NETWORKS OF PUBLIC AND PRIVATE ORGANIZATIONS: BUILDING MATERNAL AND CHILD HEALTH PROGRAMS IN MICHIGAN, 1910-1930

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ABSTRACT

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In Michigan's towns and rural communities a network made up of women's voluntary organizations, the Michigan Bureau of Child Hygiene and Public Health Nursing, nurses and private physicians, enabled local communities to open maternal and child health clinics before the passage of the Sheppard- Towner Maternity and Infancy Act. These clinics expanded in number during 1923-1929 when federal funds were available to support maternal and child health programs. Clinics continued to function after the funds were withdrawn. The Board of Health of the City of Detroit operated separately from the Michigan State Board of Health and did not received support from the Sheppard-Towner funds. Nonetheless, here also a network of public and private organizations enabled the Detroit Urban League to establish a Baby Clinic prior to the Sheppard-Towner Act, to expand its services from 1923-1929 and continue operating after 1929.

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INTRODUCTION

Molly Ladd-Taylor observes that "scholars have as yet paid little attention to the history of women's health and public policy, but it is a promising area for research in which much work needs to be done. Women played a key role in the creation of the American public health system as activists, health professionals, and the primary consumers of health care. However, the separation between women's history and scholarship on public health has left historians with only a partial explanation for the development of the public health system."[1] This thesis explores the development of child and maternal health programs in Michigan during the first three decades of the twentieth century. Focusing largely on the Michigan Department of Public Health yearly reports has allowed me to piece together the operational structure of Michigan's early public child and maternal health clinics. Admittedly, the voices of the women served are missing; this is yet another unexplored piece of the puzzle for historians of public health and women's history to uncover. Even without these voices the documents explored herein give evidence to the importance of the cooperative networks among public agencies and private organizations during this period. Largely due to these networks, Michigan developed maternal and child health care programs that continued to serve women at a time when twenty-seven other states' maternal and child health programs disappeared. These organizational networks were heavily indebted to the networks developed by the growth of women's associations in the late 19th century and of black community associations in the early 20th century.

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[1]Molly-Ladd Taylor "Women's Health and Public Policy," Women, Health and Medicine in America ed. Rima D. Apple (New York & London, 1990).

If current maternal and child health programs are a product of the New Deal and the following decades, the essential shape and orientation of these programs is the result of early twentieth century concerns and solutions to infant and maternal mortality.[2] To understand the roots of our current system and thus the subsequent changes that occurred, scholars need to closely examine this period. In the second half of the nineteenth century, fifteen to twenty percent of all infants born in the United States died before their first birthday. In large cities and industrial towns these numbers probably soared to thirty percent.[3] Richard Meckel writes, "Of all the health revolutions that have taken place in the United States since 1850, the reduction of infant mortality is arguably the most dramatic and far-reaching." No other modern reduction of mortality in sheer numbers and the concentration of those numbers in a single year of life has come close to comparing with the reduction of infant mortality.[4]

Scholars consider women volunteers to be the principal campaigners for the expansion of public maternal and child health and welfare programs nationwide during this period.[5] Every year new research appears on the role women's organizations played in developing welfare policy.[6] Recent historical work focuses primarily on national politics,

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[2]Richard Meckel, Save the Babies: American Public Health Reform and the Prevention of Infant Mortality 1850-1929 (Baltimore and London: The Johns Hopkins University Press, 1990) 4.

[3]Ibid, p. 1

[4]Ibid, p. 1

[5]Molly Ladd-Taylor, Mother Work: Women, Child Welfare and the States 1890-1930 (Chicago: University of Illinois Press, 1994) 2. Alisa Klaus, Every Child A Lion: The Origins of Maternal and Infant Health Policy in the United States and France, 1890-1920, (Ithaca, New York: Cornell University Press, 1993) 5. Robyn Muncy, Creating a Female Dominion in American Reform 1890-1935, (New York: Oxford University Press, 1991); Kriste Lindenmeyer, "Saving Mothers and Babies; The Sheppard-Towner Act in Ohio," Ohio History, (June 1990) 107.

[6] Noralee Frankel and Nancy S. Dye, eds. Gender, Class, Race and Reform in the Progressive Era (Lexington: The University Press of Kentucky 1991); Muncy, Creating a Female Dominion; Meckel, Save the Babies; Linda Gordon, "Black and White Visions of Welfare: Women's Welfare Activism, 1890-1945" Journal of American History (September 1991); Linda Gordon, "Social Insurance and Public Assistance: The Influence

leading activists and their national networks, the Children's Bureau, and the rise and decline of national support for the Sheppard-Towner Maternity and Infancy Protection Act, the first national welfare measure. Little work has been done on state level structuring of maternal and child health policy; this may be due in part to the relatively recent interest in women's influence on the formation of the welfare state as a research topic. In addition, historic limitations of the definition of "political," as well as modern feminists' rejection of motherhood and maternalism as incompatible with female emancipation have contributed to the scholarly neglect of this research area.[7] In the last decade significant changes have been made in how historians look at political participation, especially that of women and minorities. Rather than limit politics to voting and political office holding, new definitions expand the realm of the political to encompass social activism in both its private and public forms.[8]

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of Gender in Welfare Thought in the United States, 1890-1935" American Historical Review (Februrary 1992); Klaus, Every Child A Lion; Linda Gordon, Pitied But Not Entitled: Single Mothers and the History of Welfare 1890-1835 (New York: The Free Press, 1994); Ladd-Taylor, Mother-Work; Gwendolyn Mink, The Wages of Motherhood: Inequality in the Welfare State, 1917-1942 (Ithaca and London: Cornell University Press, 1995); Theda Skocpol, Protecting Soldiers and Mothers (1992); Seth Koven and Sonya Michel eds., Mothers of a New World: Maternalist Politics and the Origins of Welfare States (New York and London: Routledge, 1993).

[7]Koven and Michel, Mothers of a New World, p. 2.

[8] Paula Baker "The Domestication of Politics: Women and American Political Society 1780-1920" Women , the State and Welfare, Linda Gordon, ed. (Madison Wisconsin: The University of Wisconsin Press, 1990) 76; Skocpol, Protecting Soldiers and Mothers, p. 3, 10. Maureen A. Flanagan, "Gender and Urban Political Reform: The City Club and the Woman's City Club of Chicago in the Progressive Era," American Historical Review (October 1990) 1033; Sara M. Evans, "Women's History and Political Theory: Toward a Feminist Approach to Public Life," Visible Women: New Essays on American Activism Suzanne Lebsock and Nancy Hewitt, eds., p. 121; Katheryn Kish Sklar, "Hull House in the 1890s: A Community of Women Reformers," Unequal Sisters: A Multicultural Reader, second edition, Vicki L. Ruiz and Ellen Carol DuBois, eds., (New York: Routledge, 1994) 109-121; Nancy A. Hewitt, "Politicizing Domesticity: Anglo, Black, and Latin Women in Tampa's Progressive Movements," Gender, Class, Race and Reform in the Progressive Era Frankel and Dye, eds., (Lexington: University of Kentucky Press 1991); Kathryn Kish Sklar, "The Historical Foundations of Women's Power in the Creation of the American Welfare State 1830-1930," Mothers of A New World, Koven and Michel eds., (New York and London: Routledge 1993) 43-93. Eileen Boris, "The Power of Motherhood: Black and White Activist Women Redefine the 'Political'," Mothers of a New World, Koven and Michel, eds.

State and local studies can help to follow the course of sociopolitical activism, exposing the continuity of private, non-governmental organizations' participation in American political and public life and the consequences of their work on social policy accomplished through networks of individuals and organizations. Kriste Lindenmeyer has done a state level study of the Sheppard-Tower programs in Ohio. Presently no other state level studies have been published. A distinctly different development of state Sheppard-Towner programs occured in Ohio from what occurred in Michigan. According to Lindenmeyer, Ohio's Sheppard-Towner programs were headed by a male physician strongly opposed to the federal act. Women's organizations in Ohio were not involved in the decision making process nor in the implementation of Ohio's programs.[9] Ohio, like Michigan, formed an advisory committee but the Ohio committee consisted of physicians, nurses, and representatives from some of the state's health organizations. Thus, Ohio's Sheppard-Towner programs were formulated by Ohio State Medical Association physicians and other health professionals. This contrasts sharply with Michigan, where a female physician, strongly connected to state and national level women's organizational networks, headed the Bureau in charge of overseeing the state's program. A committee made up of heads of women's organizations concerned and already involved with infant health and welfare advised the Michigan Bureau of Child Hygiene and Public Health Nursing in aiding their organizations in providing health education and clinical care to communities across the state. Thus, women's organizations played on important role in creating and implementing Michigan's Sheppard-Towner programs. This may partially explain the different programs and organizational structure of maternal and child health care programs between the neighboring states. The comparative strength of the state medical associations and women's organizations between the two states also may have been a factor in the differing structure and survival of the programs.

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[9]Lindenmeyer, p. 115.

The Ohio advisory committee with the State's Director of Health as chair outlined three programs for spending the Sheppard-Towner funds. The first was a set of research programs, similar to research done in Michigan at the same time: a statewide survey into the causes of infant and maternal mortality, a study of hospital reporting procedure in an effort to standardize statistical records, and a statewide study of midwives practicing in Ohio. The second program, where the difference between the two states is most acute, was the creation of a series of "district demonstrations" which would "show the application of practical, specific health education in which every agency in the community is invited to take part." Michigan's Bureau ran traveling clinics throughout the state, but more importantly aided local county committees and women's clubs in setting up maternal and child health clinics widely distributed across the state. The third Ohio program was a series of conferences run by specialists intended to "interest the public in regular, periodic health examination for expectant [sic] mothers and children as well as the presumably normal adult and to enlist the complete sympathy, understanding and cooperation of the medical profession," as well as an immunization campaign.[10] Michigan's Bureau was, likewise, heavily concerned with enlisting the aid and support of Michigan's medical professionals; however, the lectures and educational programs were directed primarily at women's groups and other non-professional organizations interested in maternal and child health care.

