

EVERY
CHILD
A LION

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The Origins of
Maternal and Infant Health Policy in the
United States and France, 1890–1920

ALISA KLAUS

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“Baby’s Health—Civic Wealth”:
The Work of the U.S.
Children’s Bureau

By 1913 it was clear that the men who controlled political and economic power in France—the national administration, legislators, industrialists, and professionals—saw the welfare of France’s children as a critical factor in the nation’s future. Convinced that population growth, military power, and national survival were intimately linked, the government and legislators acted in the belief that the state had an interest in expending resources to protect mothers and infants. In contrast, before the U.S. entry into World War I, reformers in the United States did not employ military metaphors in their discussions of child health. Not only was there no pervasive national sense of military urgency to exploit, but those most interested in maternal and child health did not believe that the nation’s strength resided in military might or that its greatest threats came from foreign enemies. American infant health workers often wrote that healthy citizens made a nation great in some unspecified way—“The Children of Today Are the Citizens of Tomorrow” was a popular slogan—but more often they described the value of child health in purely economic terms. “The greatest asset of any nation is the health and efficiency of the people,” proclaimed the letterhead of the National Women’s Christian Temperance Union’s Department of Health.¹

In appealing to the economic interests of individuals and com-

1. Frances Lerther to “Friends,” 9/20/16 (U.S. Children’s Bureau, 4-12-4).

munities, reformers hoped to tap the motivating force of American society. For the most part, they failed. Until 1917 maternal and infant health was never the subject of debate in the U.S. Congress; private organizations continued to bear most of the costs of local maternal and infant health programs; and public agencies constantly struggled for the funds they needed to fulfill their goals.² Historians have cited a "heightened concern over the state of natural resources" and a sense that children were the nation's greatest resource as the sources of Progressive child welfare reforms.³ The reformers' writings and activities are evidence that such an interest existed, but their pleas that the public recognize the value of child life did not have the political resonance that such arguments had in France.

At first the campaigns of medical specialists to improve and standardize medical education through new clinical and research institutions influenced maternal and infant health care primarily in large cities, which had the necessary resources and population. Relatively few communities provided public funding for milk stations and visiting nurses, and in 1915 43 percent of the nation's 551 infant welfare stations and 49 percent of visiting nurses were located in just eight large cities. Only four states and eighteen cities had bureaus of child hygiene. When the U.S. Children's Bureau was created in 1912 no other agency dealt to any significant extent with infant health and no agency had a broad conception of child welfare policy.⁴

Thus President Taft's decision to place the U.S. Children's Bureau in the hands of women and to appoint Julia Lathrop as its first chief in effect empowered women to shape American maternal and child welfare policy. The absence of a public health and welfare bureaucracy in the United States worked to the advantage of the bureau; its staff had no obligation to work through or rely on existing federal, state,

2. Richard A. Meckel, *Save the Babies: American Public Health Reform and the Prevention of Infant Mortality, 1850-1929* (Baltimore: Johns Hopkins University Press, 1990), pp. 133-34, 142-43.

3. Quote from Nancy Pottishman Weiss, "Save the Children: A History of the Children's Bureau, 1903-1918," Ph.D. diss., University of California, Los Angeles, 1974, pp. 23-24. See also Manfred J. Wasserman, "The Emergence of Modern Health Care: Pediatrics, Public Health, and the Federal Government," Ph.D. diss., Catholic University, 1982, p. 77.

4. See Meckel, *Save the Babies*, pp. 134, 142; Jacqueline K. Parker and Edward M. Carpenter, "Julia Lathrop and the Children's Bureau: The Emergence of an Institution," *Social Service Review* 55 (1981): 64.

or local agencies. Even within the limits defined by its funds and official mandate, the bureau staff had considerable freedom to pursue their visions, and they made the most of it. Interpreting broadly their assigned task of initiating research and disseminating the results, the bureau, along with leaders of the public health nursing profession and of women's voluntary organizations, developed and propagated a distinctive vision of maternal and child welfare. This vision owed more to the settlement philosophy, female physicians' sense of social mission, and maternalist activism than to the new specialties of pediatrics and obstetrics or to male Progressive leaders' dedication to economic efficiency.

Focused on rural areas and small towns, where the grass-roots strength of the women's infant health movement was concentrated and where the bureau did not come into conflict with institutional pediatrics, obstetrics, and public health, the bureau's work increasingly emphasized the health of mothers for their own sake and not just because it affected their children. The bureau staff saw the mobilization of women to demand assistance and protection during pregnancy and childbearing as an essential feminist goal of women's political activism, since it required society to recognize the value of women's lives and labor. The bureau was also unusual in articulating a conception of human potential which did not emphasize the utilitarian value of human life. In the words of Julia Lathrop, the Children's Bureau was "an aid in securing for every child the life and liberty, which the fundamental law of the republic has promised—life and liberty interpreted in terms of to-day and tomorrow, life full and healthful—education free and public, opening and training the mind and the heart and the hand—occupation in due order, in brief, a fair start for the pursuit of happiness."⁵

5. Julia C. Lathrop, "The Children's Bureau," *Thirty-ninth National Conference of Charities and Corrections*, 1912, p. 30. See also Lillian Wald, *The House on Henry Street* (New York: Henry Holt, 1915), pp. 68, 167–68. On the Children's Bureau's approach to child welfare see Robyn Muncy, *Creating a Female Dominion in American Reform, 1890–1935* (New York: Oxford University Press, 1991), chap. 2. Molly Ladd-Taylor distinguishes two views of infant mortality: clubwomen and social settlement workers saw baby-saving as part of a larger campaign for women's dignity, the rights of mothers, and the recognition of the value of children's lives; conservatives saw infant mortality as a waste of national resources and associated child health with the eugenic goal of the perfection of the race. Mary Madeleine Ladd-Taylor, "Mother-work: Ideology, Public Policy, and the Mothers' Movement, 1890–1930," Ph.D. diss., Yale

The bureau operated, however, within the limits posed by American political culture. Though fighting for government action in areas previously considered outside the proper realm of federal activity, its staff struggled to create a maternal and infant health policy that would not appear to impose government will on communities or individuals and that would not stifle their independent initiative. Unlike French maternal and child welfare agencies, the U.S. Children's Bureau sought primarily to foster, inspire, and guide an independent infant health movement by providing models, information, and limited material assistance.

This conception of maternal and infant welfare arose alongside the medical model of pediatric and obstetrical care. While the bureau treated infant mortality as a social and economic problem, male obstetricians and pediatricians tended to see it essentially as a medical problem to be solved through improving the training of physicians, increasing research opportunities, and building hospitals. These two models did not come into direct conflict before World War I, partly because much of their vision was a shared one and partly because the Children's Bureau chose to concentrate its efforts in small towns and rural areas where few medical specialists chose to work. When the U.S. Congress began to consider major federal allocations for maternal and infant welfare after World War I, however, the two groups struggled for control over national policy.

The Children's Bureau Infant Mortality Studies

Though the Children's Bureau had been conceived by reformers involved primarily in the movement against child labor, the staff deliberately selected infant health as its initial focus, because child labor was politically volatile. Infant health work, they thought, could establish the bureau's credibility without inviting attacks.⁶ As its first project the bureau undertook a series of studies of infant mortality in representative medium-sized cities: Johnstown, Pennsylvania; Brockton, Massachusetts; Manchester, New Hampshire; Montclair,

University, 1986, p. 295. I would argue that the line dividing the two perspectives was not always clear.

6. Weiss, "Save the Children," p. 185; Parker and Carpenter, "Julia Lathrop and the Children's Bureau," p. 64; Muncy, *Creating a Female Dominion*, pp. 38-46.

New Jersey; and Saginaw, Michigan. The bureau chose to avoid larger cities where infant health work was relatively well established and where the staff would inevitably have competed with the male physicians, long-established charitable organizations, and public health officials who dominated public health work. The smaller cities welcomed the bureau's resources and allowed them considerable freedom in which to operate.

Through these studies, which absorbed most of the bureau's energy for two years, the staff began to articulate its conception of maternal and child welfare.⁷ From the first, the bureau's researchers treated infant mortality as a social problem. In part, this was a decision based on the fact that the bureau had no medical staff, but this approach was entirely compatible with the researchers' convictions that health problems had a social basis.⁸ Thus they surveyed the sanitary conditions of the neighborhoods they visited and studied the relationship between infant mortality rates and housing conditions, men's wages, women's employment, nativity, literacy, and methods of infant feeding.

The researchers decided that the best way to obtain the information they needed was to interview in their homes all the women who had borne children within the past year. This effort to come into contact with individual mothers was to become a characteristic feature of the bureau's work; it reflected the staff's belief that infant welfare was properly a concern of women and that women's own stories constituted more reliable evidence than aggregate statistics. Over the next eight years they became increasingly certain that their mission would be accomplished through the awakening, education, and mobilization of women.

The staff sought the cooperation of community organizations and leaders in publicizing the survey in an effort to gain the confidence of the women they wanted to interview: "The greatest care was taken to make clear that the Government does not desire to intrude upon the privacy of family life, but that it asks the cooperation of American mothers in an effort to safeguard the lives of babies."⁹ It was important

7. Parker and Carpenter, "Julia Lathrop and the Children's Bureau," p. 66.

8. *First Annual Report of the Chief, U.S. Children's Bureau to the Secretary of Labor* (Washington, D.C.: Government Printing Office, 1913), p. 8.

