could use the grants to prevent or treat disease for this group of American children.⁹⁴⁰ Medicaid also provided health insurance to low-income families, so they could receive care at private clinics and hospitals. The expansion of Social Security allowed more American children access to the increasingly private health care sector.

The Social Security Act underwent many changes in the 1960s. In the mid-1960s, the federal government appropriated funds for family planning services in maternal and

⁹³⁸ Starr, *The Social Transformation of American Medicine*, 335.

⁹³⁹ Wilbur J. Cohen and Robert M. Ball, "Social Security Amendments of 1965: Summary and Legislative History," *Bulletin* (September 1965): 3.

⁹⁴⁰ *Ibid.*, 21.

child health state grants. Many states already offered family planning services and the federal funding helped expand these programs. Sociologist Mihnea Panu reported that most of these family planning clinics were in African American communities and that the first “tax-funded birth control program” started in Alabama.⁹⁴¹ The clinics provided birth control and family planning advice to women regardless of marital status. The Johnson Administration continued to study the population crisis and studied family planning including new contraceptive methods. The Administration and Congress reexamined the Social Security Act in 1967 and once again updated the Maternal and Child Health Section.⁹⁴² For the first time, the federal government required states to incorporate family planning into their maternal and children’s health service. The federal government allocated six percent of the annual maternal and child health budget for family planning including access to birth control. When the law was enacted in January 1968, some states quickly complied with the new law, while others delayed. According to an article from the *Congressional Quarterly*, the government was spending millions on birth control, which was a “taboo only a few years ago” and continues to be in some American communities. The government family planning programs were “aimed mainly at needy mothers in rural areas.”⁹⁴³ The government no longer simply considered maternal health,

⁹⁴¹ Mihnea Panu, *Contextualizing Family Planning: Truth, Subject, and the Other in the U.S. Government* (New York: Palgrave MacMillian, 2009), 74.

⁹⁴² Derek S. Hoff, *The State and the Stork: The Population Debate and Policy Making in US History*, (Chicago: The Chicago University Press, 2012), 148-157; Donald T. Critchlow, *Intended Consequences: Birth Control, Abortion, and the Federal Government in Modern America* (Oxford: Oxford University Press, 1999) 6, 79, 87, 228.

⁹⁴³ Andrea Schoenfeld, “Feds Are Pushing the Pill,” *The Montgomery Advertiser*, October 17, 1968, 4. *Congressional Quarterly* originally published this article, but various papers published it under varying titles. For instance, *The Cincinnati Enquirer* published it under the title, “Birth Rate, Poverty Spur U.S. Aid Effort” on September 29, 1968.

but social welfare activists recognized the significance of women's health and the financial and social benefits of family planning. This maternal and child health program specifically addressed women's health rather than maternal health at the time the women's health movement was gaining traction. By 1970, Congress passed The Family Planning Services and Population Research Act or Title X of the Public Health Service Act, which provided more funds for family planning services and research for better contraceptives. The United States Public Health Service (USPHS) managed Title X, not the CB.⁹⁴⁴ During this time, women started viewing their health care as separate from childbirth and maternity.⁹⁴⁵

By the 1960s, maternal and children's health entered a "new frontier."⁹⁴⁶ As demonstrated in this dissertation, the early twentieth century campaigns centered around preventive physical and later emotional health care for all children. While not all programs were successful, maternal and child welfare advocates addressed current events to promote maternal and child healthcare. Similarly, in the 1960s, activists used concerns with poverty to expand women's and children's health. However, these programs did not target all American children like the earlier plans. By the 1960s, approximately seventy-five percent of Americans had some health insurance, but mothers and children from low

⁹⁴⁴ Donald Critchlow, *Intended Consequences*, 228.

⁹⁴⁵ Please consult the following primary source by the Boston's Women's Health Book Collective entitled *Our Bodies, Ourselves* (1971).

⁹⁴⁶ John F. Kennedy, "A New Frontier," Gerald Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill*, 249-278. Grob dedicates a chapter to "The New Frontier and the Promise of Community Mental Health." In the 1960s, the successive Social Security Amendments helped create a stronger mental health system.

socio-economic classes often lacked coverage.⁹⁴⁷ The child welfare activists had already laid the foundation for basic physical and emotional healthcare for mothers and children by the 1960. Throughout the twentieth and the early twentieth-first centuries, maternal and children's health programs remained an important part of Social Security, yet Title V programs expanded to include much more than maternal and infant health care. By 1969, the Children's Bureau lost control of maternal and child health program to the USPHS. Mothers were gaining more control over their healthcare and reproductive rights. The CB's era of safeguarding mothers and children was over.⁹⁴⁸

⁹⁴⁷ Ronald L. Numbers, "The Third Party: Health Insurance in America," in *Sickness and Health in America: Readings in the History of Medicine and Public Health, Third Edition, Revised*, eds. Judith W. Leavitt and Ronald L. Numbers (Madison: The University of Wisconsin Press, 1997), 277.

⁹⁴⁸ "Safeguarding the Health of the Mothers and Children" was a periodic article that appeared in *The Child*, a Children's Bureau Journal.

BIBLIOGRAPHY

Primary Sources

Archival Materials

Alabama Department of History and Archives, Montgomery, Alabama.

Series 028237: Alabama Department of Public Health State Publications, 1870-2011

Series 13499: Alabama Department of Public Health Newspaper Articles Scrapbooks, 1922-1924

Series 7074: Alabama Department of Public Health Administrative Files of the State Health Officer, 1851-1997

Archives Department, Tuskegee University Libraries, Tuskegee, Alabama.

“First and Present Movable Schools (1931)”

Dwight D. Eisenhower Presidential Library and Museum, Abilene, Kansas.

Accession 85-14: White House Conference on Children and Youth: Records, 1930-1970

Eleanor Crowder Bjoring Center for Nursing Historical Inquiry, University of Virginia, Charlottesville, Virginia.

Collection: Mississippi Public Health Nursing: The Historical Collection of Caroline H. Benoist

Franklin D. Roosevelt Presidential Library and Museum, Hyde Park, New York.

Collection: Charles Taussig Youth Files

General Records: President’s Interdepartmental Committee to Coordinate Health and Welfare Activities

History of Medicine Division, United States National Library of Medicine, Bethesda Maryland.

Eugene L. Bishop White House Conference on Child Health and Protection Collection
Hoover Institute Library & Archives, Stanford University, Stanford, California.

White House Conference on Child Health Protection Records

Mississippi Department of Archives and History, Jackson, Mississippi.

Series 1014: Weekly Health Suggestions, 1924-1932

Series 1863: Public Health Nursing Files and Photographs, 1918-1980

Series 2012: Public Health Library Subject Files, 1931-1985

Series 2028: Office Files- Dr. Felix J. Underwood, 1922-1959.

Series 2031: County Health Department Files, 1935-1971.

Series 2036: Midwife Program Files and Photos-Public Health Nursing Division, 1911-1976

Series 2080: Division Activities Reports, 1935-1972

Series 2170: Mississippi State Department of Health Photograph Album, ca. 1930s

National Archives and Records Administration, College Park, Maryland.

Record Group 62: Records of the Council of National Defense

Record Group 64: Records of the National Archives and Records Administration

Record Group 102: Records of the Children's Bureau

New York State Archives, Albany, New York.

A3274: Files Relating to Public Health, 1937-1943

Reynolds-Finley Historical Library, The University of Alabama at Birmingham, Birmingham, Alabama.

Transactions of the Medical Association of the State of Alabama

The Historic New Orleans Collection, New Orleans, Louisiana.