The Ohio Director of Health set up four demonstration districts in the state: one in a mining settlement, one in a rural district, one in a small town community and one in an urban center. A key determining factor in the selection of the demonstration district was evidence of high maternal and infant death rates. Public health nurses performed the bulk of the work in the demonstration districts. While the demonstration districts did not solely focus on maternal and infant health, but rather general health as well, nurses were expected to devote at least 2/5ths of their time to the welfare and hygiene of mothers and babies as Ohio. This was the agreement Ohio's Director of Health had made with the Children's

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[10]Ibid, p. 117.

Bureau when his program was approved.[11] This raises another distinction between Ohio and Michigan. Michigan's programs were entirely focused on maternal and child health and did not combine community health in general with maternal and child health work.

While the three chosen districts predominantly served white native and immigrant communities, the Cincinnati district, focused on saving the lives of black mothers and babies whose death rates were much higher than white women. This district demonstration ran from late 1923 through June 30, 1925. As in other minority communities, black nurses were hired to work in the district. The nurses made home visits and held clinics in two area schools. A series of lectures for 'colored doctors' was also sponsored by the pediatric department of the University of Cincinnati College of Medicine, the Cincinnati General Hospital and the Ohio State Department of Health during the observance of Negro Health Week in the spring of 1924. Lindenmeyer writes, "this was the only effort focused solely on black mothers and babies undertaken with the Sheppard-Towner funds in Ohio."[12]

Ohio may be an anomally in respect to targeting the black population in the state for receipt of Sheppard-Towner programs. In other welfare activitiy, pension programs for mothers specifically, half of the black mothers in the country receiving pensions lived in Pennsylvania and Ohio. While black mothers accounted for only 3 percent of the recipient population in 1931, Pennsylvania and Ohio, in contrast with other states, made significant efforts to address the needs of their black population. Michigan did not use Sheppard-Towner funds to address the health of black mothers and babies in the state. This neglect rose due to the several interrelated issues. The Sheppard-Towner funds were given to the state department of health. The Michigan State Department of Health did not oversee, do research or run programs in Detroit. The Board of Health of the City of Detroit had complete autonomy from the state department of health. Detroit held the majority of

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[11]Ibid, p. 120-123.

[12]Ibid, p. 124-125.

Michigan's black population and so cooperated with the Detroit's board of health rather than the state department of health which received the funds. Also, Detroit was the largest urban center, but underrepresented politically at the state level and thus was not in position to influence the spending of the maternity and infancy funds. In addition, the racial and ethnic makeup of the Detroit left large segments of its population outside national and state political structures which made policy and allocated resources. Furthermore, Sheppard-Towner funds were directed predominantly at rural communities and that combined with the autonomy of Detroit in health matters, left the Detroit black community, along with the rest of the Detroit population, on its own during the Sheppard-Towner years. However, this did not mean that the city's inhabitants went without maternal and child health care. Detroit had its own organizational networks that ran maternal and child health care programs throughout the city. The Detroit Black community, through the work of the Detroit Urban League was a part of this network.

Thus on numerous grounds the development of the child and maternal health programs in Michigan differed from that of Ohio. In Michigan, professional and non-professional white and black men and women, working in networks made up of voluntary organizations, public organizations, nurses and private physicians, actively used public resources, as well as private resources, to improve maternal and child health in their communities before 1923. Significantly, this structural difference the administration of Sheppard-Towner programs Ohio and Michigan allowed Michigan to maintain child and maternal health programs after the repeal of the Sheppard-Towner Act, where as Ohio's programs declined. The continuity in Michigan's programs before 1922 and after 1929 points to the centrality of organizational networks to the success of Michigan's child health programs, showing that these networks were able to successfully continue the work they had begun before the Sheppard-Towner Act after the federal funds were withdrawn. While public and private networks, such as those in Michigan, are not new to historians, they do add weight and a local dimension to the work historians have done on the national

networks created by women reformers in the early twentieth century. The existance of these networks also reinforces a gender distinction in the way white men and women participated in public policy making. In addition, the networks seen in Michigan show that white women activists and black activists (both men and women) participated in a similar mode. Working outside conventional politics, both groups created networks linking public with private organizations which provided for the health care needs of women and children in their communities.[13]

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[13]For readings on maternalist networks: Mink, The Wages of Motherhood; Klaus, Every Child a Lion; Koven and Michel, eds., Mothers of New World; Ladd-Taylor, Mother-Work; Meckel, Save the Babies; For readings on race and gender in connection with the formation of the welfare state see Mink, The Wages of Motherhood; Koven and Michel, eds., Mothers of New World; Ladd-Taylor, Mother-Work; Meckel, Save the Babies; Gordon, "Social Insurance and Public Assistance: The Influence of Gender in Welfare Thought in the United States 1890-1935," American Historical Review (February 1992) 19-54; Gordon, "Black and White Visions of Welfare: Women's Welfare Actisim. 1890-1945"; Frankel and Dye, eds., Gender, Class, Race and Reform in the Progressive Era.

CHAPTER 1

Building Popular Support for Maternal and Child Health Programs

In 1921, the Michigan Public Health Department asserted the obligation of society to preserve the lives of its infants stating, "All babies have a right to live; a right to the best there is. They come into the world without their consent, and society is inhuman when it neglects or refuses to provide for them."[14] This sentiment often expressed in the Michigan Public Health Journal grew out of Progressive Era activism of women's voluntary organizations working to remedy what they identified to be social injustices towards women and children.[15] Women activists believed that women had a unique role to play in the public realm, one that focused on the improvement of the family and the protection of women and children. Women's moral vision, compassion, and capacity to nurture became linked with motherhood, these private qualities became central to the public discourse scholars now identify as maternalism. Maternalism upheld women's domesticity at the same time it legitimated women's public 'domestic' role. As Koven and Michel write, "Using political discourses and strategies that we have called 'maternalist,' they transformed motherhood from women's primary *private* responsibility into *public* policy."[16]

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[14] J. P. Sedgwick, M.D. and E. C. Fleischner, M.D. "Breast Feeding in the Reduction of Infant Mortality," Public Health (May-April, 1921) 117.

[15] Paula Baker, "The Domestication of Politics," Women, the State and Welfare, Linda Gordon, ed. (Madison Wisconsin: The University of Wisconsin Press 1990) 63.

[16] Koven and Michel eds., Mothers of New World, p. 2. For more on maternalism and women's emerging public role and the developement of public health and welfare in the late 19th and early 20th century see: Skocpol, Protecting Soldiers and Mothers, p. 349,

The ethic of maternalist reform can be traced to the early nineteenth century when women in American began to organize to promote social reform and moral purity. Within a newly defined domestic sphere of activity drawn from an domestic ideology that stressed the difference between men and women, white, middle class women began to work in the public sphere in efforts to provide the civic moral reform they believed industrializing America needed. In 1874, the formation of the Woman's Christian Temperance Union (WCTU) put women's volunteerism into a larger arena of political activism. Not limited to temperance issues, the WCTU moved into openings created by the American tradition of limited government and members generated a wide range of needed social services. As Koven and Michel write, "The WCTU created new opportunities for middle-class women's social activism in a social environment that was absorbing massive numbers of recent European immigrants and a political environment where municipal, state and national governments offered little if any assistance to needy men, women, and children.[17] Increased access to higher education contributed to women's new public role. By 1880, one out of every three undergraduates was female.[18] The social sciences by this time were gendered so that women predominated in three of the five departments of the American Social Science Association - education, public health and social economy.[19] College-trained women reformers thought of themselves as policy experts and used social science tools in their work. A group of educated reform leaders turned to settlement work among the immigrants communities in America's cities, such as, Jane Addams' Hull House in

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353; Regina Morantz, "Making Women Modern: Middle-Classs Women and Health Reform in Nineteenth-Century America," Women and Health in America ed., Judith Walzer Leavitt , (Madison, Wisconsin: The University of Wisconsin Press 1984) 348-349; Klaus, Every Child a Lion. For imormation on domestic ideologies of the 19th century see: Linda A. Kerber, Women of the Republic: Intellect and Ideology in Revolutionary America (New York and London: W.W. Norton & Company, 1986) Chapter 5.

[17]Koven and Michel, Mothers of New World, p. 61.

[18]Ibid, p. 62.

[19]Ibid, p. 65.

Chicago. Beyond the reform leadership, by the 1890's tens of thousands of urban middle-class women put their educations to use in the women's club movement. The General Federation of Women's Clubs (GFWC), drew together after 1890, a vast network of local women's organizations and channeled women's energies into concerted political action.