9. *Ibid.*

to the bureau that it avoid any suggestion of coercion; even more than in France, the family was sacred territory.

The bureau's administrators insisted that the national government had no right to force a program on any community, but they also argued that each community had the responsibility to develop its own programs. When they referred to "civic responsibility" they did not mean that the local government should initiate action; instead they suggested that voluntary organizations take on the task of raising funds and arousing the public, with public programs as their ultimate goal. On one level, this intent reflected a faith that American local governments functioned democratically as an organic expression of the community's will.¹⁰ At the same time, the bureau staff translated the moral ideal of self-reliance and responsibility from the individual to the community level, so that in the bureau's correspondence and publicity community initiative resembled a moral imperative.

The consensus among historians of the Children's Bureau is that the urban studies, in concluding that poverty was the single most important factor in infant mortality, challenged the assumption of early infant health programs that maternal ignorance was the primary cause of infant mortality.¹¹ It is true that the researchers repeatedly pointed out the close correlation between poverty and infant mortality, sometimes antagonizing local elites. Angry that the bureau's report on their city seemed to blame infant mortality on low wages, mill owners in Manchester, New Hampshire, tried to fight the bureau by taking their complaints to Congress.¹² The authors of the reports qualified this emphasis on poverty, however, admitting their inability to separate the effects of poverty on infant health from those of ignorance, illiteracy, inadequate housing, and poor sanitation. Ultimately, while they sympathized with the plight of the poor, they proposed education and environmental improvements rather than financial assistance as solutions to the problem of infant mortality. The solutions the bureau staff recommended included educational pro-

10. On settlement leaders' ideals of democracy and community see Rivka Shpak Lissak, *Pluralism and Progressives: Hull House and the New Immigrant, 1890-1919* (Chicago: University of Chicago Press, 1989), pp. 13-20.

11. See Weiss, "Save the Children," p. 197; Meckel, *Save the Babies*, pp. 180-83; Janet Pacht Brickman, "Mother Love—Mother Death: Maternal and Infant Care, Social Class and the Role of Government," Ph.D. diss., City University of New York, 1978, pp. 287-90; Ladd-Taylor, "Mother-work," pp. 313-17.

12. See Parker and Carpenter, "Julia Lathrop and the Children's Bureau," p. 66.

grams along the lines of existing urban public health programs: infant health consultations, follow-up home visits by public health nurses, municipal sanitation measures, and tenement inspection.¹³

It is not clear that economic assistance would have been the most effective immediate infant health measure. After all, Ireland, one of the poorest countries in Europe, had the third lowest infant mortality rate, probably because breast-feeding was almost universal there.¹⁴ In a comparative perspective, however, it is important to note that the bureau even chose to consider such characteristics as literacy and ethnicity. French researchers also believed the correlation between housing conditions and alcoholism and infant mortality to be an important one; they too argued that maternal ignorance of hygiene was one of the primary causes of infant mortality, especially among the poor. They did not focus so closely, however, on defining the behavioral characteristics of the poor and they were certain that economic hardship in itself contributed directly to infant mortality because it deprived infants of their mothers' care.

Perhaps with the aid of a computer and multiple regression analysis the bureau's researchers would have felt confident in ranking their variables in order of the importance of their influence on infant health. As it was, they found only a tangle of social pathology with poverty at the center. In attempting to explain, for example, why infant mortality rates were highest in the most crowded neighborhoods, a bureau writer suggested that a mother was often tempted to overfeed her baby or feed it irregularly if it slept with her and disturbed her rest. Ignorance was also partly responsible because mothers often kept the windows closed even when the means for good ventilation existed. If, however, the rooms were badly heated and opening the

13. See Mary V. Dempsey, *Infant Mortality: Results of a Field Study in Brockton, Massachusetts*, U.S. Children's Bureau, Infant Mortality Series No. 8 (Bureau Publication No. 37) (Washington, D.C.: Government Printing Office, 1919), p. 56; Nila F. Allen, *Infant Mortality: Results of a Field Study in Saginaw, Michigan*, U.S. Children's Bureau, Infant Mortality Series No. 9 (Bureau Publication No. 52) (Washington, D.C.: Government Printing Office, 1919), p. 62; *Infant Mortality, Montclair, New Jersey: A Study of Infant Mortality in a Suburban Community*, U.S. Children's Bureau, Infant Mortality Series No. 4 (Bureau Publication No. 11) (Washington, D.C.: Government Printing Office, 1915), p. 13.

14. Carlo M. Cipolla, *The Economic History of World Population*, 7th ed. (Middlesex, England: Penguin, 1978), p. 98. Among European countries, only Sweden and Norway had lower rates of infant mortality than Ireland.

windows would make it too cold or would let in soot, ashes, and dirt, they had no choice. The reporter concluded with an indictment of conditions beyond the parents' control: "The foreigners, who generally have the most miserable homes, are not dirty people who select bad living conditions through innate poor judgment, low standards and lack of taste." It was the only housing they could afford.¹⁵

The researchers also found that wealthy mothers could often overcome the disadvantages of artificial feeding, while poverty partly nullified the benefits of breast-feeding. Perhaps, the authors of the Manchester study concluded, "poverty usually means low standards and ignorance on the part of the mother," while well-off mothers had better medical attention and more knowledge of infant hygiene.¹⁶ They also concluded that literacy was an independent factor in infant mortality—though highly correlated with poverty—since literate women had access to written sources of information on the care of infants.¹⁷ In Saginaw the survey showed that children of foreign-born parents who did not speak English had a higher mortality rate than those whose parents were immigrants but spoke English. In this case the reporter suggested that, since they were more likely to be recent immigrants, "poverty and its attendant evils are factors probably more important than the inability of the mother to speak English."¹⁸

On the other hand, the researchers puzzled over why the French-Canadians in Manchester had a higher infant mortality rate than other immigrant groups had, even though they had a higher income, the women were employed less in the lower income categories, they spoke English more often, had been in the country longer, and were more likely to be literate. Perhaps, the researchers concluded, it was because the French-Canadians were not "Americanized": they retained their foreign language and distinct "channels of expression" such as separate schools, churches, orphanages, political and pleasure

15. Emma Duke, *Infant Mortality; Results of a Field Study in Johnstown, Pennsylvania*, U.S. Children's Bureau, Infant Mortality Series No. 3 (Bureau Publication No. 9) (Washington, D.C.: Government Printing Office, 1915), p. 26.

16. Beatrice Sheets Duncan and Emma Duke, *Infant Mortality: Results of a Field Study in Manchester, New Hampshire*, U.S. Children's Bureau, Infant Mortality Series No. 6 (Bureau Publication No. 20) (Washington, D.C.: Government Printing Office, 1917), p. 71.

17. Dempsey, *Infant Mortality . . . Brockton*, p. 28.

18. Allen, *Infant Mortality . . . Saginaw*, p. 25.

clubs, and their own daily French newspaper. They also were more likely than other groups to feed their children artificially.¹⁹

The bureau staff, like others in the social settlement tradition, represented a strain of social reform which deemphasized the responsibility of the poor for their own plight and in particular tended not to blame their immorality and lack of self-control.²⁰ The researchers chose not to consider venereal disease and alcoholism in their study, for example, though physicians treated these as important factors in infant mortality, because it would not have been "fair or practicable" to enter the home and ask questions regarding issues that could be considered "personally humiliating."²¹ In this respect the bureau stood out against others who entirely discounted poverty as a factor in infant mortality. "[In] the last analysis," wrote Helen Putnam, a Boston reformer, "it is the individual mother herself who must assume the largest responsibilities for the prevention of infant mortality."²² A matron in a factory in East St. Louis, Illinois, concerned about tuberculosis, also blamed working-class women for their ill health and that of their children. She wrote to the National Americanization Committee asking, "Isn't there some medium through which we can teach these girls the dangers and fatal results of the crowded way they live? . . . Swift and Company bear the expenses and try so hard to care for the babies, but they don't understand the meaning of the disease, its dangers, etc."²³

In contrast, consistent with their belief in social democracy, the bureau staff sympathized strongly with the poor as the victims of industrial capitalism and were aware that poverty sometimes made it impossible for people to observe the rules of hygiene. Nonetheless, they expressed an understanding of social pathology which clearly had some relation to traditional moral concepts of virtue. Thus on

19. Duncan and Duke, *Infant Mortality . . . Manchester*, p. 63.

20. See Mina Carson, *Settlement Folk: Social Thought and the American Settlement Movement, 1885-1930* (Chicago: University of Chicago Press, 1990), pp. 122-29.

21. *Second Annual Report of the Chief, Children's Bureau to the Secretary of Labor* (Washington, D.C.: Government Printing Office, 1914), p. 7.

22. Helen C. Putnam, "Dr. Snedden on Public Schools and Infant Mortality," *Child-Welfare Magazine* 9 (1914): 121. See also Sonya Michel and Robyn Rose, "The Paradox of Maternalism: Elizabeth Lowell Putnam and the American Welfare State," *Gender and History* (forthcoming).