John T. Mendes Photograph Collection

Legislation

First Deficiency Appropriation Act, 1943

Labor-Federal Security Appropriation Act, 1944

Maternal and Child Health and Mental Retardation Planning Amendments of 1963

The Promotion of the Welfare and Hygiene of Maternity and Infancy Act of 1921

The Social Security Act of 1935

The Social Security Amendments of 1939

The Social Security Amendments of 1965

The Social Security Amendments of 1967

Newspapers

Albuquerque Morning Journal (Albuquerque, New Mexico)

Buffalo Evening News (Buffalo, New York)

Carbonate Weekly Chronicle (Leadville, Colorado)

Chronicle-Express (Penn Yan, New York)

Coronado Eagle and Journal (Coronado, California)

Democrat and Chronicle (Rochester, New York)

Enterprise-Journal (McComb, Mississippi)

Evening Star (Washington, D.C.)

Hattiesburg American (Hattiesburg, Mississippi)

Jackson Daily News (Jackson, Mississippi)

New-York Tribune (New York City, New York)

Okolona Messenger (Okolona, Mississippi)
Our Mountain Home (Talladega, Alabama)
Our Southern Home (Livingston, Alabama)
Rankin Ledger (Brandon, Mississippi)
Stone County Enterprise (Wiggins, Mississippi)
The Arizona Republican (Phoenix, Arizona)
The Choctaw Plaindealer (Choctaw, Mississippi)
The Clarion-Ledger (Jackson, Mississippi)
The Clarksdale Press Register (Clarksdale, Mississippi)
The Delta Democrat-Times (Greenville, Mississippi)
The Elba Clipper (Elba, Alabama)
The Greenwood Commonwealth (Greenwood, Mississippi)
The Guntersville Democrat (Guntersville, Alabama)
The Mississippi Sun (Charleston, Mississippi)
The Montgomery Advertiser (Montgomery, Alabama)
The New York Times (New York City, New York)
The Nonpartisan Leader (Fargo, North Dakota)
The Sunday Star (Washington, D.C.)
The Times Record (Troy, New York)
The Washington Daily News (Washington, D.C.)
The Winona Times (Winona, Mississippi)
The Yazoo City Herald (Yazoo City, Mississippi)

Published Primary Sources

“Activities for Girls.” *The Playground* 13, no. 6 (September 1919): 228-238.

“Addendum.” *California and Western Medicine* 61, no. 3 (September 1944): 160-161.

“Corporal Kelly and His Son: The Emergency Maternity and Infant Care Program.” *The American Journal of Nursing* 44, no. 4 (April 1944): 366-370.

“Item XXXI: Maternity-Pediatric, Important Letter from California Medical Association Council to California Medical Association Members.” *California and Western Medicine* 59, no. 5 (November 1943): 282.

“Item XXXIV: Maternity-Pediatric, Resolution Adopted by Placer-Nevada-Sierra County Medical Association.” *California and Western Medicine* 59, no. 5 (November 1943): 283.

“Maternity-Pediatric-Item LVII, County Society Maternity-Pediatric Committees, Recent Rulings on E.M.I.C. on C.M.A. Suggestions.” *California and Western Medicine* 61, no. 3 (September 1944): 160-161.

“Part 204- Emergency Maternity and Infant Care Service.” *The Code of Federal Regulations of the United States of America*, title 42. Washington, D.C.: United States Government Printing Office, 1949.

“Patriotic Play Week at New Orleans.” *The Playground* 13, no. 1 (April 1919): 19-21.

“Safeguarding the Health of Mothers and Children.” *The Child* 8, no. 7 (January 1944): 111.

“The Prevalence of Typhoid Carriers in a General Population.” *Therapeutic Notes* 32, no. 6 (December 1925): 170

“The World at Play.” *The Playground* 13, no. 5 (August 1919): 163-171.

“Uncle Sam Provides Obstetric Care: Maternity and Infant Care for Wives and Infants of Men in Military Service.” *American Journal of Nursing* 43, no. 5 (May 1943): 470-471.

Abbott, Grace. “Federal Aid for the Protection of Maternity and Infancy.” *American Journal of Public Health* 12, no. 9 (September 1922): 737-742.

Baker, S. Josephine. “The Relation of the War to the Nourishment of Children.” *Woman’s Medical Journal* 18 (March 1918): 52.

Biggs, Hermann M., ed. *Fortieth Annual Report of the New York State Department of Health for the Year Ending December 31, 1919, Volume 1*. Albany: J.B. Lyon Company, Printers, 1920.

Black, John T. *Thirty-Sixth Report of the Connecticut State Department of Health for Two Years Ending June 30, 1920*. Hartford: State of Connecticut Department of Health, 1920.

Blair, Emily Newell. *The Woman's Committee: United States Council of National Defense: An Interpretative Report: April 21, 1917, to February 27, 1919*. Washington, D.C.: Government Printing Office, 1920.

Bremner, Robert H., ed. *Children and Youth in America: A Documentary History, Volume III, 1933-1973*. Cambridge: Harvard University Press, 1974.

Children in a Democracy: General Report Adopted by the White House Conference on Children in a Democracy, January 19, 1940. Washington, D.C.: Superintendent of Documents, 1940.

Clark, Kenneth B. "Effect of Prejudice and Discrimination on Personality Development." In *Midcentury White House Conference on Children and Youth*, 20–28, 1950.

Clark, Kenneth B., and Mamie P. Clark, "Emotional Factors in Racial Identification and Preference in Negro Children." *The Journal of Negro Education* 19, no. 3 (Summer 1950): 341-350.

Clark, Taliaferro and Selwyn D. Collins. *A Synopsis of the Child Hygiene Laws of the Several States Including School Medical Inspection Laws*. Washington, D.C.: United States Government Printing Office, 1925.

Cohen, Wilbur J. and Robert M. Ball. "Social Security Amendments of 1965: Summary and Legislative History." *Bulletin* (September 1965): 3-21.

Conference on Children in a Democracy: Papers and Discussions at the Initial Section, April 26, 1939. Washington, D.C.: United States Government Printing Office, 1939.

Conference Proceedings: Golden Anniversary White House Conference on Children and Youth: March 27-April 2, 1960, Washington, D.C. Washington, D.C.: Golden Anniversary White House Conference on Children and Youth, Inc., 1960.

Conn, Stetson. "Highlights of Mobilization, World War II, 1938-1942." U.S. Army Center of Military History Department of the Army. Accessed October 2016. <http://www.history.army.mil/documents/wwii/ww2mob.htm>.

DePorte, Joseph V. *Sixty-Second Annual Report of the Department of Health for the Year Ending December 31, 1941, Volume II*. Albany: New York State Department of Health, 1943.

DePorte, Joseph V. *Sixty-Second Annual Report of the Department of Health for the Year Ending December 31, 1941, Volume I*. Albany: New York State Department of Health, 1943.

Dunn, Halbert L. , ed. *Vital Statistics of the United States 1937: Part II Natality and Mortality Data for the United States Tabulated by Place of Residence*. Washington: United States Government Printing Office, 1939.

Eliot, Martha M. "EMIC Program: The Children's Bureau, EMIC and Postwar Planning for Child Health." *The Journal of Pediatrics* 25, no. 4 (October 1944): 351-367.

Eliot, Martha M. "The Children's Bureau, EMIC and Postwar Planning for Child Health: A Statement." *The Journal of Pediatrics* 25, no. 4 (October 1944): 351-67.
doi:10.1016/S0022-3476(44)80081-6.

Eliot, Martha M. and Lillian R Freedman. *Four Years of the EMIC Program*. Washington, D.C.: Federal Security Agency, Social Security Administration, U.S. Children's Bureau, 1947.

Etats-Unis, and Children's Bureau. *Maternal and Child Health Services, U.S. Department of Health Education and Welfare. Social Security Administration. Children's Bureau*. Washington, D.C.: Government Printing Office, 1965.

Farrand, Livingston, and Thomas Parran, Jr. *Public Health in New York State: Report of the New York Health Commission to His Excellency, The Honorable Franklin D. Roosevelt, Governor of the State of New York*. Albany: State of New York Department of Health, 1932.

Ferrell, John A., Wilson G. Smillie, Platt W. Covington, and Pauline A. Mead. *Health Departments of States and Provinces of the United States and Canada*. Washington: United States Government Printing Office, 1932.