The movement for maternal and child health rose as women's political activism grew. Concern over infant mortality developed alongside sanitary reform in America's urban centers in the late 19th century. Reformers sought first to reduce infant mortality by improving the general public health through sanitizing the environment. The Pure Milk campaign began when statistics showed that the greatest proportion of infant deaths were due to digestive and nutritional disorders and when bacteriology emerged as a science.[20] By the 1890s, cities established milk stations, especially in tenement districts, in efforts to reduce infant deaths due to poor quality or contaminated milk. By 1913, 297 milk stations chiefly operated by private agencies, existed in thirty-eight cities.[21] While milk reform addressed the nearly one third of infant deaths that were due to diarrhea, infant mortality rates remained high, as respiratory diseases and infectious diseases killed sizable numbers of infants. Believing that educating mothers on rules of infant hygiene and management could lower infant mortality rates still further, new reform work defined infant mortality as a problem of motherhood and reformers turned their attention towards improving mothers abilities to carry, bear and raise healthy infants.[22]

Voluntary agencies formed the core of the campaign against infant mortality. In the 1910s, organized women ran infant health clinics staffed by hired or volunteer physicians and nurses. They examined, weighed, and measured children and instructed mothers on

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[20]"Introduction" and "Historical Foundations of Women's Power," Mothers of New World Koven and Michel eds.; Meckel, Save the Babies, p. 5-6; John Duffy, The Sanitarians: A History of American Public Health (Urbana and Chicago: University of Illinois Press 1990) Chapter 12.

[21]Meckel, Save the Babies, p. 79.

[22]Ibid, p. 6, 94-124.

nutrition and hygiene.[23]. By 1915, hundreds of private agencies, in almost 300 Americans cities and towns, conducted some form of educational infant welfare work.[24]

While voluntary agencies formed the core of the campaign against infant mortality, few of those involved in the campaign believed volunteerism alone was sufficient to meet the vast array of social and economic problems common to industrial society. Reformers concerned about child health and welfare argued that only government had the authority, resources and centralized bureaucratic organization to pursue and coordinate effective reform and regulation. Women's organizations, at the local, state and national levels, finding their own funds inadequate to meet the great demand for health care, lobbied the government for publicly funded child health and later maternal health services.[25] Local concern supported a growing national coalition of women's organizations and professional reformers who worked to pass their voluntary work to the government as they campaigned for mothers' pensions, minimum wage regulations and the creation of the U.S. Children's Bureau in 1913.[26] Support from local women's organizations, the social settlements, the National Conference of Charities and Corrections, the General Federation of Women's Clubs, the Mothers' Congress, and local child welfare societies was central to the establishment of the Children's Bureau [27] Skocpol argues that the campaigns led by female

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[23]Ladd-Taylor Mother-Work,p. 51 and Meckel, Save the Babies, p. 113-114.

[24]Meckel, Save the Babies, p. 129.

[25]Molly Ladd-Taylor, Raising Baby the Government Way: Mother's Letters to the Children's Bureau, 1915-1932, (New Brunswick: Rutgers University Press, 1986) 152. Meckel, Save the Babies, p. 112-114.

[26]Paula Baker, "The Domestication of Politics," p. 76.; Skocpol, Protecting Soldiers and Mothers, p. 3,10; Mink, The Wages of Motherhood, p. 13; Meckel, Save the Babies, Chapter 5,

[27] Skocpol, Protecting Soldiers and Mothers, p. 3, 10. Most scholars recognize the centrality of women's organizations to the establishment of the Children's Bureau. For other accounts read: Linda Gordon, Pitied But Not Entiteld, p. 70-80. She presents the campaign for welfare in terms of a white women's network. This networking style of organization was vital to Michigan's maternal and child health programs that were later formed. For a more through discussion of women's campaign for maternal and child health see also: Ladd-Taylor, Mother-Work; Muncy, Creating a Female Dominion; Skocpol,

professionals "would not have succeeded without the locally rooted women's federations already engaged in child welfare work and other civic activities.[28]

It took eleven proposed bills before the Children' Bureau was signed into law on April 9, 1912. Housed in the Department of Commerce and Labor, the Children's Bureau was intended to be a research agency to "'investigate and report...upon all matters pertaining to the welfare of children and child life among all classes of our people.'"[29] As the first federal agency headed and staffed primarily by women, the Children's Bureau focused national attention on maternal and child welfare and coordinated the disparate activities of voluntary women's organizations into a powerful nationwide campaign.[30] Working with leaders of the public health nursing profession, women's voluntary organizations and other voluntary organizations, the Children's Bureau worked to foster, inspire and guide an independent infant health movement by providing models, information and limited material assistance,.[31] Local studies directed by the Children's Bureau quickly became associated with women's groups and therefore established the primacy of women in child welfare work.

Historian Molly Ladd-Taylor writes of the Children's Bureau, that "the spotlight it placed on maternal and child welfare made many women feel they had a stake in politics for the first time."[32] Volunteers from all over the country promoted the Children's Bureau and its work towards reducing infant mortality. Women's clubs asked the Children's Bureau for direction on how to reduce infant mortality in their communities. These voluntary

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Protecting Soldiers and Mothers; Meckel, Save the Babies and Alisa Klaus, Every Child a Lion: The Origins of Maternal and Infant Health Policy in the United Staes ad France, 1890-1920, (Ithaca and London: Cornell University Press, 1993) Chapter 3.

[28]Skocpol, Protecting Soldiers and Mothers, p. 2, 482.

[29]Muncy, Creating a Female Dominion, p. 46-47;

[30] Ibid, p. 38; See also Ladd-Taylor, Mother-Work, Chapter 3.

[31] Klaus, Every Child A Lion, p. 210-211.

[32]Ladd-Taylor, Mother-Work, p. 74.

women's organizations functioned as active partners in the Bureau's work by forming child welfare committees in state and national women's organizations. The national chair of child welfare then worked directly with the Bureau and sent orders down to her state chairs, who directed the activities of local branches.[33] Commenting on the widespread recognition of the power of organized women and the Children's Bureau, historian Robyn Muncy writes, "State health officials and legislators knew that if they wanted an immediate force of lobbyists on behalf of better birth registration laws, they need only write to [Julia] Lathrop, [head of the Children's Bureau] and the lobby would materialize."[34] Pressure from organized women and the publicity generated by the Children's Bureau prompted state health officials to back the child hygiene movements and to ask the Bureau for help in achieving higher birth registration rates. The legislative victories of the alliances between the Children's Bureau and local women's organizations exposed the potential power of even a small, federal agency without the legal right to prompt states or individuals into action. This power lay primarily in the networks of public and private agencies in the Progressive era.[35]

Enthusiasm for child welfare programs at the local, state and national level was boosted by US. engagement in W.W.I.[36] Congress created the Council of National Defense in 1916 to study the country's economic capacity for war. In June of 1917, the Council of Defense Special Committee for Child Welfare recommended "that the Council of Defense call upon all communities to see that there is no abatement, but on the contrary a decided increase in their activities along the lines of maternal, infant and child welfare; this to apply to all public and private agencies." The Council further recommended that "the

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[33]Muncy, Creating a Female Dominion, p. 61.

[34]Ibid, p. 58-60.

[35]Ibid, p. 60-62.

[36]For readings on the connection between WWI and the infant health movement see: Mink, The Wages of Motherhood, Chapter 3 and Meckel, Save the Babies, p. 200.

Council of National Defense through the several state councils of defense, cooperate with local organizations interested in maternal, infant and child welfare, and establish an agency or appoint an existing agency to secure information as to the specific needs of each community and to show how these needs can be adequately met." [37] This attention to child welfare was due in part to the large number of young men rejected from military service for defects at least a third of which could have been recognized and treated in infancy. During the war, 29.1 percent or 730,000 young American men were declared physically unfit for military service. Most of the defects appeared to be the result of early childhood diseases such as, scarlet fever and rickets.[38]

Reformers read the army data as proof of the social and human costs of ignorance, illiteracy, poverty and cultural isolation. Maternalist leaders used this evidence to lobby government for more generous and more systematic social investment in motherhood and child health and to included organized women and the Children's Bureau into the campaign when the Council added a Woman's Committee after the declaration of war to coordinate the voluntary, war-related activities of men and women in the states it named Dr. Anna Howard Shaw, former NAWSA president, chair of the Woman's Committee..[39] She immediately established ten departments, each with a national chair and chair in every state, directed state chairs to act as child welfare agents for the Children's Bureau and to assume the responsibility for implementing the Bureau's war time program.[40] Setting up the

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[37]Margaret Hughes, "Building Up Our Last Line of Defense," Public Health (April 1918) 110.

[38]Muncy, Creating a Female Dominion, p. 97; Meckel , Save the Babies, p. 201 for statistics; Paul Starr in The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry (Basic Books 1982) 193. He presents slightly different figures: He reports of 3,760,000 men examined, about 550,000 were rejected as unfit; and of the 2.7 million called into service, about 47 percent were said to have physical impairments.

[39]Mink, The Wages of Motherhood, p. 23.

[40]Muncy, Creating a Female Dominion, p. 97 and Skocpol, Protecting Sodiers and Women, p. 496.

Woman's Committe in this way, Shaw replicated long established women's cooperative associational methods. The establishment and work of a Woman's Committee tied women's social and political roles together and placed greater responsibility on the state for child welfare.

The Children's Bureau's wartime program, a publicity campaign called Children's Year, began April 6, 1918.[41] The publicity of Children's Year and rising popular sentiment, caused many communities to establish permanent health clinics funded and administered by local governments working in cooperation with the Children's Bureau.[42] During the war the Children's Bureau and the State and National Councils of Defense, cooperating with Federated Clubs, Health Departments and all organizations interested in child welfare, began a drive to save 100,000 children, designating each state a quota of babies to save. [43] Women's organizations were key to the success of this drive. Bina West, Chair of the Michigan Child Welfare Department wrote, "No greater problem than this exists in the world today. While nations are destroying the manpower and the natural resources of the world in the carnage and devastation of war, organized women are called upon to help make good that waste by the conservation of child life for the future."[44]

The baby saving campaign generated state involvement.[45] Success of Michigan's campaign to meet its quota of 2,808 babies, depended on the work of voluntary organizations in the state. The April 1918 edition of the Michigan Public Health Department magazine, Public Health, explained that state and federal agencies, either official or voluntary, "can make plans and offer suggestions, but each community must

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[41]"Child Welfare Campaign," Public Health (April 1918) 98.