23. Alice B. Woodring to "Madam," n.d. (U.S. Children's Bureau, 4-12-1-4-10).

the one hand they pointed to economic injustice as a critical factor in infant health: they noted "a coincidence of underpaid fathers, overworked and ignorant mothers, and those hazards to the life of offspring which individual parents can not avoid or control. This points toward the imperative need of ascertaining a standard of life for the American family."²⁴ At the same time, in answer to the question of whether Brockton's liquor-control law was a factor in that city's relatively low infant mortality rate (as many inhabitants believed), they answered: "Any influence which tends to make healthier parents, better homes, and more contented families will tend to reduce the number of infant deaths. . . . In a city having excellent sanitation facilities, a strong sense of civic pride, good wages, and intelligent workers, the abolition of saloons might be considered either as cause or effect."²⁵

"Education, not charity," could have been the motto of the American infant health movement. Though French politicians, physicians, and feminists rejected traditional forms of charity, they did not exhibit the same antipathy as Americans did toward public assistance or the principle of charity. Even Radical Republican politicians in France saw private charity, particularly female benevolence, as a potential solution to some of the spiritual problems of the bourgeoisie and as a way of mediating class conflict. In particular, financial assistance of mothers seemed justified to French policy makers because it could prevent the separation of mother and child. In the United States neither women's failure to fulfill their maternal duties nor the employment of mothers carried the emotional or political force apparent in French studies.

Children's Bureau and other researchers in the United States who studied the relationship between women's employment and infant health concluded that women's wage labor contributed little to the infant mortality rate in the United States. From their reading of reports of European studies the Children's Bureau staff were aware that high rates of women's industrial employment were generally assumed to be associated with high infant mortality rates. They were reluctant to draw definitive conclusions from the results of their own research, however.

24. *Second Annual Report of the Chief, Children's Bureau*, p. 8.

25. Dempsey, *Infant Mortality . . . Brockton*, p. 55.

In Montclair the researchers found that infant mortality was closely related to the mothers' employment, but because they counted women who took in laundry or had lodgers in their homes as employed, they did not single out the separation of children from their mothers as the central issue. Instead they argued that hard work of any kind during pregnancy could weaken a woman's health and decrease her chances of bearing a healthy child. If she kept working after birth she was likely to stop breast-feeding.²⁶ In Manchester the researchers found, not unexpectedly, that the number of stillbirths and the infant mortality rate were higher among children of women who worked outside the home in all income groups.²⁷ In Brockton, however, the infant mortality rate was actually slightly higher among children of women who were *not* gainfully employed than for mothers earning wages either at home or outside the home. The researchers concluded that little difference existed between the two groups because mothers who were "not gainfully employed" actually did as much hard physical labor as those who worked for wages.²⁸

This sympathy for the hard work that women did at home was typical of the Children's Bureau staff and became even more evident in their later studies of rural maternal welfare. The bureau researchers may have been deliberately avoiding an outright condemnation of women's industrial work so as not to supply evidence for attacks on women's right to work. Lathrop, commenting to the press on the results of the studies, emphasized that women worked in order to supplement their husbands' low wages and not for their amusement or personal satisfaction. "And we must not forget," she wrote, "that there can be a standard of life so low that the mother who is without a job and sits at home hungry can do less for her child's life than the mother who works for wages and can feed it and herself." Thus, she noted, while the death rate among infants of wage-earning mothers was higher than among non-wage-earning, the reverse was true in the group in which fathers had the lowest income.²⁹

26. *Infant Mortality, Montclair, New Jersey*, p. 21.

27. Duncan and Duke, *Infant Mortality . . . Manchester*, pp. 53-54.

28. Dempsey, *Infant Mortality . . . Brockton*, p. 37.

29. Julia C. Lathrop, "The Relation of the Father's Wage to Infant Mortality," 11/5/15 (U.S. Children's Bureau, 8-2-1-5).

Women's Employment and Infant Mortality

Suffragists commenting on infant mortality also seemed at pains to deny that women's employment directly threatened child welfare. Eva Ward, for example, writing in support of maternity benefits in the *Woman's Journal* in 1916, argued that poverty, not women's work, was the worst enemy of child welfare. Similarly, Harriot Stanton Blatch cited a study by Clara Collett for the British government which showed no clear relationship between the employment of married women and infant mortality.³⁰

Advocates of women's rights were not the only ones to come to this conclusion. A U.S. Senate commission appointed to study the employment of women and children devoted a volume of its report to a study of the relationship between women's employment and infant mortality in Massachusetts.³¹ Though the state's most important industries employed women in large numbers, the researchers concluded that women's wage labor had very little influence at all on the infant mortality rate in Massachusetts.

Edward Bunnell Phelps, writing for the commission, analyzed aggregate statistics for twelve Massachusetts cities; he argued that the birthrate in a community and the percentage of foreign-born and illiterate women were more closely associated with mortality than was the employment of women. Waltham, Lynn, and North Adams, for example, were among the ten cities in Massachusetts with the highest rates of female employment but among the fifteen with the lowest infant mortality. Conversely, Boston, Cambridge, and Chelsea had relatively few employed women but high infant mortality rates.³² Immigrants, Phelps wrote, lived in the worst of the social and economic conditions that fostered infant mortality: they were usually poor and ignorant; they tended to marry early and have large families; they preferred to employ midwives; they lived in the worst

30. Eva Ward, "In Defense of the Maternity Benefit," *Woman's Journal*, April 29, 1916: 138; Harriot Stanton Blatch, *Mobilizing Woman-Power* (New York: Woman's Press, 1918), p. 113.

31. U.S. Cong., Senate, 61st Cong., 2d Sess., Document No. 645, *Infant Mortality and Its Relation to the Employment of Mothers*, vol. 13 of *Report on Condition of Woman and Child Wage-Earners in the United States*, 1912.

32. *Ibid.*, p. 38.

housing; and the women were not equipped to cope with their new, unfamiliar environment.³³

The Senate's researchers also conducted an intensive study of infant mortality in Fall River. After interviewing the mothers of all the infants who had died over the past year they concluded that women's employment actually contributed little to infant mortality in that city. First, they found no significant difference in the age or cause of death between the children of women who had worked during pregnancy and those of women who had not worked outside the home.³⁴ The most striking finding was that the percentage of deaths in the first year from diarrhea, enteritis, and gastritis was 62.7 percent for children whose mothers worked and only 34.6 percent for those whose mothers did not work; the researchers concluded, however, that maternal employment raised the city's overall infant mortality rate only slightly, inasmuch as the percentage of infant deaths due to these diseases was only 38.6 percent for the city as a whole because relatively few mothers of infants were employed.³⁵

Thus, though there was evidence that the employment of women deprived children of proper care, Charles H. Verrill, reporting the results of the Senate study, concluded that even in New England's textile cities the employment of women presented no urgent threat to infant life. Instead, he placed the blame solely on maternal incompetence: "The causes of excessive infant mortality in Fall River may be summed up in a sentence as the mother's ignorance of proper feeding, of proper care, and of the simplest requirements of hygiene. To this all the other causes must be regarded as secondary."³⁶

Though the Senate commission report focused far more on ignorance than the Children's Bureau reports would, both furnish evidence that mothers who worked outside the home were all but invisible to policy makers. To a certain extent the difference between the United States and France in this respect can be attributed to a difference in objective conditions: relatively few married women in the United States worked outside the home, especially if they had young children. Nonetheless, French researchers were predisposed to focus on women's work outside the home. The separation of children

33. *Ibid.*, p. 53.

34. *Ibid.*, p. 119.

35. *Ibid.*, p. 74.

36. *Ibid.*

from their mothers had tremendous political and symbolic significance in France and was associated with doubts about the maternal instincts of French women and fears about the degeneration of the family. Had physical labor really been their primary concern they might, like the U.S. Children's Bureau, have taken seriously the work women did in their homes and on family farms. Despite the extensive debates about women's work in France, public and private agencies in that country acknowledged the fact of women's employment, recognized many of the needs of working women, and did far more to assist them than did reformers in the United States.³⁷

In the United States, there were efforts on the state level to regulate new mothers' employment. In 1912, Massachusetts and Vermont passed laws prohibiting employers from knowingly employing women within two weeks before or four weeks after childbirth; New York passed a similar law that applied only to the period *after* childbirth.³⁸ None of these laws included provisions to compensate women for the wages lost, and critics argued that the laws were essentially unenforceable because it was virtually impossible to prove that an employer had "knowingly" hired a woman who had recently given birth.³⁹ Testimony before the New York State Factory Investigating Commission suggests that even among advocates of regulation there was no consensus that maternity benefits were a necessary corollary of a prohibition of women's work.

Several of those who testified, including Melinda Scott of the Wom-

37. See Jane Jenson, "Representations of Gender: Policies to 'Protect' Women Workers and Infants in France and the United States before 1914," in *Women, the State, and Welfare*, ed. Linda Gordon (Madison: University of Wisconsin Press, 1990), p. 71. Jenson argues that in the United States "women's citizenship rights were claimed almost exclusively because of their supposed maternal qualities." Thus they were invisible, as workers and welfare programs addressed them only as mothers. In contrast, in France, there was widespread social acceptance of women's participation in the labor force, and women claimed the identity of "citizen-producer."

38. Connecticut passed legislation similar to that of Massachusetts and Vermont in 1913, but extended the period of prenatal rest to four weeks. Mrs. Max West, "The Development of Prenatal Care in the United States," *Transactions of the American Association for the Study and Prevention of Infant Mortality* 5 (1914): 74.