For Every Child a Healthy Personality: A Digest of the Fact-Finding Report to the Midcentury White House Conference on Children and Youth. Washington, D.C.: Midcentury White House Conference on Children and Youth, Inc., 1950.

General Accounting Office. *Maternal and Child Health Programs Authorized by Title V, Social Security Act: Report to the Committee on Ways and Means, House of Representatives*. Washington, D.C.: Government Printing Office, 1972.

Georgia Council of Defense. *Final Report of Woman's Committee Council of National Defense Georgia Division. April, 1917-July, 1919.* Atlanta: Index Print Company, 1924.

Godfrey, Edward S., Jr. *Fifty-Eighth Annual Report of the Department of Health for the Year Ending December 31, 1937, Vol. I.* Albany: New York State Department of Health, 1938.

Hallock, Arthur C. K., and Beatrice S. Stone. "Children in a Democracy." *ALA Bulletin* 36, no. 6 (June 1, 1942): 404–7.

Handley, Harry E. *The Field Unit in Local Public Health Service: Tennessee and Mississippi, 1930-1937.* New York: The Commonwealth Fund, 1938.

Heaton, Leonard D. Surgeon General of the United States Army, *Medical Department, United States Army Personnel in World War II.* Washington, D.C.: Office of the Surgeon General of the United States Army, 1963.

Heaton, Leonard D. *Medical Department, United States Army Personnel in World War II.* Washington, D.C.: Office of the Surgeon General of the United States Army, 1963.

John F. Kennedy. "Special Message to the Congress on Mental Illness and Mental Retardation." February 5, 1963. The American Presidency Project. Accessed January 2018. <http://www.presidency.ucsb.edu/ws/?pid=9546>.

Johnson, Lyndon B. "Annual Message to Congress on the State of the Union." The American Presidency Project. Accessed July 24, 2015. <http://www.presidency.ucsb.edu/ws/index.php?pid=26907>.

Kaiser, A.D. "Midcentury White House Conference on Children and Youth: Health Aspects." *New York State Journal of Medicine* 52, no. 1 (1952): 63–67.

Kennedy, John F. "A New Frontier." July 15, 1960, Democratic National Convention, Los Angeles, California, John F. Kennedy Presidential Library and Museum. Accessed January 2018. <https://www.jfklibrary.org/Asset-Viewer/Archives/JFKSEN-0910-015.aspx>.

Kotinsky, Ruth, and Helen Leland Witmer. *Community Programs for Mental Health: Theory, Practice, Evaluation.* Cambridge: Harvard University Press, 1955.

Lathrop, Julia C. *Save 100,000 Babies: Get a Square Deal for Children,* Publication no. 36. Washington, D.C.: Government Printing Office, 1918.

Lathrop, Julia. "Seventh Annual Report of the Chief, Children's Bureau to the Secretary of Labor, Fiscal Year Ended June 30, 1919."

Love, Albert G. and Charles B. Davenport. *Defects Found in Drafted Men: Statistical Information Compiled from the Draft Records Showing the Physical Condition of the Men Registered and Examined in Pursuance of the Requirements of the Selective-Service Act.* Washington, D.C.: United States Government Printing Office, 1920.

Lundberg, Emma O. *Standards of Child Health, Education, and Social Welfare: Based on Recommendations of the White House Conference on Children in a Democracy: And Conclusions of Discussion Groups.* Washington, D.C.: Government Printing Office, 1942.

Maassen, Leland and David Whipple. "A History of Military Dependent Medical Care Programs." Technical Report for Naval Postgraduate School, August 1975.

Maddux, Walter, Edward Gatlin, and Charles Hunter. *Abstract of Lectures: Maternal and Child Health.* Jackson: Mississippi State Board of Health, 1937.

Manual for Midwives. Jackson: Mississippi State Board of Health, 1922.

McCombs, Carl E. *City Health Administration.* New York: The MacMillan Company, 1927.

McCown, Albert. "Part I-Maternal and Child-Health Services." *The Child* 1, no. 1 (July 1936):6-7.

McIntire, Ross T. and Norman T. Kirk. "A Message from the Surgeons General of the Army and Navy," *The Child* 8, no. 10 (April 1944): 151.

McIntire, Ross T. *The History of the Medical Department of the United States Navy in World War II.* Washington, D.C.: United States Government Printing Office, 1953.

Medicare and Social Security Explained. Chicago: Commerce Clearing House, 1965.

Meigs, Grace L. "The Children's Year Campaign." *The Journal of the American Medical Association* 71, no. 4 (July 27, 1918): 243–46. doi:10.1001/jama.1918.02600300007003.

Midcentury White House Conference on Children and Youth Fact Finding Committee. *Children and Youth at the Midcentury: A Chart Book.* Washington, D.C.: National Printing Company, 1950.

Midcentury White House Conference on Children and Youth, Inc. *Platform Recommendations and Pledge to Children.* Raleigh: Health Publications Institute, 1950.

Mid-century White House Conference on Children and Youth. "Midcentury White House Conference on Children and Youth: Progress Bulletin." *Midcentury White House Conference on Children and Youth: Progress Bulletin*, 1949.

Mid-century White House Conference on Children and Youth. *Children and Youth at the Midcentury Fact-Finding Report*. Washington, D.C.: Government Printing Office, 1950.

Mid-century White House Conference on Children and Youth. *Citizens in Action; Report on State and Local Action to the Midcentury White House Conference on Children and Youth, December 3-7, 1950*. Washington: Government Printing Office, 1950.

Midcentury White House Conference on Children and Youth: Why a Conference, How Will It Work, What Can It Mean to You? Washington, D.C.: Children's Bureau, Federal Security Agency, 1949.

Milbank, Samuel, Chair. *The Four Million: Report of the New York State Citizens' Committee of One Hundred for Children and Youth, 1951*. Albany: New York State Citizen's Committee of One Hundred for Children and Youth, 1951.

Mississippi Governor's Committee on Children and Youth. *Mississippi Report on Services to Children and Youth, 1940-1950: Midcentury White House Conference on Children and Youth*. Jackson, 1950.

Mississippi State Board of Health. *May Day: Child Health Day, 1930*. Jackson: Mississippi State Board of Health, 1930.

Mora, F. Luis. *The Health of the Child is the Power of the Nation: Children's Year, April 1918-April 1919*. New York, The W.F. Powers Co., 1918. Accessed July 3, 2015. <http://loc.gov/pictures/resource/cph.3g09867/>.

National Office of Vital Statistics of the United States Department of Health, Education, and Welfare. *Vital Statistics of the United States, 1958: Volume I*. Washington, D.C.: United States Government Printing Office, 1960.

New York City Department of Health. *Emergency Maternity and Infant Care Program - EMIC- A Federal Program for Servicemen's Wives and Infants Administered Locally by the New York City Department of Health. Policies and Procedures. Information Guide for Physicians*. New York, 1945.

Parran, Thomas, Jr. *Fifty-Sixth Annual Report of the Department of Health, Vol. 1*. Albany: New York State Department of Health, 1936.

Peixotto, Jessica B. "The Children's Year and the Woman's Committee." *Annals of the American Academy of Political and Social Science* 79 (Sept 1918): 257- 262.

Pessin, Vivian, Helen M. Wallace, and Leona Baumgartner, "Medical Care of Maternity Patients Under the Emergency Maternity and Infant Care Program in New York City." *American Journal of Public Health* 41, no. 4 (April 1951), 402-409.

Public Health in New York State 1947: Sixty-Eighth Annual Report of the State Department of Health. Albany: New York State Department of Health, 1948.

Report of Sub-Committee on Legislation, White House Conference on Child Health and Protection, Section III-C, Committee on the School Child. Washington, D.C., 1930.

Rice, John L., Margaret Barnard, Thomas J. Duffield, and Jules L. Blumenthal. "Infant Mortality in New York City." *American Journal of Public Health* 27 no. 7 (July 1937): 701-706.