[42]Ladd-Taylor, Mother-Work, p. 89-90.

[43]Margaret Hughes, "Building Up Our Last Line of Defense," p. 113.

[44]Bina M. West, "Child Welfare," Public Health (April 1918) 106.

[45]For more on the Better Baby movement see Klaus, Every Child a Lion, Chapter 4.

bear its full share of responsibility in making the campaign a success."[46] The Women's Committee recommended lending aid to already existing organizations working for child welfare and advised readers of Public Health to get in touch with parent teacher associations.[47] Arguing for the importance of local women's organizations to child health in writing, Bina West wrote that "The work of this Department [State Child Welfare Department] covers the welfare of all children, and it affords an excellent opportunity for women's clubs, societies and organizations of all kinds in Michigan to cooperate in a general plan of work which will benefit the children of the state who need this help."[48]

The wartime nationalistic rhetoric apparent in public health literature such as Public Health also helped to propel support for maternal and child health and welfare programs. The April 1918 isse included articles asking, "Is there any greater patriotic duty for the civilian population than to safeguard the welfare of the Nation's Children?" and stating that "National Liberty rests upon national vitality. The health and strength of the people are, therefore, fundamental factors in national defense."[49] The essay, "Building up Our Last Line of Defense," by Margaret Hughes, Director Child Welfare Division from Helena Montana, asserted that "there is not greater patriotic service than fitting the children of today to physical and mental efficiency, for the heavy burdens that will rest upon them as the citizens of tomorrow."[50] Wests article further emphasized community responsibility towards children by arguing that "Although the United States now lacks the machinery for such Federal Aid as England has enabled to grant to local work it has power enough locally to make a very credible showing, and, it may be hoped, to pave the way for such

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[46]West, "Child Welfare Work," p. 122.

[47]Ibid, p. 106.

[48]Ibid, p. 105.

[49]Ibid, p. 98 and 108.

[50]Hughes, Public Health, p. 109.

Governmental provisions as will enable the United States to show that even greater salvage which its unexhausted condition makes possible."[51]

After World War I, the statewide and local child and maternal health campaign drew upon this momentum. The 1920 April issue of Public Health, featuring child welfare exclusively, opened with a cartoon of a baby on a pedestal flanked by a soldier and a worker in overalls holding a mallet. The Pedestal read, "The Baby-To him we look for reconstruction and the future strength of all nations." The caption below read, "The Biggest thing to have come out of the war."[52] The first article titled, "Killing America's Babies," stated, "Fifty thousand American soldier were killed in the great world war in Europe the past two years. Dreadful. But 300,000 babies were killed in the United States only last year.... As a matter of fact, 600,000 children under the age of six years are buried in the United States annually."[53] The author urged women voters to inform themselves for the purpose of saving American babies arguing, "Woman must enter the domain of sociology, of politics, of political economy. To neglect these fundamental sources of knowledge and power is to be responsible for this dreadful slaughter of the innocents."[54]

Attention turned increasingly to maternal health. Dr. Josephine Baker, Chief of the Child Hygiene Bureau in New York City wrote that "for every soldier killed a mother died in childbirth, and for every soldier killed six babies died at childbirth , and all because the social and the economical conditions are so poor."[55] In May 1919, the Children's Bureau wrote standards for public protection of maternity at the Children's Bureau Conference on

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[51]West, "Child Welfare Campaign," p. 100.

[52]Public Health (April 1920) 153.

[53]Ibid, p. 155. Even with the baby saving campaign, U.S. child and maternal mortality rates were still high compared to European rates.

[54]Judson Grenell, "Killing America's Babies," Public Health (April 1920) 155.

[55]Ann Wilson, "Development of the U.S. Federal Role in Children's Health Care: A Critical Appraisal," Children and Health Care: Moral and Social Issues, ed. Loretta M. Kopelman and John C. Moskop (Boston, London, Dordrecht: Kluwer Academic Publishers 1989) 39.

Standards of Child Welfare that stressed the need for education on hygiene, having a complete physical examination by a physician, and the availability of adequate maternity and prenatal care to all women.[56] Public support was vital to the Children's Bureau's vision, "Laws alone will not make people civic or healthy. They must spring out of a public sentiment, and be backed by public sentiment, or else they will be like so many laws that are only occupying book space."[57]

Through the 1920's public sentiment would support maternal and child health programs. Public Health continually reaffirmed the neccessary role of the state in lowering infant mortality. The April-May issue of 1921 opened with a graphic featuring a map of Michigan broken into counties with a smiling baby pasted over the state. The caption below read, "11,041 Babies under one year of age died in Michigan in 1920. What are you doing in your community for the Babies?" It ended by asking, "Do You Know that the boys and girls of today are the mothers and fathers of tomorrow and it is up to you to keep them well?"[58]

The publicity generated in the early 1910s and 1920s led many communities to established permanent health clinics funded and administered by local governments, philanthropic or social service agencies working in cooperation with state departments of health and the U.S. Children's Bureau.[59] These state divisions owed no allegiance to the Children's Bureau legally; yet, they took advice from the Children's Bureau and submitted regular reports on budgets, legislation and programs in their states. After World War I the Council of National Defense was dismantled and the Woman's Committee transferred its work to newly created state agencies or to permanent women's organizations.[60] These

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[56] Public Health (April, 1920) 155.

[57] Public Health (April, 1920) 159.

[58] Public Health (May-April 1921).

[59] Ladd-Taylor Mother-Work, p. 89-90; Meckel Save the Babies, p. 141.

[60] Muncy, Creating a Female Dominion, p. 101.

agencies and organizations advocated for the creation of maternal and child health programs during the post war years and their support would ultimately lead to the passage of the Sheppard-Towner Act.

CHAPTER 2

The Sheppard-Towner Maternity and Infancy Act: Federal Maternal and Child Health Policy

The Children's Bureau and its supporting voluntary organizations actively pushed for more maternal and child health initiatives from national government reinforcing the points that maternity care was a public responsibility and that local funds were not adequate to reverse the limited availability and underconsumption of quality obstetric services thet were responsible for America's high maternal mortality rates. They cited statistics that every year 17,000 mothers died and that, since 1900, no decrease has been seen in the maternal mortality rate although other death rates had been reduced.[61] Reminding readers that the U.S. maternal mortality rate was higher than fourteen other countries, the Children's Bureau cited the need for state and national aid to provided borth the education and health services neccessary to lower these rates. Federal support and funding for maternal and child health programs thus became the goal of the Children's Bureau.

The campaign to secure the passage of the Sheppard-Towner Maternity and Infancy Act brought concerns about infant and prenatal care into the world of politics.[62] Women's organizations across the country lobbied in support of the bill. The Charter members of the Women's Joint Congressional Committee, established in 1920, unanimously voted to make

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[61] Judson Grenell, "Killing America's Babies," Public Health (April 1920) 155. Meckel, Save the Babies, presents Meigs 1916 maternal moralty study p. 202.

[62] Ladd-Taylor, Mother-Work, p. 168. For Sheppard-Towner History see also Meckel, Save the Babies, Chapter 8; Wilson, "Development of the U.S. Federal Role in Chilren's Health Care: A Critical Appraisal"; Ladd-Taylor, Raising A Baby the Government Way: pp. 24-32.

passage of the Sheppard-Towner Maternity and Infancy Bill its primary goal.[63] Good Housekeeping, Ladies Home Journal, Woman's Home Companion and McCalls urged women to write their congressmen and provided petitions to circulate and sign.[64] Thousands of women wrote congressmen and senators urging the passage of the bill. Other women joined an organized lobbying effort what was described by many in Washington as the most intensive campaign to influence the vote on a single bill they had ever seen[65] Signed into law by President Harding on November 23 ,1921, state legislatures still needed to vote acceptance of the Act. The Federation of Women's Clubs, League of Women Voters, and other women groups led lobbies in state capitols. By June 30 1922, all but six of the 48 states had accepted the Sheppard-Towner Act.[66] Ultimately only three states refused to do so. Illinois and Connecticut established their own maternal and infant health programs. Massachusetts did not and challenged the constitutionality of the Sheppard-Towner Act. The Supreme Court dismissed their suit.[67]

The Sheppard-Towner Act "provided federal matching grants to states for information and instruction on nutrition and hygiene, prenatal and child health clinics, and visiting nurses for pregnant women and new mothers. It furnished no financial aid or

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[63]Muncy, Creating a Female Dominion, p.104. The charter organizations were: the General Federation of Women's Clubs, the National Consumers' League, the National League of Women Voters, the National Women's Trade Union League, the National Congress of Mothers and Parent-Teacher Associations, The American Association of University Women, The Women's Christian Temperance Union, the National Federation of Business and Professional Women's Clubs, the National Council of Jewish Women, and the American Home Economics Association.

[64]Ladd-Taylor, Mother-Work, p. 170.

[65]Meckel, Save the Babies, p. 210; Mink, The Wages of Motherhood, Chapter 3; Ladd-Taylor, "My Work Came Out of Agony and Grief": Mothers and the Making of the Sheppard-Towner Act," Mothers of a New World, Koven and Michel eds., Chapter 9.