39. Edward Bunnell Phelps, "The World-Wide Effort to Diminish Infant Mortality—Its Present Status and Its Possibilities," *Transactions of the Fifteenth International Congress on Hygiene and Demography* (1912) (Washington, D.C.: Government Printing Office, 1913), vol. 6, p. 171. The French Strauss Law also stipulated that employers could not be penalized unless they knowingly violated the law, but because women who took leaves were entitled to cash benefits there was some incentive for them to do so.

en's Trade Union League, E. B. Phelps, Frances Perkins, director of investigations for the commission, and George Goler of the Rochester Public Health Department insisted that compensation was essential—otherwise, as Phelps pointed out, women would be faced with a choice between breaking the law and starving.⁴⁰ Others who testified in favor of the bill either ignored the issue of compensation or suggested that the only real solution was to pay men wages high enough to enable them to support their families. “I think it a monstrous outrage that a woman should be employed in that condition,” labor reformer Florence Kelley testified; she did not believe, however, that it was necessary for women to work under existing economic conditions. Women did it, she argued, “largely through a mistaken idea of thrift on the part of the family, or by the shiftlessness and selfishness of the husband drinking up the family earnings, and largely encouraged by the manufacturers or employers for the purpose of reducing the wages by having both heads of the family and all the children contributing to the family purse.”⁴¹ Woods Hutchinson, a New York City physician, agreed that the wisest way of preventing the employment of women before and after childbirth was to give men a decent living wage.⁴²

Because American reformers did not consider the employment of married women to be essential to the family or the economy—and in fact actively opposed it—they did not make a great effort to reconcile childbearing and wage labor.⁴³ If they saw the employment of pregnant women as exploitative their solution was simply to prohibit it. Similarly, the few employers in the United States who tried to provide maternity assistance seemed more concerned with keeping pregnant women out of the factory than with providing material benefits or care. Mary Barrett Gilson of the Clothcraft Shops of the Joseph and Feiss Company in Cleveland, for example, wrote to Mrs. Max West of the Children's Bureau boasting that her company

40. New York State Factory Investigating Commission, *Preliminary Report* (Albany: Argus, 1912), pp. 331–32, 964, 1280, 1804.

41. *Ibid.*, p. 1599.

42. *Ibid.*, p. 154.

43. Jane Jenson, “Paradigms and Political Discourse: Protective Legislation in France and the United States before 1914,” *Canadian Journal of Political Science* 22 (1989): 235–58. Deborah Dwork makes a similar argument about Britain in *War Is Good for Babies and Other Young Children: A History of the Infant and Child Welfare Movement in England, 1898–1918* (London: Tavistock, 1987), pp. 35–36.

had largely solved its problem with pregnant women by trying to eliminate young married women from its work force "in cases where no hardships result from this policy."⁴⁴

The Medical Model of Maternal and Infant Care

Having successfully reduced infant deaths from diarrhea, members of the American Association for the Study and Prevention of Infant Mortality and urban public health officials turned their attention to early infant deaths, those presumably the result of prenatal factors. While French physicians focused primarily on women's wage labor as the prime villain, medical specialists in the United States paid little attention to women's work and did not emphasize harmful environmental and economic conditions at all. Instead they initiated programs to instruct women and provide them with medical supervision. Their work was closely linked with the development of a medical model of maternal welfare, one that would come into conflict with the Children's Bureau's broader social vision.

Central to this medical model was the assumption that childbearing was a pathological condition. If only the public would believe this, argued Joseph B. DeLee, a Chicago obstetrician, midwives would be eliminated, women would naturally give birth in hospitals, a "better class of men" would choose to practice obstetrics, physicians would be better educated to care for women in existing surroundings, and women would routinely seek prenatal care.⁴⁵ Another obstetrician, Edward P. Davis, believed that outpatient obstetric services should be eliminated altogether. "Why," he asked, "should students of obstetrics be sent into filthy tenements to learn how to practice obstetrics properly?"⁴⁶

The midwife controversy, the subject of debate year after year at the meetings of the American Association for the Study and Prevention of Infant Mortality, provides fascinating evidence of the often

44. Mary Barrett Gilson to Mrs. Max West, 4/28/15 (U.S. Children's Bureau, 4-2-0-3).

45. Quoted in Edward P. Davis, "The Springs of a Nation's Life," *Transactions of the American Association for the Study and Prevention of Infant Mortality* 9 (1918): 114-16.

46. *Ibid.*, p. 111.

blatantly self-serving motives of obstetricians and their exploitation of infant mortality in creating propaganda for the profession.⁴⁷ In the late nineteenth century, midwives in cities in the United States served primarily immigrant and black women; native-born white women employed physicians. Many immigrant midwives had been trained in European schools, but American obstetricians considered them all incompatible with their vision of modern scientific medicine. The obstetricians' own studies showed that general practitioners were responsible for more maternal and infant deaths than were midwives, but outspoken obstetricians such as J. Whitridge Williams of Baltimore obstinately insisted that it was ridiculous to believe that illiterate immigrant women could learn to do competent obstetrics. The only solution, Williams insisted, was to improve the obstetrical training of physicians.⁴⁸

Most who agreed with Williams on this point also believed that some training and regulation of midwives was necessary until alternative institutions were available and women were convinced of the superiority of physicians. Some public health officials, including S. Josephine Baker, hoped to establish an extensive training system for midwives and envisioned the incorporation of midwives into maternity-care programs. Under Baker's leadership, New York City established the first municipally supported school for midwives in the United States in 1911; most physicians and public health officials considered the Bellevue School to be the only institution in the United States that provided adequate training.⁴⁹

Those who called for the immediate abolition of midwives, however, had enough influence in Massachusetts that in 1907 all practitioners other than licensed physicians were prohibited from attending births. Though midwives continued to practice, the law prevented any training or regulation of their work, because theoretically they did not exist. That midwives attended 40 to 90 percent of all births in many large cities was galling to obstetricians, because medical

47. For detailed discussions of the midwife controversy, see Judy Barrett Litoff, *American Midwives, 1860 to the Present* (Westport, Conn.: Greenwood Press, 1978), chap. 5; Frances E. Kobrin, "The American Midwife Controversy: A Crisis in Professionalization," *Bulletin of the History of Medicine* 40 (1966): 350-63.

48. J. Whitridge Williams, "The Midwife Problem and Medical Education in the United States," *Transactions of the American Association for the Study and Prevention of Infant Mortality* 2 (1911): 183.

49. Litoff, *American Midwives*, p. 48.

schools coveted the midwives' patients for training purposes. Midwives, Charles Ziegler protested, had charge of 50 percent of all the obstetrical "material" in the country without contributing anything to the knowledge of the subject.⁵⁰

"Prenatal care is plainly the coming thing in infant work, and all the cities are beginning to talk about it," wrote Mrs. Max West to Lathrop in 1914 from Springfield, Massachusetts, where she was on a trip to study prenatal care in New England.⁵¹ The discussions at the meetings of the American Association for the Study and Prevention of Infant Mortality, the reports of affiliated societies, and correspondence with the Children's Bureau staff provide ample evidence that prenatal care represented the most important trend in infant health work in the mid-1910s. The new prenatal programs conformed to the same pattern as the programs to prevent deaths from diarrheal diseases, with an emphasis on instruction in the home and medical supervision. Public health authorities and private health and charitable agencies hired nurses to visit mothers and instruct them in nutrition, hygiene, and the need for medical examinations and helped them to make preparations for childbirth.

Some public health officials and obstetricians hoped to use these prenatal services, sometimes combined with free maternity care, to undermine midwives' practices. Free clinics could be used, suggested Charles V. Chapin of Providence, Rhode Island, to draw patients away from midwives. Though he admitted that he knew of no evidence that midwives hindered public health work, he thought it was important that the clinic patients could be used for teaching purposes.⁵² Some agencies provided prenatal care or nursing care at the time of delivery only to women under the care of a physician; women who chose to employ a midwife were denied access to these services.⁵³

50. Charles Edward Ziegler, "The Elimination of the Midwife," *Transactions of the American Association for the Study and Prevention of Infant Mortality* 3 (1912): 224-25. On midwives in Massachusetts see Eugene R. Declercq, "The Nature and Style of Practice of Immigrant Midwives in Early Twentieth Century Massachusetts," *Journal of Social History* 18 (1985): 113-29.

51. Mrs. Max West to Julia Lathrop, 11/16/14 (U.S. Children's Bureau, 4-15-4-1-1); Meckel, *Save the Babies*, pp. 165-68.

52. Charles V. Chapin, "The Control of Midwifery," in U.S. Children's Bureau, *Standards of Child Welfare: A Report of the Children's Bureau Conferences, May and June 1919*, Conference Series No. 1 (Bureau Publication No. 62) (Washington, D.C.: Government Printing Office, 1919), p. 162.

53. Physicians at the New York Midwifery Dispensary refused to allow midwives

The Maternity Center Association of New York City provides a good example of the way in which prenatal care programs could lead women to abandon midwives for physicians and hospital delivery. Founded by a group of male physicians working with the city's Health Commissioner and with the financial aid of the Women's City Club, the Maternity Center Association had as its goal the provision of supervision and scientific care for every expectant mother, "so that every child born in the city of New York shall have proper care before birth, at birth, and during the days immediately following birth." By 1920 the association had nineteen centers and subcenters, each serving a particular geographical zone. Each center tried to keep a record of every pregnancy in its district. Nurses canvased for pregnant women and impressed on them the importance of medical supervision and of good medical care at childbirth. The nurses made regular and frequent home visits, instructed the mothers in the hygiene of pregnancy and in child care and the importance of breast-feeding, and helped them to make the necessary arrangements for the birth. At the clinics women received medical exams and were persuaded to engage a private physician or register at a hospital. Whenever possible, the workers encouraged the women to accept medical aid for confinement rather than employ a midwife.⁵⁴

The medical model acquired new legitimacy during World War I, when in 1917, the Child Welfare Committee of the General Medical Board of the Council for National Defense created a subcommittee on midwife practice. The report of this committee, made up of three men, including J. Whitridge Williams, articulated the views of obstetricians. The committee concluded that founding or extending schools to teach midwifery was neither possible nor desirable. No midwife, the committee argued, should be allowed to attend a birth

to participate at all in their patients' care. Nancy Schrom Dye, "Modern Obstetrics and Working-class Women: New York Midwifery Dispensary, 1890-1920," *Journal of Social History* 20 (1987): 558.