Richards, Edward A. ed. *Proceedings of the Midcentury White House Conference on Children and Youth: Report of Conference Sessions Washington, D.C., December 3-7, 1950.* Raleigh: Health Publications Institute, Inc. 1951.

Richmond, Julius B. "Health Supervision of Infants and Children: A Statement for the Midcentury White House Conference on Children and Youth." *The Journal of Pediatrics* 40, no. 5 (May 1952): 634-50. doi:10.1016/S0022-3476(52)80158-1.

Roberts, Dean W. "Highlights of the Midcentury White House Conference on Children and Youth." *American Journal of Public Health and the Nation's Health* 41, no. 1 (January 1951): 96-99.

Rogers, James Frederick. *School Health Activities in 1930: Summary of Information Collected for the White House Conference on Child Health and Protection.* Washington, D.C.: United States Department of the Interior, Office of Education, 1931.

Roosevelt, Franklin D. "Proclamation 2348-Neutrality of the United States." September 5, 1939. The American Presidency Project. Accessed October 2016. <http://www.presidency.ucsb.edu/ws/?pid=15802>.

Rude, Anna. "The Children's Year Campaign." *American Journal of Public Health* 9, no. 5 (May 1919): 346-351.

Sinia, Nathan and Odin W. Anderson. *Emergency Maternity and Infant Care: A Study of Administrative Experience.* Ann Arbor: University of Michigan, 1948.

Spock, Benjamin. *The Common Sense Book of Baby and Child Care.* New York: Duell, Sloan and Pearce, 1946.

Tennessee Committee of the Midcentury White House Conference on Children and Youth.

The Boston Women's Health Book Collective. *Our Bodies, Ourselves: A Book By and For Women.* New York: Simon and Schuster, 1973.

The Boston Women's Health Collective. *Women and Their Bodies: A Course*. Boston: The Boston Women's Health Collective, 1970.

The Children's Charter. White House Conference on Child Health and Protection. Washington, D.C.: 1931.

The Mississippi Children's Code Commission. *Mississippi Report on Services to Children and Youth*. Jackson: The Mississippi Children's Code, 1956.

Thompson, W. Benbow. "Emergency Maternity and Infant Care (E.M.I.C.) Program." *California and Western Medicine* 61, no. 2 (August 1944): 72-75.

Truman, Harry S. "Address Before the Midcentury White House Conference on Children and Youth." December 5, 1950. The American Presidency Project. Accessed December 2016. <http://www.presidency.ucsb.edu/ws/?pid=13677>.

U.S. Congress. House of Representatives. Subcommittee of the Committee on Appropriations. 1943. *Department of Labor-Federal Security Agency Appropriation Bill for 1944: Hearings before a Subcommittee of the Committee on Appropriations, 78th Cong., 1st sess.*

U.S. Congress. Senate. Subcommittee of the Committee on Appropriations. 1946. *Labor-Federal Security Appropriation Bill for 1947: Hearings before a Subcommittee of the Committee on Appropriations, 79th Cong., 2nd sess.*

U.S. Congress. Senate. Subcommittee of the Committee on Appropriations. 1943. *First Deficiency Appropriation Bill for 1943: Hearings before a Subcommittee of the Committee on Appropriations, 78th Cong., 1st sess.*

U.S. Department of Commerce. *Mortality Statistics 1924*. Washington, D.C.: United States Government Printing Office, 1927.

U.S. Department of Commerce. *Mortality Statistics 1929*. Washington, D.C.: United States Government Printing Office, 1932.

United States Bureau of the Census, *Fifteenth Census of the United States: 1930, Population Vol. III, Part I*. Washington, D.C. United States Printing Office, 1932.

United States Bureau of the Census, *Fifteenth Census of the United States: 1930, Population Vol. III, Part II*. Washington, D.C. United States Printing Office, 1932.

United States Bureau of the Census. *Birth, Stillbirth, and Infant Mortality Statistics 1933*. Washington, D.C.: United States Government Printing Office, 1936.

United States Bureau of the Census. *Birth, Stillbirth, and Infant Mortality Statistics for the Continental United States and the Territory of Hawaii, the Virgin Islands, 1935*. Washington, D.C.: United States Government Printing Office, 1937.

United States Bureau of the Census. *Fifteenth Census of the United States: 1930, Population Vol. III, Part II*. Washington, D.C.: United States Government Printing Office, 1932.

United States Bureau of the Census. *Fourteenth Census of the United States Taken in the Year 1920, Volume III: Population 1920 Composition and Characteristics of the Population by States*. Washington, D.C.: United States Government Printing Office, 1922.

United States Bureau of the Census. *Mortality Statistics: 1917*. Washington, D.C.: United States Government Printing Office, 1919.

United States Children's Bureau. *Administrative Policies. Emergency Maternity and Infant Care Program. EMIC Information Circular No. 1*. Washington, D.C.: Government Printing Office, 1944.

United States Children's Bureau. *April and May Weighing and Measuring Test: Part 3 Follow-Up Work*, Publication no. 38. Washington, D.C.: United States Government Printing Office, 1918.

United States Children's Bureau. *An Outline for a Birth-Registration Test*, Publication no. 54. Washington, D.C.: United States Government Printing Office, 1919.

United States Children's Bureau. *Back-To-School Drive*, Publication no. 49. Washington, D.C.: United States Government Printing Office, 1919.

United States Children's Bureau. *Children's Year: A Brief Summary of Work Done and Suggestions for Follow-Up Work*, Publication no. 67. Washington, D.C.: United States Government Printing Office, 1920.

United States Children's Bureau. *Children's Year Working Program*, Publication no. 40. Washington, D.C.: United States Government Printing Office, 1918.

United States Children's Bureau. *Conference on Children in a Democracy: Papers and Discussions at the Initial Session Held in Washington, D.C. April 26, 1939*. Washington, D.C.: United States Government Printing Office, 1939.

United States Children's Bureau. *Emergency Maternity and Infant Care for Wives and Infants of Enlisted Men in the Armed Forces*. Washington, D.C.: Government Printing Office, 1943.

United States Children's Bureau. *Maternal and Child-Health Services Under the Social Security Act, Title V, Part 1, Development of Program, 1936-1939*, Publication no. 259. Washington, D.C.: United States Government Printing Office, 1941.

United States Children's Bureau. *Patriotic Play Week: Suggestions to Local Child-Welfare Committees*, Publication no. 44. Washington, D.C.: United States Government Print Office, 1918.

United States Children's Bureau. "Preliminary Monthly Statistical Report on the EMIC Program." *Preliminary Monthly Statistical Report on the EMIC Program*.

United States Children's Bureau. *Preliminary Statements Submitted to the White House Conference on Children in a Democracy, Washington, DC, January 18-20, 1940*.

United States Children's Bureau. *Proceedings of Conference on Better Care for Mothers and Babies, Held in Washington, D.C., January 17-18, 1938*. Washington, D.C.: Department of Labor, 1938.

United States Children's Bureau. *Proceedings of the White House Conference on Children in a Democracy: Washington, D.C., January 18-20, 1940, Including the General Report Adopted by the Conference*. Washington, D.C.: Government Printing Office, 1940.

United States Children's Bureau. *Promotion of the Welfare and Hygiene of Maternity and Infancy: Text of Act of November 23, 1921 and Maximum Amounts Available to the States*, Publication no. 95. Washington, D.C.: United States Government Printing Office, 1921.

United States Children's Bureau. *Scholarships for Children*, Publication no. 51. Washington, D.C.: United States Government Printing Office, 1919.

United States Children's Bureau. *Services for Children: How Title V of the Social Security Act Benefits Children*. Washington, D.C.: Government Printing Office, 1965.

United States Children's Bureau. *Standards of Child Welfare: A Report of the Children's Bureau*, Publication no. 60. Washington, D.C. United States Government Printing Office, 1919.

United States Children's Bureau. *Suggestions to Local Committees for the Back-to-School Drive*, Publication no. 50. Washington, D.C.: United States Government Printing Office, 1918.