[66]Muncy, Creating a Female Dominion, p. 107.

[67]Meckel, Save the Babies, p. 211.

medical care, and limited appropriations to a period of five years."[68] The grants, available from 1923-1929, supported a marked increase in child and maternal health activities in the states. The Southern and Western states, where prior to the Sheppard-Towner Act maternal, infant, and early childhood health programs had been all but non-existent, particularly benefited from the Act.[69] Almost every state used Sheppard-Towner funds to hold health conferences, make home visits, promote birth registration, and distribute literature. A number of states also ran mobile health clinics, organized training programs for midwives, immunized children against diphtheria and smallpox, and encouraged the use of silver nitrate to prevent blindness in infants. Some funded research into maternal and infant mortality and investigated local hospitals, maternity homes, and day nurseries.[70] Even though it was not intended to finance medical care, a number of states also ran mobile health clinics, and immunized children against diphtheria and smallpox.

Not all communities benefited from the Sheppard-Towner Funds. For example, the Detroit black community operated a Baby Clinic run by the Detroit Urban League and the Board of Health of the City of Detroit that remained untouched by the federal program. This is due in part to the rural emphsis of the Sheppard-Towner Act. The Children's Bureau had first concentrated its investigations on urban areas assuming the problem of infant mortality was essentially an urban one, but then it shifted its work by 1920's to a largely rural focus. According to Meckel, in 1917, as maternal mortality became an increasing concern, lack of rural obstetrics care redirected the Children's Bureau focus from urban centers to rural regions. Though he argues it recognized that urban mothers died more frequently in childbirth and from pregnancy complications than the rural mother,

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[68]Ladd-Taylor, Mother-Work, p. 168-169.

[69]Meckel, Save the Babies, p. 211.

[70]Ladd-Taylor, Mother-Work, p. 177. Raymond Devries, Regulating Birth: Midwives, Medicine & the Law (Philadephia: Temple University Press 1985) 38.

it continued to pursue rural programs.[71] Lloyd C. Taylor attributes this shift to the work of Dr. Frances Sage Bradley of the Children's Bureau rural medicine program.[72] Ladd-Taylor argues that the first maternity and infancy bill introduced in 1918 specifically targeted rural areas, where mortality was thought to be highest. Thus the subsequent Sheppard-Towner Act reflected this early emphasis.[73]

Aside from conflicting beliefs about rural and urban mortality there are other explanations for the uneven distribution of programs across racial and ethnic lines. According to Alisa Klaus, the Children's Bureau had chosen to work in smaller cities and in the rural communities where the grass-roots strength of the women's infant health movement was concentrated to avoid competition with already established service groups, located in larger cities like Detroit. Consequently, this was where Sheppard-Towner programs were later developed.[74] Ladd-Taylor , who also maintains that Sheppard-Towner programs chiefly benefited white farm women even though statistics showed higher death rates in urban areas, argues that the decision to concentrate on rural areas was made partly to avoid conflict with health agencies already established in a number of cities, but also because this promised less conflict with the medical profession, since the specialists who dominated the AMA had less influence in rural areas. Ladd-Taylor also suggests that the rural focus may be due in part to the large correspondence between Lathrop and her staff and the white farm women who were the main audience for the Bureau's pamphlets.[75] Historical racial and ethnic inequality left black and ethnic minorities outside of networks of political power whose middle-class members formed

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[71]Meckel, Save the Babies, p. 204.

[72]Lloyd C. Taylor, The Medical Profession and Social Reform, 1885-1945 (New York: St. Martin's Press 1974) Chapter 5.

[73]Ladd-Taylor, "My Work Came Out of Agony and Grief," p. 328.

[74]Klaus, Every Child a Lion, p. 210-212.

[75]Ladd-Taylor, "My Work Came Out of Agony and Grief," p. 337-338.

public policy, and the Sheppard-Towner Act itself, which allowed states and localities to determine their own programs, contributed to the focus on a white rural population. Southern and border states developed infancy protection measures either for whites only or on a Jim Crow basis. In northern cities de facto segregation reinforced the white ethnic bias of maternalist reform.[76] This is in part why Detroit operated uneffected by the funds. Ladd-Taylor argues that despite this racial and ethnic bias the federal Children's Bureau worked to reduce infant and maternal mortality in all racial and ethnic groups, hiring black physicians and nurses to work in black communities, Spanish-speaking nurses to work among the Mexicans and Native Americans to work on reservations.[77] Ultimately, the states had control over the spending and direction of their programs and no single factor can be identified as the determinant of who the recipients would be; as in the cases of Michigan and Ohio these programs could vary greatly as well as the recipients. In the case of Michigan another factor also must be considered. The historical separation of Detroit's Board of Health and the Michigan State Department of Health, combined with active involvement of grass-roots, white, women's organizations across the state in getting maternal and child health clinics established in their own communities, led to the de facto white bias in Michigan's Sheppard-Towner programs.

Some physicians opposed federal maternal and child health programs, others supported federal involvement in maternal and child health issues although they pushed for the creation of programs under the public health service. Believing that the medical profession should be in charge of health bureaus across the nation, rather than 'lay' women associated with the Children's Bureau, physicians supported federal involvement, but along different lines that defined by the women of the Children's Bureau. Taliaferro Clark (Surgeon, U.S. Public Health Service) read a paper before the Homeopathic Medical Society of Pennsylvania on Sept. 21, 1920 discussing the needs in child hygiene. Clark

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[76]Mink, The Wages of Motherhood, p. 67-68.

[77]Ladd-Taylor "My Work Came Out of Agony and Grief," p. 331.

heavily emphasized the importance of prenatal care of the mother across the country. Citing the 1910 census data, he noted, that children aged birth to fourteen made up 32 % of the population.[78] Two-thirds of these deaths were due to causes that current child hygiene programs did not address, (namely prenatal sources of death).[79] He criticized state departments of health for leaving the creation of a bureaus of child hygiene to the last. He further criticized the departments of health for placing nurse or lay women in charge of the bureaus. This was a concern in common with many in the medical field. He claimed that a proper child hygiene program must have a foremost place in the public health organization including in the budget, and stressed that even trained women or men from the medical profession and public health profession would be challenged to oversee such a program.[80] He wrote, "There is no lack of child hygiene programs. Practically every civic organization has one and virtually all of them are directed to one-third of the baby deaths, with the exception of pubic health organizations providing prenatal supervision in a limited way. The great need is to pull all these organizations together, and to give them scientific direction under centralized administrative control. The combined support of private organizations behind well-directed public health education as to the real needs of the Divisions of Child Hygiene would enable health departments to establish them on an adequate basis successfully to attack some of the more fundamental problems relating to child health." [81]

Despite the apparent success and wide spread support of Sheppard-Towner programs, opposition to renewing the Sheppard-Towner Act was almost immediate. The American Medical Association began its campaign against renewal of the Act with an editorial in The Journal of American Medicine, in February, 1921. The AMA perceived the

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[78]Public Health, (April-May 1921) 122.

[79]Ibid, p. 124.

[80]Ibid, p. 130.

[81]Ibid, p. 130.

Sheppard-Towner Act as a threat to male doctors incomes and control over the health care system. The AMA argued on three grounds against renewal of the Act: "it made a political issue of women's and children's health; it expanded the social welfare function of the state; and it increased professional women's authority over public health and welfare programs."[82] At the heart of the AMA's oppostion was a perceived challenge to male authority. Doctors questioned the ability of the "lay" women on the Children's Bureau staff to administer maternity and infancy programs, overlooking the fact that a female physician headed the Maternity and Infancy Division of the Children's Bureau. Medical leaders urged that, if passed, the maternity bill should be administered by the Public Health Service run by male doctors, rather than by the (female) "social workers at the Bureau".[83] Sheppard-Towner opponents also argued that the act was fiscally irresponsible, that it violated states rights, that it endangered private medicine and declared it socialistic, in addition to objecting to an agency staffed by "spinster feminists."[84]

Since the Sheppard-Towner Act had initially been funded for five years ending June 30, 1927, proceedings for the extension of the funds were initiated in 1926.[85] The Act passed in the House 218-44, but it was blocked in the Senate by the conservative wing and a compromise had to be reached. Sheppard-Towner was extend for two years after which it automatically was repealed. Many women assumed that the well-organized women's movement would crush the opposition, as Anna Rude told Michigan Director of the Bureau of Child Hygiene and Public Health Nursing, Blanch Haines in 1922, "'With the women of your state well organized, one does not have to take their [doctors'] action too seriously." Yet two years after thirty thousand Michigan women signed petitions and

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[82]Ladd-Taylor, Mother-Work, p. 171-173.

[83]Ibid, p. 171-173.

[84]Meckel, Save the Babies, p. 209. See Taylor, The Medical Profession and Social Reform, p. 107-111 for brief summary of support and opposition to the Sheppard-Towner Act.

[85]Muncy, Creating a Female Dominion, p. 125.

succeeded in getting their state to accept Sheppard-Towner funds, Haines facing another round over appropriations complained, "If any thing has made me want to get out of my job it is facing the situation."[86] Organized women were no longer able to push the funds through Congress.