54. Anne Stevens, "A Program for Maternity Care," *Public Health Nursing Quarterly* 10 (1918): 95-99; quote in Anne A. Stevens, "The Work of the Maternity Center Association," *Transactions of the American Child Health Association*, 1919: 53; Reports of Affiliated Societies, *Transactions of the American Association for the Study and Prevention of Infant Mortality* 9 (1918): 303; Brickman, "Mother Love—Mother Death," p. 305; Anne Shannon Monroe, "Adventuring in Motherhood," *Good Housekeeping*, May 1920: 129-30.

unless a physician had examined the patient, supervised her prenatal care, and certified that she was likely to have a normal delivery.⁵⁵

*The U.S. Children's Bureau Model of
Maternal and Infant Care*

Grace Meigs, head of the Medical Division of the Children's Bureau, found the implications of the General Medical Board's report disturbing. The object of the proposed regulations, she pointed out in a memo to Julia Lathrop, was clearly to hasten the abolition of midwives. In any case, she argued, the plan was not practicable inasmuch as a woman who preferred a midwife would hardly be willing to submit to an examination by a male physician first. Instead, Meigs proposed that public health nurses with obstetrical training be responsible for supervising midwives without supplanting them.⁵⁶ It was this rejection of the primacy of the physician and hospitals in maternity care which characterized the bureau's model of maternal and infant welfare, one which was shared by some other women physicians and leaders of the nursing profession.⁵⁷

Like obstetricians, these women advocated prenatal instruction and saw the provision of professional maternity care to all women as an urgent priority. The bureau staff, public health nursing leaders, and the leaders of national women's organizations, however, struggled to avert the increasing hegemony of male obstetricians and the pathological conception of childbirth. They defined the public health nurse as the primary agent of instruction and the primary caregiver, particularly in rural areas, and warned that the trend toward the hospitalization of childbirth was a dangerous one. They believed that nurses with obstetrical training could supervise most aspects of ma-

55. "Report of the Sub-Committee on Midwife Practice of the General Medical Board of the Council for National Defense," n.d. (c. 1918) (U.S. Children's Bureau, 10,333).

56. Grace Meigs, "On the Report of the Sub-Committee on Midwife Practice of the General Medical Board of the Council for National Defense," 9/12/18 (Ibid., 10,333).

57. For example, see S. Josephine Baker, "Schools for Midwives," *Transactions of the American Association for the Study and Prevention of Infant Mortality* 2 (1911): 232; Carolyn Van Blarcom's comments in *ibid.*, p. 247; Wald, *House on Henry Street*, pp. 57-58.

ternity care and rarely mentioned physicians in their plans for rural programs for maternity care.⁵⁸

Small towns and rural areas provided the greatest opportunities for the bureau staff to realize their ideals; where medical institutions and public health agencies were rudimentary the bureau did not have to worry about competing with the medical establishment. Local women's organizations were a vital political force in small towns; in these the bureau hoped to find grass-roots support for their work. The success of the baby health contests was proof that rural women were eager for help in child rearing. Letters to the U.S. Department of Agriculture and the U.S. Children's Bureau indicated that isolation and poverty made themselves felt most severely during pregnancy and childbirth. In the sparsely settled prairie and mountain states many women had no access to either traditional or modern health care.⁵⁹

In 1915, Congress increased the bureau's funding to more than five times its previous level, enabling the agency to hire Grace Meigs as its first medical expert. The greatly expanded staff began planning a series of investigations of rural counties, beginning in Indiana and North Carolina in the fall of 1915. Broadly interpreting the bureau's charter, they incorporated direct educational work into their plans and hoped to stimulate permanent local child health institutions. They chose the child health conference—at which physicians examined infants and instructed their mothers—as an ideal way of gathering information and at the same time advising individual mothers. They hoped too that their work would stimulate ongoing programs; the conference was also a model that small communities could easily duplicate. By January 1916, Florence Sherbon, former secretary of the American Baby Health Contest Association, was holding child health conferences in Indiana in conjunction with a series of talks, demonstrations, slide show programs, and a child welfare exhibit.⁶⁰

58. Carolyn Van Blarcom, "Visiting Obstetrical Nurses," *Transactions of the American Association for the Study and Prevention of Infant Mortality* 2 (1911): 343.

59. Elizabeth Moore, *Maternity and Infant Care in a Rural County in Kansas*, U.S. Children's Bureau, Rural Child Welfare Series No. 1 (Bureau Publication No. 26) (Washington, D.C.: Government Printing Office, 1917), p. 8; Grace L. Meigs, "Rural Obstetrics," *Transactions of the American Association for the Study and Prevention of Infant Mortality* 7 (1916): 46.

60. A. L. Strong, "Plan for Cooperation in County Work between the Children's Bureau and Any University Extension Division or Any State Federation of Clubs," 1915 (U.S. Children's Bureau, 4-12-5-1); memorandum on interview about Chil-

Sherbon stayed in each community for about a week after the conference to organize a committee of local residents interested in planning follow-up work, helping them to draw up plans for the employment of a visiting nurse or for the creation of a child welfare center.⁶¹

The North Carolina study, carried out by Frances Sage Bradley, was a far more ambitious project. Bradley had been one of the first women to graduate from Cornell Medical School and in her practice in Atlanta had established a reputation as a pioneer in child hygiene.⁶² Working for the Children's Bureau, she held a conference and child welfare exhibit in each township in two counties, one representative of the lowland region, the other the most remote mountain county she could find. She also undertook an intensive, detailed house-to-house study of one township in the lowland county and three townships in the mountain county. She visited every midwife who had attended a case within the past five years, studied the effectiveness of birth-registration laws and conducted a brief survey of the hygienic conditions in the local schools. The study covered nearly all aspects of the social and economic conditions that affected child welfare; its goal, as Bradley stated it, was to reveal if possible the "relation of early home life to later health and efficiency."⁶³ In none of its subsequent studies did the bureau undertake such a complete survey of social and economic conditions; the later studies, in Wisconsin, Montana, Wyoming, and Mississippi, reflect an increasing interest in prenatal care and childbirth.

Unlike most public health officials and urban medical specialists, the Children's Bureau focused on women's experience of maternity. While French public policy protected women as childbearers and American urban programs for infant health emphasized prenatal care as an essential aspect of infant welfare, the bureau staff assumed that

dren's Health Conference, Indiana, 11/1/15 (ibid., 4-11-1-1); Grace Meigs to Bittner, 12/31/15 (ibid., 4-11-1-1); Parker and Carpenter, "Julia Lathrop and the Children's Bureau," pp. 65-66.

61. Grace Meigs, Memorandum on Indiana Conferences, 2/21/16 (U.S. Children's Bureau, 4-11-1-0).

62. See Lloyd C. Taylor, *The Medical Profession and Social Reform, 1885-1945* (New York: St. Martin's Press, 1974), p. 63.

63. Frances Sage Bradley, "Suggested Plan for an Investigation of Conditions Concerning Mothers and Babies in a Rural County," 2/16 (U.S. Children's Bureau, 4-11-2-2).

women's lives had inherent value separate from the lives of their children and argued that maternal suffering and death was in itself intolerable. As the rural studies progressed, improving the quality of women's lives and encouraging communities and families to recognize the importance of women's work and existence became as important to the researchers as saving infant lives.⁶⁴

It may not be accidental that the bureau staff's sense of female solidarity emerges most clearly through the rural studies. As native-born white women they could probably more easily empathize with rural and small-town women, most of whom were native-born or northern European, than with southern and eastern European urban immigrants. For the most part the rural studies suggest little of the ambivalence about the relationship between poverty and maternal and infant mortality that characterized the urban studies, except where the researchers worked in a black community in the North Carolina lowland county. Suspicious of the corrupting influence of the urban environment, the bureau staff also inherited the belief characteristic of American reformers that farm living fostered a wholesome independence, pride, and moral fortitude. To the French bourgeoisie, rural life was synonymous with backwardness, ignorance, and superstition. Urban Progressives in the United States believed that the inefficiency of agricultural production was a hindrance to progress but they also believed that rural life was the source of the moral strength that supported the nation's democracy. Improving the quality of rural life, they thought, might help to stem the tide of urban migration.⁶⁵

To the bureau staff and to the agricultural and home economics extension agents with whom they worked, a sense of community was a critical aspect of the ideal small town. When they entered a small town or rural township, they looked for community spirit—an eagerness of individuals to mobilize their resources to address the community's problems. The bureau insisted that its job lay in stimulating permanent local work and not in imposing programs on pas-

64. See, for example, Grace Meigs, memorandum to Lathrop, Sumner, and Bradley on plans for rural investigations, 6/17 (*ibid.*, 4-12-5-1).