United States Children's Bureau. *The Promotion of the Welfare and Hygiene of Maternity and Infancy: The Administration of the Act of Congress of November 23, 1921, For Fiscal Year Ended June 30, 1924*. Washington: United States Printing Office, 1925.

United States Children's Bureau. *The Promotion of the Welfare and Hygiene of Maternity and Infancy: The Administration of the Act of Congress of November 23, 1921, For Fiscal Year Ended June 30, 1929*. Washington: United States Government Printing Office, 1931.

United States Congress, House of Representative, *Congressional Record*. HR 7544, 88th Cong., 1st sess. Vol. 109, pt. 12.

United States Congress. House of Representatives. Committee on Interstate and Foreign Commerce. 1921. *Public Protection of Maternity and Infancy: Hearings Before the Committee on Interstate and Foreign Commerce of the House of Representatives*, 67th Congress, 1st sess.

United States Department of Labor. *Reports of the Department of Labor*, 1919. Washington, D.C.: United States Government Printing Office, 1920.

United States Interdepartmental Committee on Children and Youth. *Children in a Changing World: A Book of Charts*. Washington, D.C.: Golden Anniversary White House Conference on Children and Youth, 1960.

United States Selective Service Board. *Selective Service Regulations, Volume One: Organization and Administration*. Washington, D.C.: United State Government Printing Office, 1940.

Weller, Charles Frederick. "Patriotic Play Week and the War-Time Recreation Drive." *The Playground* 12, no. 4 (July 1918): 175-189.

White House Conference on Child Health and Protection, ed. *Official Proceedings of the White House Conference on Child Health and Protection*. Washington, D.C.: United States Daily Publishing Corporation, 1930.

White House Conference on Child Health and Protection. *White House Conference 1930: Addresses and Abstracts of Committee Reports*. New York: The Century Company, 1931.

White House Conference on Child Health and Protection: Preliminary Committee Reports. New York: Century Company, 1930.

White House Conference on Children in a Democracy, Washington, D.C., January 18-20, 1940: Final Report. Washington, D.C.: Government Printing Office, 1942.

White House Conference on Children in a Democracy. *Children in a Democracy: General Report*. Washington, D.C.: United States Government Printing Office, 1940.

White House Conference on Children in a Democracy. *Preliminary Statements Submitted to the White House Conference on Children in a Democracy, January 18-20, 1940.* Washington, D.C.: Superintendent of Documents, 1940.

White House Conference on Children in a Democracy. *Preliminary Statements Submitted to the White House Conference on Children in a Democracy, January 18-20, 1940.* Washington, D.C.: Superintendent of Documents, 1940.

White House Conference on Children in a Democracy. *White House Conference on Children in a Democracy Final Report.* Washington, D.C.: Superintendent of Documents, 1940.

White House Conference, 1930: Addresses and Abstracts of Committee Reports, White House Conference on Child Health and Protection, Called by President Hoover. New York: Century Company, 1930.

Winslow, Charles-Edward Amory. *Handbook of Health in War and Peace: A Manual of Personal Preparedness.* New York: Departments of Public Health and Public Education of the American Museum of Natural History, 1917.

Winslow, Charles-Edward Amory. *Healthy Living: How Children Can Grow Strong for Their Country's Service.* New York: Charles E. Merrill Company, 1920.

Winslow, Charles-Edward Amory. *Healthy Living: Principles of Personal and Community Hygiene.* New York: Charles E. Merrill Company, 1920.

Winslow, Charles-Edward Amory. *The Evolution and Significance of the Modern Public Health Campaign.* New Haven: Yale University Press, 1923.

Winslow, Charles-Edward Amory. *The Public Health Nurse: How She Helps to Keep the Babies Well.* Washington, D.C.: U.S. Children's Bureau, 1918.

Winslow, Charles-Edward Amory. "The Untilled Fields of Public Health." *Science* 51, No. 1306 (January 1920): 23-33.

Witmer, Helen Leland, and Ruth Kotinsky. *Personality in the Making.* New York: Harper & Row, 1952. <http://www.tcrecord.org/library/abstract.asp?contentid=4988>.

Woodbury, Robert Morse. *Statures and Weights of Children Under Six Years of Age.* Washington, D.C.: United States Government Printing Office, 1921.

Secondary Sources

"History of U.S. Army Enlisted Ranks." The Institute of Heraldry Office of the Administrative Assistant to the Secretary of the Army. Accessed 2017.

<http://www.tioh.hqda.pentagon.mil/Catalog/HeraldryMulti.aspx?CategoryId=9168&grp=2&menu=Uniformed%20Services>.

“Mary D. Osborne (1875-1946) 1996 Inductee.” American Nurses Association. Accessed August 2017. <http://www.nursingworld.org/MaryDOsborne>.

“World War II, 1939-1949.” Lewis Army Museum. Accessed March 2018 <https://lewisarmymuseum.com/history-of-the-army-at-camp-lewis-fort-lewis-and-joint-base-lewis-mcchord/world-war-ii-1939-1949/>.

Apple, Rima. *Mothers & Motherhood: Readings in American History*. Columbus: Ohio State University Press, 1997.

Apple, Rima. *Mothers and Medicine: A Social History of Infant Feeding, 1890-1950*. Madison: The University of Wisconsin Press, 1987.

Apple, Rima. *Perfect Motherhood: Science and Childrearing in America*. New Brunswick: Rutgers University Press, 2006.

Baker, Jeffrey and Howard Pearson. *Dedicated to the Health of All Children*. Elk Grove Village: American Academy of Pediatrics, 2005.

Barker-Benfield, G.J. *The Horrors of the Half-Known Life: Male Attitudes toward Women and Sexuality in Nineteenth-Century America, 2nd Edition*. New York: Routledge, 2014.

Beck, Rochelle. “The White House Conferences on Children: An Historical Perspective.” *Harvard Educational Review* 43, no. 4 (December 1, 1973): 653–68. doi:10.17763/haer.43.4.h80r773u3413t914.

Bellafaire, Judith A. *The Army Nurse Corps: A Commemoration of World War II Service*. Ft. McNair: U.S. Army Center of Military History, 2000.

Besley, Timothy, and Masayuki Kudamatsu. “Health and Democracy.” *The American Economic Review* 96, no. 2 (May 1, 2006): 313–18.

Bolton, Charles C. “‘Mississippi’s School Equalization Program, 1945-1954:’ A Last Gasp to Try to Maintain a Segregated Educational System.” *The Journal of Southern History* 66, no. 4 (November 2000): 781-814.

Borst, Charlotte G. *Catching Babies: The Professionalization of Child Birth, 1870-1920*. Cambridge: Harvard University Press, 1995.

Bullard, Katharine. *Civilizing the Child: Discourses of Race, Nation, and Child Welfare in America*. Lanham: Lexington Books, 2013.

Bullough, Vern L., and Lilli Sentz, eds. *American Nursing: A Biographical Dictionary, Volume 3*. New York: Springer Publishing Company, 2000.

Burnham, John C. *Health Care in America: A History*. Baltimore: Johns Hopkins University, 2015.

Busbee, Westley Jr. *Mississippi: A History*. Wheeling, Illinois: Harlan Davidson, Inc., 2005.

Butler, Judith. "Performative Acts and Gender Constitution: An Essay in Phenomenology and Feminist Theory." *Theatre Journal* 40, no. 4 (Dec 1988): 527-528.

Campbell, D'Ann. *Women at War with America: Private Lives in a Patriotic Era*. Cambridge: Harvard University Press, 1984.

Capozzola, Christopher. *Uncle Sam Wants You: World War I and the Making of the Modern American Citizen*. New York: Oxford University Press, 2008.

Carnegie, M. Elizabeth. "Black Nurses in the United States, 1879-1992." In *Nursing Issues in the 21st Century: Perspectives from the Literature*, edited by Eleanor Hein. Philadelphia: Lippincott, 2001.

Cassedy, James H. *Charles V. Chapin and the Public Health Movement*. Cambridge: Harvard University Press, 1962.