After the funds were repealed, twenty-one states tried to continue maternity and infancy work.[87] Michigan, through state and local funding, successfully continued child and maternal health work. The Michigan legislature, in 1929, amended the 1927 law which established county health departments and allowed the payment of $3,000 per year to every county health department to meet the requirements of the State Department of Health.[88] The establishment of the Children's Fund of Michigan trust in 1929 also ensured that child welfare work continued in Michigan.[89]

The Children's Fund was created in April 1 1929, by Michigan Senator, James Couzens, with a 10 million dollar gift. According to The Michigan Nurse, Couzens believed "that each generation is capable of taking care of its social needs and that other generous persons will constantly make equally generous gifts, so that there is no need for endowments of this kind in perpetuity." [90] The trust money, used over twenty-five years, to promote child welfare was intended to "promote the health, welfare, happiness and development of the children of Michigan primarily, and elsewhere in the world."[91] Its Child Health Division, one of three divisions created by the trustees, gave grants to independent health nursing services, such as the Visiting Nurse Association of Detroit, as

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86 Ladd-Taylor, Mother-Work, p. 85.

87 Ibid, p. 190.

88 The 57th Annual Report of the State Health Commissioner, Michigan Department of Health 1929, p. 10.

89 "The Children's Fund of Michigan," Michigan Public Health XXII (July 1934) 128.

90 "The Children's Fund of Michigan" The Michigan Nurse 3, (April 1930) 1.

91 Children's Fund of Michigan Reference File, Bentley Historical Library; University of Michigan, Ann Arbor Michigan i.

well as, to the Michigan State Department of Health, and to the Detroit Urban League for its Green Pastures Camp, a program that took black children out of the slums.[92] The Children's Fund and continuing support from other private organizations enabled maternal and child health programs to continued at the state and local levels in Michigan. Programs begun on Sheppard-Towner initiatives were maintained and new programs added, in addition, programs that had not received Sheppard-Towner funds benefited from this Fund.

Even though the Sheppard-Towner funds were repealed in 1929, the program's existence, even if brief, had made a lasting national impact. Women of all social and economic groups read baby books, women's magazines, and child care bulletins published by the federal Children's Bureau. At the end of the 1920s, according to Ladd-Taylor, "women from virtually every social and economic group had begun to look outside their female support networks to new sources of expertise on child care...and turned increasingly to physicians and to the childrearing advice found in government pamphlets and women's magazines for information and encouragement that had once been handed down informally."[93] The act raised individual women's expectations for their children's health and made them more knowledgeable about prenatal and well-baby care. Physicians responded by incorporating preventative health education into their private practices and worked to improve obstetrical training in medical schools.[94] Today all fifty state health departments have departments of maternal and child health.[95]

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92 Children's Fund of Michigan Reference File, i; Richard Thomas, Life for Us is What We Make It: Building Black Community in Detroit, 1915-1945, (Bloomington and Indianapolis: Indiana University Press, 1992) 76.

93Ladd-Taylor, Mother-Work, p.17, 33.

94Ibid, p. 189.

95Marshall W. Raffel, and Norma K. Raffel. The U.S. Health System: Origins and Functions, third edition (New York: John Wiley & Sons 1989) 267. All fifty departments reported having environmental health, helath education and nursing departments.

CHAPTER 3

Women's Voluntary Organizations and the Michigan Bureau of Child Hygiene and Public Health Nursing: Creating Maternal and Child Health Clinics in Michigan's Rural Communities and Towns, 1920-1930

Professional and non-professional Michigan women, working in a network of women's voluntary organizations, the Michigan Bureau of Child Hygiene and Public Health Nursing, other health organizations and private health care professionals actively sought public resources and private resources to improve maternal and child health in their communities before and during the Sheppard-Towner years. These women remained active and maintained maternal child health programs they had run locally after the repeal of Sheppard-Towner funding.

The Michigan Bureau of Child Hygiene and Public Health Nursing was created during a period of heightened public concern over health and sanitation across the nation. By the end of the nineteenth century a majority of states had a state board of health.[96] However, at the beginning of World War I, relatively few communities had infant welfare stations or public funding for milk stations. The communities that did have these services were predominantly large cities. Forty-three percent of the nations 551 infant welfare stations and forty-nine percent of the visiting nurses were located in eight large cities. Detroit's Board of Health began focusing attention on the welfare of children, founding its first "Mothers' Clinic" in January 1 1910. Its purpose was "instructing mothers in the care

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[96] Wilson G. Smillie, Public Health Administration in the United States, (New York: McMillian 1947) 16. In 1872 the American Public Health Association was formed. Massachusetts and California had already formed a state boards of health in 1869 and 1870. Virginia and Minnesota followed in 1872. Michigan was the fourth in 1873, followed by Delaware and Alabama in 1875 and Wisconsin in 1876.

of their babies with a view to reducing the unnecessarily great infant mortality."[97] Three years later, in 1913, Detroit's Board of Health founded its Child Health Department.[98] The Board also ran Infant Welfare Stations and Prenatal Clinics [99] During the 1910s and 1920s many other local communities established permanent health clinics funded and administered by local governments, philanthropic or social service agencies working in cooperation with state departments of health and the U.S. Children's Bureau.[100] Still in 1914, only four states and eighteen cities had bureaus of child hygiene in their state departments of health.[101]

Between 1918 and 1920, with pressure from the Children's Bureau, women's organizations and members of the medical community, twenty-eight other states created bureaus of child hygiene By November of 1920, thirty-five states had created child hygiene divisions in their Departments of Health; by 1924 only one state had not done so. These state divisions owed no allegiance to the Children's Bureau legally; however, they took advice from the Children's Bureau and submitted regular reports on budgets, legislation and programs in their states.[102] The creation of these state divisions aided in establishing maternal and child health programs outside of major urban areas.

Michigan formed its Bureau of Child Hygiene and Public Health Nursing as part of the Michigan Department of Health on September 15, 1920. Miss Harriet Leck R.N., formerly superintendent of the nurses of Grace Hospital in Detroit, was named the first

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[97] 29th Annual Report of the Board of Health of the City of Detroit, 1910.

[98] 32nd Annual Report of the Board of Health of the City of Detroit, 1913.

[99] 34th Annual Report of the Board of Health of the City of Detroit, 1915

[100] Ladd-Taylor, Mother-Work, p. 89-90; Meckel, Save the Babies, p. 141.

[101] Klaus, Every Child a Lion, p. 209. Tennessee had been the first to create a child hygiene bureau in 1912.

[102] Muncy, Creating a Female Dominion, p. 100-101.

Director of the Bureau.[103] Hope Romani, another nurse, was one of her assistants. Leck credited her with having "blazed the trail" for the Bureau of Child Hygiene.[104] Two assistant salaries were paid by the State Anti-Tuberculosis Association and by the American Red Cross.[105] In February 1921, Leck published an article in Public Health discussing the purpose and plan of the Bureau. The aims were:

> "To follow up the work begun during the war in the Children's Year Campaign, which demonstrated to the people of the state the need for child health work. To emphasize the importance of improving the health of children and the value of keeping children well. To secure one-hundred per cent birth registration. To encourage breast feeding of babies. To enroll mothers and young girls in health study groups, so that all women maybe informed on the care of mothers and infants. To encourage the women of local communities to establish Health Centers and to place scales in rural schools with proper charts for keeping records."[106]

During its first year, the Michigan Bureau "concentrated on perfecting an organization which will assist in lowering the infant mortality of the state and aiding communities in their public health nursing service."[107]

The Michigan Bureau of Child Hygiene and Public Health Nursing worked in cooperation with local women's groups. Local women's groups, connected through state and national federations had long been involved with child hygiene in the state and had been key to the success of Children's Bureau Baby Saving Campaign in Michigan. Across the country, national federations of local women's clubs worked for maternal and child health and welfare campaigns lead by the professional female reformers. These campaigns would not have succeeded without the locally rooted women's federations already engaged

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[103]Richard M. Olin, M.D., "To Michigan Nurses," Public Health (February 1921) 37.

[104]Public Health (April-May 1921) 108.; Public Health (February 1921) 42.

[105]Public Health (February 1921) 41.

[106]Public Health (February 1921) 43.

[107]The 50th Annual Report of the State Health Commissioner, Michigan Department of Health (Lansing, Michigan 1921 & 1922) 97.

in child welfare work and other civic actives.[108] This interdependence of professional women with lay women characterized the early years of the development of state social policy.[109] Dr. Clark of the U.S. Public Health Service observing the increased child welfare work wrote in 1921, "There is no lack of child hygiene programs. Practically every civic organization has one and virtually all of them are directed to one-third of the baby deaths, with the exception of pubic health organizations providing prenatal supervision in a limited way." [110] Although recognizing women's activity, he obviously did not value women's organizations work in this area, the Michigan Bureau of Child Hygiene did. During the Michigan Bureau's first year, Leck specifically addressed women's clubs, outlining for them how women's clubs could aid child and maternal health.[111] She urged women of local communities to establish Health Centers so that the work of the county nurse could be more easily extended.[112] The Bureau worked in cooperation with women's clubs, nurse's associations, and medical doctors to provide maternal and child health screening and health education to their communities.[113] On the

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[108]Skocpol, Protecting Soldiers and Mothers, p. 2, 482.

[109]Muncy, Creating a Female Dominion, p. 58.

[110]Public Health (April-May 1921) 130.

[111]Ibid, p. 121. She advised women's clubs to set up a committee which would find rooms for baby clincis to be held and for the publicizing the baby clinic in the local newspaper, movies and churches. Next a physican was to be secured for examination of the babies and a nurse to weigh and measure them. She also gave advise on what type of room should be found an what equipment would be neccessary.

[112]Public Health (February 1921) 43.