65. See David D. Danbom, *The Resisted Revolution* (Ames: Iowa State University Press, 1979), pp. 24-36; William L. Bowers, *The Country Life Movement in America* (Port Washington, N.Y.: Kennikat Press, 1974), p. 15; Carson, *Settlement Folk*, pp. 112-13.

sive or unwilling communities. The staff sometimes even implied that it was better to have no infant health institution than to have one that the "community" did not initiate or at least welcome. "We feel very sorry," Grace Meigs wrote to Sherbon, who was struggling with an apathetic Wisconsin county, "that you and the Bureau should be put in the position of urging upon a community something which they are not anxious to receive."⁶⁶

In part this attitude reflected the staff's understanding of the proper role of the national government in social policy. As one of the few federal social welfare agencies—one whose very existence was controversial—the bureau was anxious not to imitate "autocratic" European government agencies in any way. The bureau staff also placed a moral value on community responsibility and initiative analogous to the value they placed on individual thrift and independence. Thus they argued that child welfare programs that relied on wealthy philanthropists were dangerous because they hindered the collective taking of responsibility by the community. In the eyes of the bureau staff, "Work for infant welfare is coming to be regarded as more than a philanthropy or an expression of good will. It is a profoundly important public concern which tests the public spirit and the democracy of a community."⁶⁷

As chief of the Division of Child Hygiene of the Kansas State Board of Health, Lydia DeVilbiss put this principle to work when she organized a child welfare contest for the counties of Kansas in 1916. She convinced the governor to offer a trophy to the county with the best health record for the year, based on both public and voluntary activities.⁶⁸ DeVilbiss reported to Lathrop on the moral benefits of such a program: "Instead of going into the country districts and trying to persuade the farmer folk to do what we want them to do, this plan proposes to put them on their mettle and let them do for them-

66. Grace Meigs to Florence Sherbon, 5/19/16 (U.S. Children's Bureau, 4-11-3-5).

67. *Second Annual Report of the Chief, Children's Bureau*, p. 8. On settlement leaders' ideas of community responsibility see Lissak, *Pluralism and Progressives*, pp. 13-14, and Carson, *Settlement Folk*, p. 112.

68. *Baby Week Campaigns*, U.S. Children's Bureau, Miscellaneous Series No. 5 (Bureau Publication No. 15) (Washington, D.C.: Government Printing Office, 1917), pp. 51-52.

selves what we want them to do and what we should have difficulty in getting them to do in any other way."⁶⁹

Thus, when the Children's Bureau researchers began to consider working in a particular county, they first sought the cooperation of influential and representative local organizations, focusing especially on the informal power structures. Before beginning work in any community they obtained the assurance of cooperation from the state board of health, the county medical society, and the local women's organizations. As soon as they arrived they contacted physicians and ministers, the city and county superintendants of schools, any visiting or school nurses or county extension agents, and sometimes leading businessmen.

The members of local women's organizations were essential contacts. If they could get the interest and active cooperation of the local club women, Bradley wrote, other women would surely follow.⁷⁰ The bureau viewed women's clubs as the manifestation of female solidarity and also believed that they had genuine power and importance in local politics. Never did Sherbon, Bradley, or their assistants complain that men did not listen to the women's organizations; nor did they mention women's inability to vote as a disadvantage in local politics. On occasion, their confidence that a united group of women could overcome the inertia or opposition of male-dominated bodies was indeed borne out. Thus their concept of democracy seems to have hinged not so much on the existence of formal political structures but rather on an environment and social life that fostered a spirit of cooperation and responsibility. This concept in turn rested on the assumption that a consensus was possible because social relations were fundamentally harmonious.⁷¹

The bureau staff had great faith in the schools as a potential base for community cooperation. They saw public schools as the most important of democratic institutions, since they believed that literate and well-informed citizens constituted the essence of democracy. Un-

69. Lydia Allen DeVilbiss to Julia Lathrop, 11/23/15 (U.S. Children's Bureau, 4-15-2-1-8).

70. Frances Sage Bradley to Grace Meigs, 11/11/15 (ibid., 4-11-1-1).

71. See Lissak, *Pluralism and Progressives*, pp. 13-15, on democracy and consensus in Hull House philosophy. On women's political culture, see Paula Baker, "The Domestication of Politics: Women and American Political Society, 1780-1920," *American Historical Review* 89 (1984): 620-47.

fortunately, schools were not always important in rural communities. Bradley wrote of her disappointment that in many country districts parents paid little attention to the school; many parents did not know the teacher and never even entered the building. "The place of the meeting," she concluded reluctantly, "should be left to the parents, notwithstanding our desire to establish the school as a community center."⁷²

The bureau sought the cooperation of local physicians not as potential allies but as an obstacle to be overcome before the real work could proceed. When Arthur B. Emmons, a prominent eastern pediatrician, responded to West's request for suggestions as to how to proceed with the rural investigations, he suggested that the people could be reached through the "community physician," but the bureau's researchers expected little help from the local physicians in the rural counties they studied.⁷³ More often than not they found physicians either overtly hostile to their work or so ignorant of child hygiene as to be of little assistance.

Many physicians feared that any form of free medical care would undermine their practices.⁷⁴ Sometimes an unfortunate public health nurse had to contend with a local physician like the "sick old man who calls births registration 'damn nonsense.'" ⁷⁵ Some physicians changed their minds, however, when they found out that the conference physician actually encouraged people to see their family doctors. Others were pleased to discover that a public health nurse could take over time-consuming bedside care. Many other physicians were simply apathetic, and Sherbon and Bradley frequently reported that professional jealousy or personal conflicts among the local physicians prevented them from cooperating.⁷⁶ Of course, hostility and indif-

72. Frances Sage Bradley, "Lessons Learned in Making Rural Studies" (U.S. Children's Bureau, 4-12-5-1).

73. Arthur B. Emmons to Mrs. Max West, 4/25/16 (ibid., 4-3-0-4).

74. "A Trip to Lexington, Virginia, May 10 and 11, 1915" (ibid., 4-15-0).

75. Mary Bartlett Dixon to Miss Rose, 5/22/18 (ibid., 4-12-1).

76. "Question Corner," *National Organization of Public Health Nursing*, 1917, p. 197; Grace Meigs, memorandum on visit to Boston, November 15-16, 1917 (U.S. Children's Bureau, 4-15-4-3); Florence Sherbon to Grace Meigs, 3/31/17 (ibid., 4-11-1-10); 3/24/16 (ibid., 4-11-1-1); 6/12/16 (ibid., 4-11-3-5); Meigs, Report on Indiana Conferences, 2/21/16 (ibid., 4-11-1-0); E. J. Huenekens, "The Minnesota Plan for the Establishment of Infant Welfare Clinics in Smaller Towns," *Transactions of the American Association for the Study and Prevention of Infant Mortality* 9 (1918): 189.

ference among physicians were not universal, and public health officials and the bureau staff sometimes found unexpected allies among physicians eager to help. Bradley, attending the meetings of the North Carolina State Medical Association, initially "heard the same old gags about the stupid obstinate women who are determined to die in spite of the Med. Profession etc. etc." To her astonishment, however, the membership voted almost unanimously to interrupt the meeting to hear her speak and each delegate wanted the bureau to study his community.⁷⁷ In Indiana, Sherbon found a physician who had been unfriendly and sarcastic before her program, but afterward called it a "revolutionary thing" and claimed that he could see the results in the attitude of his patients toward their children and in the conduct of pregnant women.⁷⁸

Even if physicians were interested in helping with the conferences, however, the bureau's workers frequently found them embarrassingly ignorant. Sherbon wrote to Meigs from Indiana suggesting that local doctors and nurses always be asked to participate in the bureau's conferences—"not that they are any real help (sometimes quite the contrary!) but it does educate them amazingly."⁷⁹ Sherbon commented on the need for a detailed manual of private instructions for the examiners at health conferences, "as these men are embarrassed by their helplessness, and often feel like boys on the dunce block, in spite of my attempts to put them at ease." A separate pamphlet, she thought, "would spare exposing them to the laity!"⁸⁰

Male physicians, Sherbon and Bradley concluded, were apparently too arrogant to consider practical details; trained exclusively to deal with disease rather than health, they were ill suited to child health work. Bradley scorned the "thoroughly scientific" doctors she came across, none of whom had "common *horse sense*."⁸¹ "It seems quite impossible," she wrote, "to find a man doctor who will fill out a record, with simple constructive suggestions. I think they minimize the importance of the home care, and the hygiene of the mother, or

77. Frances Sage Bradley to Julia Lathrop, 4/20/16 (U.S. Children's Bureau, 4-11-2-5).

78. Florence Sherbon to West, 7/15/16 (ibid., 4-11-3-5).

79. Florence Sherbon to Grace Meigs, 11/9/15 (ibid., 4-11-1-1).

80. Florence Sherbon to Grace Meigs, 3/17/17 (ibid., 4-14-2-4-0).

81. Frances Sage Bradley to Julia Lathrop, 7/29/16 (ibid., 4-11-2-5).

else assume that the mother knows more than she does."⁸² She criticized one physician who was "evidently accustomed to working with a nurse who relieves him of all those details which mean the success or failure of a doctor's advice." She found especially frustrating a doctor who threw the stool samples of babies with diarrhea into a neighbor's yard. "And we have been trying so hard," Bradley complained, "to have them [the mothers] protect their children from flies and stools of sick children."⁸³

Sherbon and Bradley began their rural studies already predisposed to mistrust male members of the medical profession, but the studies proved to be a personally and intellectually liberating experience; they returned home to challenge the emerging medical model of maternal and child health. Traditional methods of child care and health care, they discovered, often produced results as good as those of "scientific" hygiene; childbearing was, under the right conditions, a perfectly normal physiological process, and midwives, who knew enough to let nature take its course in most cases, were not nearly as dangerous as the average physician.