Chapin, Christy Ford. *Ensuring America's Health: The Public Creation of the Corporate Health Care*. Cambridge: Cambridge University Press, 2015.

Children's Bureau. *The Story of the White House Conferences on Children and Youth*. Washington: Children's Bureau, 1967.

Cobb, James C. *The Most Southern Place on Earth: The Mississippi Delta and the Roots of Regional Identity*. Oxford: Oxford University Press, 1992.

Cone, T.E. *History of American Pediatrics*. Boston: Little, Brown, and Co., 1979.

Costin, Lela B. "Women and Physicians: The 1930 White House Conference on Children." *Social Work* 28, no. 2 (March 1, 1983): 108-14. doi:10.1093/sw/28.2.108.

Critchlow, Donald T. *Intended Consequences: Birth Control, Abortion, and the Federal Government in Modern America*. Oxford: Oxford University Press, 1999.

Dailey, Anne C. "Developing Citizens." *Iowa Law Review* 91 (2006): 432-503.

de Young, Mary. *Madness: An American History of Mental Illness and Its Treatment*. Jefferson, North Carolina: McFarland Publishing, Inc., 2010.

Dudziak, Mary. *Cold War Civil Rights: Race and the Image of American Democracy*. Princeton: Princeton University, 2000.

Dunn, P.M. "John Whitridge Williams, MD (1866-1931) of Baltimore: Pioneer of Academic Obstetrics." *Archives of Disease in Childhood, Fetal and Neonatal Edition*, vol. 92, no. 1 (January 2007): F74-F77.

Elder Jr., Glen H. *Children of the Great Depression: Social Change in Life Experience (25th Anniversary Ed.)*. Vol. xxv. Boulder: Westview Press, 1999.

Engelhardt, Tom. *The End of Victory Culture: Cold War America and the Disillusioning of a Generation*. Amherst: University of Massachusetts Press, 2007.

Enloe, Cynthia. *The Morning After: Sexual Politics at the End of the Cold War*. Oakland: University of California Press, 1993.

Ettling, John. "The Germ of Laziness": Rockefeller Philanthropy and Public Health in the New South. Cambridge: Harvard University Press, 1981.

Fairbanks, Ruth L. "A Pregnancy Test: Women Workers and the Hybrid American Welfare State, 1940-1993." PhD diss., University of Illinois, 2015.

Fleming, Thomas J. *The Illusion of Victory: America in World War I*. New York: Basic Books, 2004.

Frana, Philip. "Coordinating the Experts and the Masses: The Professions of Health and the Creation of American Community Health; 1915-1940." PhD diss., Iowa State University, 1999.

Fritz, Harry W., Mary Murphy, and Robert R. Swartout, editors. *Montana Legacy: Essays on History, People, and Place*. Helena: Montana Historical Society Press, 2002.

Gaddis, John Lewis. *The Cold War: A New History*. New York: Penguin Books, 2005.

Gaddis, John Lewis. *The United States and the Origins of the Cold War, 1941-1947*. New York: Columbia University Press, 1972.

Giesen, James C. *Boll Weevil Blues: Cotton, Myth, and Power in the American South*. Chicago: The University of Chicago Press, 2011.

Gillespie, James A. "International Organization and the Problem of Child Health, 1945-1960." *Dynamis: Acta Hispanica ad Medicinae Scientiarumque Historiam Illustrandam* 23 (2003): 115-142.

Goldfield, David. *Still Fighting the Civil War: American South and Southern History, Updated Edition*. Baton Rouge: Louisiana State University Press, 2002.

Goldman, Eden Abigail. "'A Right to be Safely Born': The Quest for Health Justice for American Mothers and Children, 1890-1965." PhD diss., Duke University, 2014.

Goodman, Richard A., Rebecca Bunnell, and Samuel F. Posner. "What is 'Community Health'? Examining the Meaning of the Evolving Field in Public Health." *Preventive Medicine* 67, Supplement 1 (October 2014): S58-S61.

Gordon, Linda, ed. *Women, the State, and Welfare*. Madison: University of Wisconsin Press, 1990.

Gordon, Linda. *Pitied but Not Entitled: Single Mothers and the History of Welfare*. New York: Free Press, 1994.

Grant, Julia. *Raising Baby by the Book: The Education of American Mothers*. New Haven: Yale University Press, 1998.

Grob, Gerald. *The Mad Among Us: A History of the Care of America's Mentally Ill*. New York: Free Press, 1994.

Halpern, Sydney Ann. *American Pediatrics: The Social Dynamics of Professionalism, 1880-1980*. Berkeley: University of California Press, 1988.

Harlman, Andrew. *Education and the Cold War: The Battle for the American School*. New York: Palgrave Macmillan, 2008.

Hartman, Andrew. *Education and the Cold War: The Battle for the American School*. New York: Palgrave Macmillan, 2008.

Hauser, Gerard, and Amy Grim. *Rhetorical Democracy: Discursive Practices of Civic Engagement*. New York: Routledge, 2004.

Henderson, Alan and Sally Champlin, editors. *Promoting Teen Health: Linking Schools, Health Organizations, and Community*. Thousand Oaks: Sage Publications, 1998.

Historical Division of the United States Marine Corps, *Marine Corps Historical Reference Pamphlet: United States Marine Corps Ranks and Grades, 1775-1969*. Washington, D.C.: United States Marine Corps Historical Division, 1970.

Hitchcock, L. and B.A. Mulvihill. "The Early Years of Title V: Extending and Improving Care for Children with Special Health Care Needs, 1935-1941." *Maternal and Child Health Journal* 15, no. 2 (February 2011): 139-147.

Hoff, Derek S. *The State and the Stork: The Population Debate and Policy Making in US History*. Chicago: The Chicago University Press, 2012.

Hoffman, Beatrix. *Health Care for Some: Rights and Rationing in the United States since 1930*. Chicago: The University of Chicago, 2012.

Honey, Maureen. *Creating Rosie the Riveter: Class, Gender, and Propaganda During World War II*. Amherst: University of Massachusetts Press, 1984.

Hulbert, Ann. *Raising America: Experts, Parents, and a Century of Advice About Children*. New York: Knopf Doubleday Publishing Group, 2011.

Hunter, Tera. *To 'Joy My Freedom: Southern Black Women's Lives and Labors After the Civil War*. Cambridge: Harvard University Press, 1997.

Ireys, H.T., R. J. Hauck, and J. M. Perrin. "Variability Among State Crippled Children's Service Programs: Pluralism Thrives." *American Journal of Public Health* 75, no. 4 (April 1985): 375-381.

Jackson, Robert L. and Helen G. Kelly. "Growth Charts for Use in Pediatric Practice." *The Journal of Pediatrics* 27, no. 3 (September 1945): 215-229.

Johnson, David. *The Lavender Scare: The Cold War Persecution of Gays and Lesbians in the Federal Government*. Reprint edition. Chicago, Ill.: University Of Chicago Press, 2006.

Jones, James. *Bad Blood: The Tuskegee Syphilis Experiment, New and Expanded Edition*. New York: The Free Press, 1993.

Kennedy, David. *Freedom from Fear: The American People in Depression and War, 1929-1945*. New York: Oxford University Press, 1999.

Kennedy, Kathleen. *Disloyal Mothers and Scurrilous Citizens: Women and Subversion during World War I*. Bloomington: Indiana University Press, 1999.

Kennedy, Rosie. *The Children's War: Britain, 1914-1918*. New York: Palgrave Macmillan, 2014.

Kevles, Daniel J. *In the Name of Eugenics: Genetics and the Uses of Human Heredity*. Berkeley: University of California Press, 1985.