[113] In that first year, the Bureau of Child Hygiene and Public Health Nursing reported 'Baby Conferences" and clinics being run across the state. Permanent "Baby Conferences" were held in four counties and three permanent Centers were started in three counties. Temporary "Baby conferences" were held and centers were started in several counties. Permananet centers were started in Lapeer, Sanilac, Berrien and Isabella and permanent baby conferences were held in Lapeer, Sandusky and St. Josheph counties. Temporary Baby Conferences were held in Eaton, Gratiot, Saginaw, Ingham, Jackson, Manistee and Otsego counties. Centers were started in Manistee, Midland, Presque Isle, Jackson and Otsego counties. Sixty-seven talks were given to women's clubs, Grange, Parent-Teacher's Clubs, Schools etc. during the first year of the Bureau June 30 1920-June

local level women's groups organized, ran and often found the funding for infant health clinics staffed by hired or volunteer physicians and nurses. Nurses and doctors examined, weighed, and measured children and instructed mothers on nutrition and hygiene.[114] Early clinics, like these served as models for prenatal and well-baby clinics later funded by the federal government under the Sheppard-Towner Act.[115]

The creation of the Central Clearing House Committee further stresses the importance of women's organizations to the development of Michigan's early maternal and child health programs. The committee was formed early in 1921, when Miss Elizabeth Parker of the Michigan Anti-Tuberculosis Association called together representatives from the M.A.C. Domestic Science Department, Michigan Department of Health, Red Cross, University of Michigan, State Federation of Women's Clubs and "others interested in rural health programs." The Central Clearing House Committee was created with the intent that each organization making up the Committee would "be informed of the programs and workers of the others and all pull together in a community for better health."[116] This committee played a vital role in establishing maternal and child health programs in

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30 1921. In the first two years, prior to July 1, 1922, thirty-four mother and baby health centers had been formed or were started through agencies other than the Bureau of Child Hygiene and Public Health Nursing. As of July 1923, thirty-four centers were organized by the Bureau bringing the total number of centers up to 68. These figures exclude Detroit and Grand Rapids which had their own health departments that worked seperately, for the most part, from the Bureau. The 50th Annual Report of the State Health Commissioner, p. 97-98 and The 51st Annual Report of the State Health Commissioner, Michigan Department of Health (Lansing, Michigan 1923) 65.

114Ladd-Taylor, Mother-Work, p. 51.

115Ladd-Taylor, Mother-Work, p. 52.

116 Harriet Leck, R.N., "Brief Summary of Work Accomplished," Public Health, (May-April 1921) 118. In Michigan, each district was made up of several counties and each county had at least one nurse. Nurses brought difficult problems to the district supervisors, "who, by advice and counsel, in close touch with the office of the bureau, is helping to bring about a greater cooperation and greater harmony among the different officials and organzation doing public health work in the distritct." Leck wrote, "There is scarcely a county in the state which has not at least three or four permanent baby clinics held weekly to which the mothers for miles around bring their babies- not because they are ailing but because their mothers have been educated in prevention- the most modern campaign in public health." Harriet Leck, "Response," Public Health (February 1921) 42.

Michigan. The 1923 Commissioners Report recognized that "the force of this committee has been seen repeatedly in promoting the field work in organizing county committees and health center committees, also when the acceptance of the federal aid for the two years from July 1, 1923 to July 1, 1925, was pending in the Legislature of 1923."[117]

The Sheppard-Towner Funds available from 1923-1929 supported a marked increase in child and maternal health activities in Michigan. Due to the additional funds available after July 1, 1922, the Michigan Bureau of Child Hygiene and Public Health Nursing reorganized and expanded to handle the increased work. The Bureau staff jumped from 2-3 to 13 people.[118] The staff then consisted of: "1 Director, a physician; 1 Assistant Director, registered nurse; 2 Associate physicians, clinicians; 1 speaker and organizer; 5 Nursing Directors, registered nurses; 1 clinic Nurse, registered nurse; 1 Secretary and Stenographer; 1 Research Worker and Clerk, college graduate."[119] Dr. Blanche M. Haines assumed the position of Director of the Bureau, June 1st 1922, replacing Harriet Leck R.N.[120] This was consistent with the trend toward a national "female dominion," as noted by Muncy, female professionals led seventy-five percent of the bureaus and divisions that directed state Sheppard-Towner programs.[121] In addition to working with the Children's Bureau in Washington D.C., the Michigan Bureau reaffirmed its past relationship with local women's organizations stating, "the fostering of local interest and local responsibility with a minimum of state supervision might be said to be the premise upon which all the activities of the bureau have been based."[122]

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117 The 51st Annual Report of the State Health Commissioner, p. 64.

118 The 50th Annual Report of the State Health Commissioner, p. 10-11.

119 The 51st Annual Report of the State Health Commissioner, p. 66. The Federal money received was listed as $48,017.18.

120 The 50th Annual Report of the State Health Commissioner, p. 98.

121 Muncy, Creating a Female Dominion, p. 108.

122 The 50th Annual Report of the State Health Commissioner, p. 9.

Women's voluntary organizations played an active role in the implementation of Sheppard-Towner Act programs across the nation. Almost all states reported cooperative work with some of the women's organizations in their state, many inviting them to serve on state advisory boards overseeing maternal and infant health work. As Muncy wrote, "Volunteers lobbied for state and local funding, publicized child health conferences, provided transportation and lodging for public health nurses, rented facilities for clinics, aided doctors and nurses during the conferences and canvassed their communities to find children and expectant mother who might use the services." Sometimes they even funded local health programs themselves when public officials refused to.[123] Ladd-Taylor also argues "the implementation as well as passage of the Maternity and Infancy Act depended on the unpaid services of women activists...The Children's Bureau also depended on volunteers to conduct prenatal and child health conferences, publicize Sheppard-Towner programs and research local health conditions." [124] She reports that in 1929 of the twenty states plus the Territory of Hawaii which kept records 700 nurses, 1,614 physicians, and 4, 683 "lay persons" worked on the programs voluntarily. The Bureau also reported that in 42 states the PTA gave assistance, in 30 states the Federation of Women's Clubs assisted, and in 18 states the American Red Cross and the League of Women's Voters helped. She argues that Sheppard-Towner programs had a "tremendous impact in states where child helath was politicized and the Children's Bureau worked effectively with activists women and physicians."[125] In line with this national picture, local level support from Michigan women's organizations was very important to the success of the Michigan Bureau of Child Hygiene and Public Health Nursing Sheppard-Towner programs.

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[123]Muncy, Creating a Female Dominion, p. 120. In 1927, thirty-one states reported cooperation with parent-teacher associations and twenty-five with states women's clubs. At least twelve states cooperated with Red Cross chapters and twelve cooperated with state tuberculosis societies. Eight worked with the Women's Christian Temperance Union and two reported aid from the Amercian Association of University Women.

[124]Ladd-Taylor, Mother-Work, p. 178.

[125]Ibid, p. 178.

The cooperation during the Sheppard-Towner years between the women's organizations and the Bureau of Child Hygiene and Public Health Nursing resulted in an increase in maternal and child health clinics run across the state. Prior to July 1, 1922, thirty-four mother and baby health centers had been formed or were started through agencies other than the Bureau of Child Hygiene and Public Health Nursing. By July 1923, thirty-four centers were organized by the Bureau bringing the total number of centers up to sixty-eight.[126] The development of permanent mother and baby centers "maintained by community funds" continued throughout the Sheppard-Towner years.[127] Lay committees sponsored the centers providing rooms and equipment. None of the centers were ever financed by the Bureau; however the Michigan Bureau distributed record blanks, report forms and literature to the centers in return for monthly reports of the work done. Thirty-one Mother and Baby Health Centers existed in June 1922 when the Bureau was organized, by 1926, with the help of local organizations the number had expanded to seventy.[128]

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[126] The 51st Annual Report of the State Health Commissioner, p. 65. These figures exclude Detroit and Grand Rapids which had their own health departments that worked seperatly for the most part from the Bureau of Child Hygiene programs. This number excludes Detriot and Grand Rapids. In the second year of Sheppard-Towner funding, eighteen more mother and baby health centers were organized bringing the number up to 86. Growth continued through 1925, with nine new centers established in Hastings, Ludington, Grayling, Hamtramck, Lansing, Grand Haven, Marshall, Ecorse and Plymouth bringing the total number of centers to 80 who reported 28,037 infants and preschool children had been examined and had performed 1,580 prenatal examinations.

[127] The 51st Annual Report of the State Health Commissioner, p. 65-66; The 53rd Annual Report of the State Health Commissioner, Michigan Department of Health (Lansing, Michigan, 1925) 125. If the Bureau organized the center the local committees were "advised.. to pay each physician for his services at the clinics." This shows that the Bureau, while it coordinated clinic activity, did not fund it.

[128] The 54th Annual Report of the State Health Commissioner, Michigan Department of Health (Lansing, Michigan, 1926) 135. Nine new Mother and Baby Health Centers were organized in the 1925-26 year. This brought the total to seventy-seven, all supported by local funds (some having become inactive). Since the centers began reporting in March 1923, 82,064 infants and preschoolers were seen, 4,884 prenatal cases advised and 112,254 home visits were made. In addition to sponsoring clinics and funding the medical staff, local communities also sponsored Little Mothers' Leagues which were begun in October 1923. A manual of 12 lessons was prepared by the Michigan Bureau. Local

The Bureau also reorganized and renamed its Central Clearing House Committee. The Bureau invited the state presidents or representatives from the women's organizations which had promoted the Sheppard-Towner bill in Congress to meet in order to form a Cooperating State Health Committee.[129] The next year the Cooperating State Health Committee members were increased to fourteen. The Michigan Bureau reported that this committee "assisted materially" in carrying on the work of the Michigan Bureau.[130]

After the creation of the Cooperating Committee, the Bureau of Child Hygiene and Public Health Nursing and its representatives organized County Health Committees in counties having no preexisting health committees (such as Tuberculosis, Red Cross or Welfare Committees). Representatives from the women's organizations in each county and often county supervisors, superintendent of schools, probate judges, physicians or others made up the members of the health committees.[131] The Bureau suggested activities to the

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school, county and bureau staff nurses ran a total of 249 classes. Little Mothers' Leagues continued in 1925 with 5,799 girls attending. Little Mother's Leagues continued to grow in 1926 and demand exceeded the supply of nurses available to conduct them. They continued to grow through 1928. By 1929, every county had had at least one series of classes.