Rarely, if ever, had any women traveled freely throughout the country at the expense of the government, undertaking a project of their own design under the direction of women and with their government authority as a badge of legitimacy. The letters Sherbon and Bradley wrote to the Washington staff vividly convey their sense of adventure. Bradley, traveling in North Carolina in the spring of 1916, found a warm welcome nearly everywhere she went. She was exhilarated at the response: "And when we find farmers and their wives, stopping their ploughing and planting in the middle of April and driving 10 and 15 miles to learn how to raise children, it makes one feel that the work is worthwhile."⁸⁴ She was thrilled at the contact she was able to have with the most "backward," "primitive," elements of American society. "They're the people we're after," she wrote of a committee of schoolteachers, "One teacher schools, moonlight schools and all the rest of it . . . deaf children, dull children, lazy children and weakly, and nobody knows why."⁸⁵ In Green's Creek

82. Frances Sage Bradley to Grace Meigs, 3/17/16 (*ibid.*, 4-11-2-5).

83. Frances Sage Bradley to Julia Lathrop, 7/29/16 (*ibid.*, 4-11-2-5).

84. Frances Sage Bradley to Grace Meigs, 4/21/16 (*ibid.*, 4-11-2-5).

85. Frances Sage Bradley to Julia Lathrop, 2/25/16 (*ibid.*, 4-11-2-3).

she was disappointed that the village was too near the little towns of Dillsboro and Sylva "to find any very interesting obstetrical data most of the women having doctors." She had found the black midwives in Cumberland most interesting, though, since they used herbs, roots, and magic.⁸⁶

Bradley and her assistant, Margaretta Williamson, approached the experience with something like a pioneer spirit.⁸⁷ As they climbed deep into the mountains in search of remote backwoods communities, Bradley wrote to Meigs that the people were very happy; she and Williamson were almost ready to become mountaineers themselves.⁸⁸ She described one community as a kind of primitive paradise, untainted by the material temptations of modern urban society. "Their contentment and rather stubborn assurance of well-being are of course the result of their limited horizon," she wrote, "and one almost doubts the wisdom or kindness of helping them see what is beyond. They are happy as long as they have no standard of comparison, much happier than the same class of people in cities." Divorce and discontent were almost unknown. If only they could be taught to cook bread and vegetables instead of half-cooked hog and hominy, Bradley concluded, "I should be inclined to build a dyke or a barbed wire fence around Grays Creek Township and keep government employees and would-be educators out."⁸⁹

Bradley came to sympathize with the rural people's mistrust of physicians. Few able physicians located in their small communities; the only doctors who came their way were traveling quacks or "accidental medical students." Women relied on midwives, who, though ignorant, were "a fairly clean, decent sort, and with a wholesome horror of interfering with nature." Though they took no aseptic precautions, Bradley had heard of very few cases of infection. "Obstetrics," she reported, "is considered a strictly normal process, often not even a midwife being considered necessary."⁹⁰

Equally inspired by her own rural experience, Florence Sherbon wrote, "This Wisconsin work has been like opening a door to the

86. Frances Sage Bradley to Grace Meigs, 11/12/16 (*ibid.*, 4-11-2-5).

87. Margaretta Williamson to Emma Duke, 3/5/16 (*ibid.*, 4-11-2-5).

88. Frances Sage Bradley to Grace Meigs, 12-3-16 (*ibid.*, 4-11-2-5).

89. Frances Sage Bradley to Grace Meigs, 6/12/16 (*ibid.*, 4-11-2-5).

90. "Report on Rural Work in North Carolina 11/15 to 12/15, 1916" (*ibid.*, 4-11-2-7).

thing which I have felt urging me in a groping, blind way ever since the child welfare work 'got me.'"⁹¹ Sitting on a culvert waiting for a chauffeur and watching a woman and man put up hay together while two toddlers sat and watched, she described to Viola Paradise in the Washington office the German families she had recently visited. None of these families, she wrote, ever called a physician for anything and yet all had healthy children. One woman worked up until delivery and made bread the third day after and yet, to Sherbon's surprise, had a happy, healthy baby. "Its awfully disconcerting to have one's preconceived ideas get such jolts," she wrote. "I am not nearly so sure about some things as I used to be!"⁹² Two weeks later she wrote to Meigs with an urgent request for information on the midwife question: "We are meeting it fair and square here and its a big problem. Another of my preconceived ideas getting a big jolt!"⁹³

The example of these healthy country women, most of whom had never had a doctor in the house, Sherbon later wrote in the *Woman's Medical Journal*, proved that expert medical service was not a basic requirement for normal maternity. Many of these women "violate every canon set by modern obstetricians as to pre-natal conduct." Country women had fewer complications than urban women, she concluded, because they had so much exercise and fresh air.⁹⁴ So enamored of the country life was Sherbon that West teased her, "Dear Doctor Lady: . . . I am most particularly interested in your researches into the pregnant state. . . . If, as I said before, the country life and all that pertains to it really are a panacea for the pain and sorrow of childbirth, it is awfully worthwhile to find that out."⁹⁵

Before beginning her study, Sherbon later recounted, she had been committed to the extermination of the midwife. She thought pregnancy was pathological and was convinced that every time a woman gave birth she took her life in her hands. Her Wisconsin experience, she reported to the American Association for the Study and Prevention of Infant Mortality, convinced her not only that the German or

91. Florence Sherbon to Julia Lathrop, 6/22/16 (ibid., 4-12-4).

92. Florence Sherbon to Viola Paradise, 7/4/16 (ibid., 4-11-3-5).

93. Florence Sherbon to Grace Meigs, 7/18/16 (ibid., 4-11-3-5).

94. Florence Sherbon, "Maternal Efficiency—a Field for Research," *Woman's Medical Journal* 27 (1917): 35; Sherbon to West, 7/15/16 (U.S. Children's Bureau, 4-11-3-5).

95. Mrs. Max West to Florence Sherbon, 7/18/16 (U.S. Children's Bureau, 4-11-3-5).

Polish midwife was far better than the country doctor but that the entire direction of maternal welfare was wrong. "I believe we are in danger," she warned, "of placidly accepting the increasing pathologicity . . . and of institutionalizing maternity, and that about the time we get this elaborate system of maternity hospitals established and going, by state and municipal appropriations, just about that time we will wake up to the fact that after all an institution is not the best place to have a baby."⁹⁶

Though some other female physicians agreed with Sherbon that pregnancy could be a normal physiological function, the conclusion to be drawn from the Children's Bureau's rural studies was not that farm women lived in an earthly paradise.⁹⁷ Instead, the studies revealed that isolation, back-breaking work, and lack of assistance in the home were reflected in a high maternal mortality rate and a high rate of early infant deaths, especially in the mountains and the high plains. Country women, argued Dorothy Reed Mendenhall, a lecturer for the Extension Service in Wisconsin who also worked for the Children's Bureau at times, suffered "infinitely more hardship and privation than would be tolerated in a city of any size."⁹⁸

Women in the mountain states had a particularly hard time. There were only three registered physicians in the 5,500 square miles of a Montana county studied by the bureau, so women frequently left the area for childbirth. Of those who stayed, more than half had only a neighboring woman—often a practical nurse—to help, while one-eighth had only their husbands. The maternal mortality rate in the area was 12.7 per thousand, five times higher than that of Italy.⁹⁹ Though the women surveyed in the bureau's Kansas study were much better off—their work was not too hard and most could afford medical care if they needed it (95 percent had a physician at childbirth)—

96. Quoted in Grace L. Meigs, "Rural Obstetrics," *Transactions of the American Association for the Study and Prevention of Infant Mortality* 7 (1916): 65.

97. See Dorothy Reed Mendenhall, "Work of the Extension Department in Educating the Mother along the Lines of Prenatal Care and Infant Hygiene," *Transactions of the American Association for the Study and Prevention of Infant Mortality* 7 (1916): 217.

98. Comments by Dorothy Reed Mendenhall, Discussion, Session on Continuation Schools, *Transactions of the American Association for the Study and Prevention of Infant Mortality* 5 (1914): 250.

99. Viola I. Paradise, *Maternity Care and the Welfare of Young Children in a Homesteading County in Montana*, U.S. Children's Bureau, Rural Child Welfare Series No. 3 (Bureau Publication No. 34) (Washington, D.C.: Government Printing Office, 1919), pp. 27, 42.

few had any kind of prenatal care. In Wyoming, the bureau found women more than fifty miles from the nearest physician or nurse.¹⁰⁰

The bureau staff were eager to hear these women's stories. They corresponded with nursing leaders in Wyoming to arrange medical and nursing care for one woman who had written to the bureau of her trouble with a complicated pregnancy.¹⁰¹ Caroline Hedger, traveling in Wyoming for the bureau, made a trip to give Mrs. Phelps, the suffering woman, a physical exam and later sent her five pounds of dried fruit.¹⁰² Phelps reported that two women and two babies in her community had died within a year. She wrote bitterly, "If the woman had been a thoroughbred cow worth 3 or 4 hundred dollars Wyoming's State veterinary would have been rushed out here to save her and the calf, but it doesn't seem worthwhile to save babies and mothers in general. That's what hurts me so."¹⁰³ The bureau staff proposed to make a collection of letters from farm women telling of the hardships they suffered during pregnancy and childbirth and the difficulty they had getting help. They envisioned a book similar to *Maternity*, a collection of stories by working-class women about the pain and poverty associated with childbearing, published by the Women's Cooperative Guild in England.¹⁰⁴

This attention to the suffering of women was central to the bureau's approach to maternity care. The isolation of women in childbirth, a high maternal mortality rate, an inadequate health care system—the bureau interpreted all of these as evidence of women's oppression. The struggle for public maternity care, they believed, meant educating and organizing women to demand attention to their interests and

100. Elizabeth Moore, *Maternity and Infant Care in a Rural County in Kansas*, U.S. Children's Bureau, Rural Child Welfare Series No. 1 (Washington, D.C.: Government Printing Office, 1917), pp. 47-48; Mrs. James E. Mills to Caroline Hedger, 4/14/17 (U.S. Children's Bureau, 4-3-0-3).