- Knupfer, Anne M., and Christine Woysner, eds. *Educational Work of Women's Organizations, 1890-1960*. New York: Palgrave Macmillan, 2008.
- Ladd-Taylor, Molly. *Mother-Work: Women, Child Welfare, and the State, 1890-1930*. Champaign: University of Illinois, 1994.
- Ladd-Taylor, Molly. *Raising a Baby the Government Way: Mothers' Letters to the Children's Bureau, 1915-1932*. New Brunswick: Rutgers University Press, 1986.
- Leavitt, Judith Walzer. *Brought to Bed: Childbearing in America, 1750-1950*. New York: Oxford University Press, 1986.
- Leder, Jane Mersky. *Thanks for the Memories: Love, Sex, and World War II*. Westport: Greenwood Publishing Group, 2006.
- Leffler, Melvyn and David Painter. *Origins of the Cold War: An International History, Second Edition*. New York: Routledge, 2005.
- Leffler, Melvyn P. *A Preponderance of Power: National Security, the Truman Administration, and the Cold War*. Stanford: Stanford University Press, 1992.
- Lemons, J. Stanley. "The Sheppard-Towner Act: Progressivism in the 1920s." *The Journal of American History* 55, no. 4 (March 1, 1969): 776–86. doi:10.2307/1900152.
- Lerner, Gerda. "Early Community Work of Black Women." *The Journal of Negro History* 59, no. 2 (1974): 158-167.
- Lesser, Arthur J. "The Origin and Development of Maternal and Child Health Programs in the United States." *American Journal of Public Health* 75, no. 6 (1985): 590–98.
- Levine, Myron M., Rosanna Lagos, and Jose Esparza. "Vaccines and Vaccination in Historical Perspective." University of Maryland School of Medicine. Accessed March 2018. <http://www.medschool.umaryland.edu/media/SOM/Research-Centers/Center-for-Vaccine-Development-CVD/docs/Levine-1-23-17-handout-2.pdf>.
- Levy, Barry S., and Victor W. Sidel. *War and Public Health*. American Public Health Association, 2000.
- Lindenmeyer, Kriste. *A Right to Childhood: The U.S. Children's Bureau and Child Welfare, 1912-1946*. Champaign: University of Illinois Press, 1997.
- Litoff, Judy Barrett. *American Midwives, 1860 to the Present*. Westport: Greenwood Press, 1978.

Lutkehaus, Nancy C. *Margaret Mead: The Making of an American Icon*. Princeton: Princeton University Press, 2008.

Mackel, Richard. *Save the Babies: American Public Health Reform and the Prevention of Infant Mortality, 1850-1929*. Ann Arbor: University of Michigan Press, 1990.

MacQueen, Kathleen M., Eleanor McLellan, David S. Metzger, Susan Kegeles, Ronald P. Strauss, Roseanne Scotti, Lynn Blanchard, and Robert T. Trotter, II. "What is Community? An Evidence-Based Definition of Participatory Public Health." *American Journal of Public Health* 91, no. 12 (December 2001): 1929-1938.

Mahnke, C. Becket. "The Growth and Development of a Specialty: The History of Pediatrics." *Clinical Pediatrics* 39, no. 12 (December 2000): 705-714.

Marcus, Alan I. "Disease Prevention in America: From a Local to a National Outlook, 1880-1910." *Bulletin of the History of Medicine* 53 (Summer 1979): 184-203.

Markel, Howard, and Janet Golden. "Successes and Missed Opportunities in Protecting Our Children's Health: Critical Junctures in the History of Children's Health Policy in the United States." *Pediatrics* 115, no. Supplement 3 (April 1, 2005): 1129-33. doi:10.1542/peds.2004-2825D.

Marshall, Dominique. "Children's Rights and Children's Action in International Relief and Domestic Welfare: The Work of Herbert Hoover Between 1914 and 1950." *The Journal of the History of Childhood and Youth* 1, no. 3 (2008): 351-88. doi:10.1353/hcy.0.0019.

Martin, Justin. *Genius of Place: The Life of Frederick Law Olmsted, Abolitionist, Conservationist, and Designer of Central Park*. Cambridge: Da Capo Press, 2011.

Maxwell, Kelena Reid. "Birth Behind the Veil: African American Midwives and Mothers in the Rural South, 1921-1962." Rutgers University: PhD diss., 2009.

May, Elaine Tyler. *Homeward Bound: American Families in the Cold War Era*. New York: Basic Books, 1988,2008.

McElvaine, Robert S. *The Great Depression: America, 1929- 1941, Twenty-Fifth Anniversary Edition*. New York: Three River Press, 2009

McEnaney, Laura. *Civil Defense Begins at Home: Militarization Meets Everyday Life in the Fifties*. Princeton: Princeton University Press, 2000.

McGowan, Brenda G. "Historical Evolution of Child Welfare Services." In *Child Welfare for the Twenty-First Century*, edited by Gerald P. Mallon, 10-46. New York: Columbia University Press, 2005.

Meckel, Richard A. *Save the Babies: American Public Health Reform and the Prevention of Infant Mortality, 1850-1929*. Ann Arbor: University of Michigan Press, 1990.

Miller, Edward. *Bankrupting the Enemy: The U.S. Financial Siege of Japan Before Pearl Harbor*. Annapolis: Naval Institute Press, 2007.

Mink, Gwendolyn. *The Wages of Motherhood: Inequality in the Welfare State, 1917-1942*. Ithaca: Cornell University Press, 1996.

Mississippi State Department of Health. "Mississippi Vital Statistics." Accessed November 2016. http://msdh.ms.gov/msdhsite/_static/resources/3010.pdf.

Mitchell, Dennis H. *Mississippi: A New History*. Oxford: University of Mississippi Press, 2014.

Morantz, Regina Markell, Cynthia Stodola Promerleau, and Carol Hansen Fenichel, eds. *In Her Own Words: Oral Histories of Women Physicians*. Westport: Greenwood Press, 1982.

Morgen, Sandra. *Into Our Own Hands: The Women's Health Movement in the United States, 1969-1990*. Piscataway: Rutgers University Press, 2002.

Morton, Margaret, Edna Roberts, and Kaye Bender. *Celebrating Public Health Nursing: Caring for Mississippi's Communities with Courage and Compassion, 1920-1993*. Jackson: Mississippi State Department of Health, 1993.

Mudry, Jessica. "Nutrition." In *A Companion to the History of American Science*, edited by Georgina M. Montgomery and Mark A. Largent, 199-212. Malden: Wiley Blackwell, 2016.

Mulligan, Joan Elizabeth. "Three Federal Interventions on Behalf of Childbearing Women: The Sheppard-Tower Act, Emergency Maternity and Infant Care, and the Maternal and Child Health and Mental Retardation Planning Amendments of 1963," 1976.

Muncy, Robyn. *Creating a Female Dominion in American Reform, 1890-1935*. Oxford: Oxford University Press, 1991.

Murray, John E. *Origins of American Health Insurance: A History of Industrial Sickness Funds*. New Haven: Yale University Press, 2007.

Nelson, Deborah. *Pursuing Privacy in Cold War America*. New York: Columbia University Press, 2002.

New York State Department of Health Division of Information. *Annual Report of Vital Statistics: New York State 2013*. Albany: New York State Department of Health, 2015.

Numbers, Ronald L. "The Third Party: Health Insurance in America." In *Sickness and Health in America: Readings in the History of Medicine and Public Health, Third Edition, Revised*, edited by Judith W. Leavitt and Ronald L. Numbers. Madison: The University of Wisconsin Press, 1997.

O'Neill, William. *A Democracy at War: America's Fight at Home and Abroad in World War II*. Cambridge: Harvard University Press, 1993.

O'Neill, William. *Coming Apart. An Informal History of America in the 1960s*. Chicago: Quadrangle Books, 1971.

Oakley, Ann. "Is Social Support Good for the Health of Mothers and Babies?" *Journal of Reproductive and Infant Psychology* 6, no. 1 (January 1, 1988): 3–21.

doi:10.1080/02646838808404014.

Panu, Mihnea. *Contextualizing Family Planning: Truth, Subject, and the Other in the U.S. Government*. New York: Palgrave MacMillian, 2009.

Parascandola, John. *Sex, Sin, and Science*. Westport: Praeger, 2008.