101. Mrs. Max West to Ella P. Crandall, 10/26/16; U.S. Children's Bureau to Mrs. Phelps, 10/27/16; Ysabelle Waters to West, 11/3/16 (U.S. Children's Bureau, 4-3-0-3). The empathy of the bureau staff with the maternity experiences of women who wrote to the bureau for advice is illustrated in Molly Ladd-Taylor, *Raising a Baby the Government Way: Mothers' Letters to the Children's Bureau, 1915-1932* (New Brunswick, N.J.: Rutgers University Press, 1986).

102. Caroline Hedger to Julia Lathrop, 11/20/16 and 11/23/16 (U.S. Children's Bureau, 4-3-0-3).

103. Mrs. Phelps to Julia Lathrop, 12/13/16 (*ibid.*, 4-3-0-3).

104. Viola Paradise to Florence Sherbon and Elizabeth Moore, 5/16/16 (*ibid.*, 4-11-3-5); Grace Meigs, "Interview with Mrs. W. N. Hutt and Leonarda Goss," 5/31/16 (*ibid.*, 4-12-1).

needs. West wrote to Arthur B. Emmons complaining of the tone of "patronage, and something like condescension toward women who must accept free medical service of this sort, if they have any at all." Doctors should be "fighting for the establishment of this right," she argued, "rather than preaching to the women as to what their duty is."¹⁰⁵

West, like other members of the bureau staff, advocated a comprehensive system of county nurses who would carry out their work primarily in the home but would also be in charge of small cottage hospitals equipped with surgical facilities to handle complicated cases.¹⁰⁶ Mary Sewall Gardner and Ella Phillips Crandall, leaders in public health nursing, argued that rural visiting nurses should also be midwives; despite physicians' opposition to midwives in the United States, Gardner and Crandall pointed out that European statistics showed that trained midwives were effective.¹⁰⁷ Gardner and Crandall proposed that maternal and infant health care be placed primarily in the hands of female professionals rather than in the hands of male general practitioners and obstetricians. The training of physicians in modern obstetrics, using poor women as clinical "material"—an important factor in the medical model of maternity care—was of little importance in their program.

When the Section on Nursing and Social Work of the American Association for the Study and Prevention of Infant Mortality passed a resolution urging the training of obstetric nurses to supervise normal maternity cases, physicians objected.¹⁰⁸ It was the issue of national medical insurance for maternity and infant care, however, that brought the bureau into direct conflict with the medical profession. The isolation of rural women from all forms of health care convinced

105. Mrs. Max West to Arthur B. Emmons, 12/18/15 (ibid., 4-2-0-4).

106. The proposal for a system of cottage hospitals staffed by nurses was based on the Canadian example. See Suzann Buckley, "Ladies or Midwives? Efforts to Reduce Infant and Maternal Mortality," in *A Not Unreasonable Claim: Women and Reform in Canada, 1880-1920's*, ed. Linda Kealey (Toronto: Women's Press, 1979), p. 137.

107. Mary Sewall Gardner and Ella Phillips Crandall, "Recommendations Concerning Rural Maternity Nursing Service in Wyoming," 4/30/17 (U.S. Children's Bureau, 4-12-5-2).

108. Discussion, Section on Nursing and Social Work with Section on Midwifery. *Transactions of the American Association for the Study and Prevention of Infant Mortality* 2 (1911): 284-85.

the bureau staff that the provision of maternity care was a proper function of government. "Certainly a woman who gives a child to the country," wrote West, "has an inherent right to the best care that can be given to her."¹⁰⁹ Economic hardship, she argued, prevented many women from obtaining good care at childbirth and from taking rest they needed; some form of maternity insurance was clearly essential. Thus, when Lathrop and her staff began to develop a proposal for a national maternal and infant health policy in 1916 and 1917, they envisioned a program that would pay for certain kinds of medical care.

In its campaigns for maternity insurance the bureau had allies among both male and female labor reformers and advocates of social insurance legislation. The American Association for Labor Legislation, for example, drafted a health insurance bill including maternity benefits that would cover medical care for insured women and the wives of insured men, and a weekly benefit for insured women on the condition they refrain from gainful employment.¹¹⁰ The bureau did not couch its argument in favor of maternity benefits primarily in terms of the dangers of women's industrial labor, however. Instead, they cited the acute shortage of medical care, especially in rural areas. Unlike the American Association for Labor Legislation bill and French maternity-benefit proposals, Lathrop's was not designed primarily to enable wage-earning women to take time off but rather to make professional health care universally available. Under the proposal Lathrop supported, a very large percentage of the rural population would fall into the income category (earning under twelve hundred dollars) eligible for benefits.¹¹¹

Advocates of maternity insurance were well aware that they supported a controversial measure and that their opponents inevitably associated compulsory insurance proposals with tyranny and socialism. Eva Ward, writing in the feminist *Woman's Journal*, attributed this opposition to a misconception of the principles of insurance;

109. Mrs. Max West to Arthur B. Emmons, 12/18/15 (U.S. Children's Bureau, 4-2-0-4).

110. Julia Lathrop, "Public Protection of Maternity," *American Labor Legislation Review* 7 (1917): 28.

111. *Ibid.*, p. 31. Lathrop saw the urban-industrial emphasis of the AALL's bill as too narrow. Meckel, *Save the Babies*, pp. 189-95.

Americans did not realize, she thought, that only those who paid into the fund for a certain period were eligible to receive benefits.¹¹² In his study of the movement for social security in the United States, Roy Lubove argues that social insurance came into conflict not only with the ideology of voluntarism but with various private vested interests. Private health insurance companies lobbied vigorously against compulsory health insurance bills. The medical profession did not hide its economic interests in its fight against maternity insurance.¹¹³

Proposed maternity-assistance legislation in Massachusetts, submitted to the state legislature in 1916, 1917, and 1919, failed each time in the face of organized opposition from the medical profession. When the subject of maternity insurance came up in 1915 in the American Association for the Study and Prevention of Infant Mortality, some physicians expressed their fears that the government would regulate their fees in connection with compulsory insurance.¹¹⁴ An official of the Wisconsin Department of Health scorned the claim that poverty and hardship were the cause of high rural maternal and infant death rates. He argued that farm families, presumably out of stubborn miserliness, simply refused to pay for a physician's services or to employ trained nurses, though these were readily available. If they did not receive prenatal care it was simply because they wanted to avoid the expense; if they did not have help in the house it was because they were unwilling to pay a reasonable wage.¹¹⁵

The pediatrician Arthur B. Emmons of Boston, on the other hand, thought that Boston had too many free prenatal care services, catering to those who were simply hunting for cheap obstetrical care; he suspected that rural people had a spirit of independence and eagerness to learn.¹¹⁶ In comparison, it is significant that the French medical profession did not see maternity insurance as a threat to itself. The American medical profession had to defend its hegemony in a way

112. Ward, "In Defense of the Maternity Benefit," p. 138.

113. Lubove, *The Struggle for Social Security*, p. 9.

114. Session on Economic Aspects of Infant Welfare: Maternity Insurance, *Transactions of the American Association for the Study and Prevention of Infant Mortality* 6 (1915): 206; Meigs, "Rural Obstetrics," p. 72.

115. Dr. Heinike to Elizabeth Moore, 2/15/18 (U.S. Children's Bureau, 4-11-3-5).

116. Arthur B. Emmons to Mrs. Max West, 3/1/17 (*ibid.*, 4-15-4-1-1); West, "Boston, Mass.—Prenatal Care," 11/9/14 (*ibid.*, 4-15-4-1-1).

the French medical profession did not. French medical organizations were among the most vocal supporters of public maternal and infant welfare programs.

Though Lathrop openly advocated maternity insurance, she was pessimistic about its prospects in the United States. Social insurance, she privately admitted in 1916, was years away.¹¹⁷ Her pessimism was justified: the bureau's campaign for a national maternal and infant health program culminated in the Sheppard-Towner Act, which provided for maternal education but did not pay for medical care, and women in the United States have yet to win the right to compensated maternity leave. World War I, however, created the conditions that enabled women activists' model of maternal and child welfare to triumph briefly. The loss of adult male lives on the battlefield made it possible for American supporters of child welfare programs to argue that child health was a patriotic issue. As women mobilized as part of the war effort, the popular child health movement became a truly national one. After the war, women's organizations and the Children's Bureau drew on this movement to drum up massive popular support for a federal maternal and infant health program.

117. Julia Lathrop to Mrs. Frederick A. Halsing, 6/3/16 (*ibid.*, 4-15-4-1).