Parkerson, Donald and Jo Ann Pakerson. *Transitions in American Education: Social History of Teaching*. New York: Routledge, 2014.

Patterson, James T. *Brown V. Board of Education: A Civil Rights Milestone and Its Troubled Legacy*. Oxford: Oxford University Press, 2001.

Peacock, Margaret. *Innocent Weapons: The Soviet and American Politics of Childhood in the Cold War*. Chapel Hill: University of North Carolina Press, 2014.

Perrenot, Preston B. *United States Navy Grade Insignia Since 1852*. Washington, D.C.: Department of the Navy, 2010.

Plant, Rebecca Jo. *Mom: The Transformation of Motherhood in Modern America*. Chicago: University of Chicago Press, 2010.

Reverby, Susan. *Examining Tuskegee: The Infamous Syphilis Study and Its Legacy* (Chapel Hill: The University of North Carolina Press, 2009)

Robertson, Andrew Whitmore. *The Language of Democracy: Political Rhetoric in the United States and Britain, 1790-1900*. Charlottesville: University of Virginia Press, 1995.

Rogin, Michael. "Kiss Me Deadly: Communism, Motherhood, and Cold War Movies." *Representations*, no. 6 (April 1, 1984): 1–36. doi:10.2307/2928536.

Rosen, George. *A History of Public Health, Revised Expanded Edition*. Baltimore: The Johns Hopkins University Press, 2015.

Rosenberg, Charles E. *The Care of Strangers: The Rise of America's Hospital System*. Baltimore: Johns Hopkins University, 1995.

Sandelowski, Margarete. *Pain, Pleasure, and American*. Westport: Greenwood Press, 1984.

Sandhya A. Marathe, Amit Lahiri, Vidya Devi Negi, and Dipshikha Chakravoty. "Typhoid Fever & Vaccine Development: A Partially Answered Question." *The Indian Journal of Medical Research* 135, no. 2 (February 2012): 161-169.

Sano, Yulonda Eadie "Health Care for African Americans in Mississippi, 1877-1946." The Ohio State University, PhD diss., 2010.

Savitt, Todd. *Race and Medicine in the Nineteenth- and Early-Twentieth-Century American*. Kent: The Kent State University Press, 2007.

Scott, Joan. "Gender A Useful Category of Historical Analysis." *The American Historical Review* 91, no. 5 (Dec 1986): 1053-1075.

Sims, Anastasia. *The Power of Femininity in the New South and Women Organizations and Politics in North Carolina, 1880-1930*. Columbia: University of South Carolina Press, 1997.

Skocpol, Theda. *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States*. Cambridge: Belknap Press, 1992.

Smith, Susan L. "White Nurses, Black Midwives, and Public Health in Mississippi, 1920-1950." In *Women and Health in America: Historical Readings, Second Edition*, edited by Judith Walzer Leavitt. Madison: The University of Wisconsin Press, 1999.

Smith, Susan L. "White Nurses, Black Midwives, and Public Health in Mississippi, 1920-1950." *Nursing History Review* 2 (1994): 29-49.

Smith, Susan. *Sick and Tired of Being Sick and Tired: Black Women's Health Activism in America, 1890-1950*. Philadelphia: University of Pennsylvania Press, 1995.

Smuts, Alice, Robert W. Smuts, R. Malcolm Smuts, Barbara B. Smuts, and P. Lindsay Chase-Lansdale. *Science in the Service of Children, 1893-1935*. New Haven: Yale University Press, 2006.

Starr, Paul. *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*. New York: Basic Books, 1982.

Stern, Alexandra M. and Howard Markel, eds., *Formative Years: Children's Health in the United States, 1880-2000*. Ann Arbor: The University of Michigan Press, 2004.

Stern, Alexandra Minna. "Making Better Babies: Public Health and Race Betterment in Indiana, 1920-1935." *American Journal of Public Health* 92, no. 5 (May 2002): 742-752.

Stern, Alexandra Minna. *Eugenic Nation: Faults and Frontiers of Better Breeding in Modern America*. Oakland: University of California Press, 2016.

Stoltzfus, Emilie. *Citizen, Mother, Worker: Debating Public Responsibility for Child Care after the Second World War*. Chapel Hill: The University of North Carolina Press, 2003.

Swain, Martha. "Mississippi White Women's Clubs in the Quest for Women's Rights in the Twentieth Century." In *Mississippi Women: Their Stories, Their Lives—Volume 2*, edited by Elizabeth Anne Payne, Martha H. Swain, and Marjorie Julian Spruill, 269-286. Athens: University of Georgia Press, 2010.

Temkin, E. "Driving through: Postpartum Care during World War II." *American Journal of Public Health* 89, no. 4 (April 1, 1999): 587-95. doi:10.2105/AJPH.89.4.587.

Thomas, Karen Kruse. *Deluxe Jim Crow: Civil Rights and American Health Policy, 1935-1954*. Athens: The University of Georgia Press, 2011.

Thomas, Mary Martha. "Black Women During the Progressive Era, 1890-1920." In *Stepping Out of the Shadows, Alabama Women, 1819-1990*, edited by Mary Martha Thomas, 75-95. Tuscaloosa: University of Alabama Press, 1995.

Tomes, Nancy. *The Gospel of Germs: Men, Women, and the Microbe in American Life*. Cambridge: Harvard University Press, 1999.

Tone, Andrea, editor. *Controlling Reproduction: An American History*. Wilmington: Scholarly Resources, Inc., 2001.

Torrey, Edwin Fuller. *American Psychosis: How the Federal Government Destroyed the Mental Illness Treatment System*. Oxford: Oxford University Press, 2014.

Torrey, Edwin Fuller. *Out of the Shadows: Confronting America's Mental Illness Crisis*. Hoboken: John Wiley, 1997.

Trent, James. *Inventing the Feeble Mind: A History of Intellectual Disability in the United States*. Oxford: Oxford University Press, 1995.

Tuttle, William M. *“Daddy’s Gone to War”: The Second World War in the Lives of America’s Children*. New York: Oxford University Press, 1993.

Underwood, Felix Joel and Richard Noble Whitfield. *Public Health and Medical Licensure in the State of Mississippi, 1939-1947, Volume II*. Jackson: Mississippi State Board of Health, 1950.

United States Children’s Bureau. *The Children’s Bureau Legacy: Ensuring the Right to Childhood*. Washington D.C., United States Children’s Bureau, 2013. Accessed June 2016.

https://cb100.acf.hhs.gov/sites/default/files/cb_ebook/cb_ebook.pdf

Wailoo, Keith. *Dying in the City of the Blues: Sickle Cell Anemia and the Politics of Race and Health*. Chapel Hill: The University of North Carolina Press, 2001.

Weiss, Nancy Pottishman. “Save the Children: A History of the Children’s Bureau, 1903-1918. PhD diss., University of California at Los Angeles, 1974.

Wertheimer, Michael. *A Brief History of Psychology, Fifth Edition*. New York: Psychology Press of Taylor & Francis Group, 2012.

Wertz, Richard and Dorothy Wertz. *Lying-in: A History of Childbirth in America, Expanded Edition*. New Haven: Yale University Press, 1989.

Willard, Charles Arthur. *Liberalism and the Problem of Knowledge: A New Rhetoric for Modern Democracy*. Chicago: University of Chicago Press, 1996.

Wolf, Jacqueline H. *Deliver Me from Pain: Anesthesia and Birth in America*. Baltimore: The Johns Hopkins University Press, 2009.

Wolf, Jacqueline H. *Don’t Kill Your Baby: Public Health and the Decline of Breastfeeding om the Nineteenth and Twentieth Centuries*. Columbus: The Ohio State University Press, 2001.

Yellin, Emily. *Our Mothers’ War: American Women at Home and at the Front During World War II*. New York: Simon and Schuster, 2010.

Zenderland, Lelia. *Measuring Minds: Henry Herbert Goddard and the Origins of American Intelligence Testing*. Cambridge: Cambridge University Press, 1998.