[129]The 51st Annual Report of the State Health Commissioner, p. 63. Dr. Richard M. Olin, Michigan Health Commissioner appointed Mrs. William Alvord (President of Michigan State Federation of Women's Clubs), Mrs. F.C. Aldinger (President, Michigan's League of Women Voters), Mrs. E.L. Calkins (President, Woman's Christian Temperance Union of Michigan), Miss Bina West (Commander, Woman's Benefit Association of the Maccabees, who had been Chairman of Child Welfare Division during the War and had written articles in Public Health supporting child welfare programs), Mrs. Frances Burns (Commander, Ladies of the Maccabees), Mrs. Louise Campbell (State Home Demonstration Leader, Michigan Agricultural College), Mrs. E. W. Kiefer (President, Congress of Mothers and Parent-Teacher Association of Michigan). Later Mrs. L. Victor Seydell (State Regent, Daughters of the American Revolution), Miss Fandira Crocker (State President, American Association of University Women), Mrs. Burton Browne (President, Michigan Child Conservation League), and Mrs. Dorian Russell (succeed Mrs. Alvord as State President of the Michigan State Federation of Women's Clubs).

[130]The 52nd Annual Report of the State Health Commissioner, Michigan Department of Health (Lansing, Michigan, 1924) 73. The additional members were Miss Alice Lake (Legislative Chairman of the State Nurse's Association), Mrs. Dora Stockman (of the State Grange), Mrs Edna Kimball Wilcox (Worthy Grand Matron of the Order of the Eastern Star), and Mrs A. D. Wallace (Legislative Chairman of the Detroit Federation of Women's Clubs).

[131]The 51st Annual Report of the State Health Commissioner, p. 64. Eighteen county health committees were organized as of July 1, 1923 by the Bureau. Gogebic, Houghton,

county health committees who then carried out the activities they chose. The activities suggested were: promoting county nursing service, establishing mother and baby health centers, sponsoring the department's Health Institute, encouraging occasional infant and prenatal clinics and clinics for preschoolers, holding mothers classes and Little Mothers' Leagues.[132] The health committees then organized, sponsored and ran what they considered important for their community. Dr. Moores wrote in the Michigan Public Health about his county health unit: "Publicity was carried by talks at the County Medical Society, the various luncheon clubs, Parent-Teacher Associations, the Chamber of Commerce, the Board of Supervisors, etc."[133] He reported that the Parent-Teacher Association sponsored preschool clinics with local physicians volunteering their services.[134] The groups involved in county activities of the 1927 Child Health Day bear further witness to the involvement of women's organizations in child health programs. In Dewitt, "Woman's Clubs [put] on a May Day program," in Iron Mountain a preschool clinic was sponsored by the Woman's Club, in Grand Haven women's clubs paid doctors and furnished clerical help for a county-wide preschool clinic, and in Cadillac, the article reported "Women's Clubs and Board of Education and Medical Society Cooperating".[135]

Menomienee, Delta, Alger, Emmet, Charlevox, Leelanau, Benzi, Manistee, Montmorency, Oscada, Clare, Isabella, Newaygo, Muskegon, St. Joseph and Branch.

[132]The 52nd Annual Report of the State Health Commissioner, p. 73. Eighteen Cooperating County Health Committees were organized in Arenac, Gladwin, Chippew, Dickinson, Mackinac, Saginaw, Livingston, Iron, Baraga, Ontonagon, Ogemaw, Calhoun, Ottawa Missaukee, Roscommon, Kalkaska, Otsego and Lake counties. The 51st Annual Report of the State Health Commissioner, p. 64. The next year saw an increase in organization of health committees in the counties and increased women's clubs support of its activities. The organization of county committees also continued into 1925 with the organization of twelve new county committees in Lenawee, Eaton, Alcona, Iosco, Presque Isle, Hillsdale, Genesee, Van Buren, Ionia, Cass, Barry and Cheboygan.

[133]S.C. Moore, M.D., "Some Experiences in the Organizations and Administration of a County Health Unit," Michigan Public Health, XVIII (September 1929) 201.

[134]Ibid, p. 203.

[135]"May Day Suggestions," Michigan Public Health, XVI (March 1928) 61-63.

After the federal funds were repealed twenty-one states continued maternity and infancy work.[136] Michigan, through state and local funding, successfully maintained its maternal and child health programs. The Michigan legislature in 1929 amended the 1927 law which established county health departments and allowed the payment of $3,000 per year to every county health department that met the requirements of the State Department of Health.[137] The establishment of the Children's Fund of Michigan trust in 1929 helped ensure that child welfare work continued.[138] Governor Fred W. Green support also contributed to maintaining Michigan's programs. On April 6, 1929, he declared May Day as official Child Health Day in Michigan. He stated, "Designating Child Health Day is but a part of the nation-wide and world-wide movement for proper care of children. It serves to remind us of the seriousness of the responsibility that we have so lately recognized."[139] May Day Child Health Day activities for 1930 were planned by organizations who were interested in child welfare. County May Day committees were formed with county nurses as chairs. The March issue of Public Health advocated, "Parades, pageants, plays- one of these may be developed under direction of a special community group such as the Parent-Teacher Association, the General Federation of Women's Clubs, the director of physical education and reactions of the shcools, or whoever in the community is willing and able to direct such a celebration."[140] This suggests that across the country similar networks existed at the local level. The 1930 Commissioners report reviewed the success of Child Health Day stating, "Immunization campaigns, clinics, physical inspection in schools,

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136Ladd-Taylor, Mother-Work, p. 190.

137The 57th Annual Report of the State Health Commissioner, Michigan Department of Health (Lansing, Michigan, 1929) 10.

138 "The Children's Fund of Michigan," Michigan Public Health XXII (July 1934) 128.

139The 57th Annual Report of the State Health Commissioner, p. 88.

140American Child Health Association, "Suggestions for Celebrating May Day Child Health Day" Michigan Public Health, XVIII, (March 1930) 60.

health talks and health plays in schools, as well as the more spectacular May pole, pageants and parades all made May Day in Michigan a day of definite value to children.[141]

The network established between the Bureau, women's organizations, nurses and physicians was vital to the maintenance of Michigan's maternal and child health programs after 1929. An article from May, 1930, advocated the importance maintaining the network strategy: "a statisfactory prental and maternal care program depends upon cooperation on the part of physicians, public health nurse and expectant mothers, together with the assistance rendered frequently by local women's organizations. This is also true of an infant welfare program and the care of the preschool child."[142] The Bureau continued to supply the centers with Record blanks and literature and the majority of the centers made monthly reports back to the Bureau.[143] In 1932, the Bureau reported an increase in attendance for the Women's Classes. The 1935 Commissioners' Report casually stated, "Health centers established and financed locally reported their activity as usual to this bureau. These centers are provided with literature and record forms by the bureau, but the examinations are made by local physician."[144] This reaffirms the importance of local level of involvment in maternal and child health and the fact that the state did not fund these clinics.

In 1947, Wilson Smillie in his book on Public Health Administration in the United States recognized the work done by voluntary organizations when explaining the Child

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[141]The 58th Annual Report of the State Health Commissioner, Michigan Department of Health (Lansing, Michigan, 1930) 20.

[142]Michigan Public Health, XVIII, (May 1930) 105.

[143]The 58th Annual Report of the State Health Commissioner, p. 19. Approximately 70 centers sent back records to the Michigan Bureau. In 1930 28,706 infants were examined at the centers and 28,134 home visited were made.

[144]The 63rd Annual Report of the State Health Commissioner, Michigan Department of Health (Lansing, Michigan, 1935) 391. Reports from these centers stated that there were 1,077 clinic days held, 14,133 babies examined, and 19,371 home visit made by local public health nurses. The reports are incomplete, not all centers reported regularly to the Bureau.

Hygiene programs of the Public Health Service "Supplementary to the general health activities that affect all age groups are certain health activities that are aimed specifically toward promotion of the health of the child. Often these special functions have been initiated by voluntary organizations, or by private enterprise, rather than by official health agencies."[145] The Child Hygiene programs he describes correspond surprisingly with Michigan's programs during the years of this study. The structure of Michigan's program from 1910-1935 may be similar to other state programs, and Smillie may be recording a dominant trend across many states.

A potentially large number of states' maternal and child health programs may have been structured similarly to Michigan's. Since seventy five percent of the state divisions of child health were initially headed by women, it is possible they depended on networks similar to those seen in Michigan. However, without close studies of other states during these years an satisfactory explanation for why Michigan succeeded when more than half of the states maternal and child health programs failed after the repeal of Sheppard-Towner funds remains conjecture. A comparison between Michigan and Ohio's programs suggests a combination of factors led to the two states differening program structures. First, the involvment and opinion of the two state's health department heads constrasted starkly. In Ohio, in 1923 the new director, John Emerson Monger, M.D.,"was hesitant about, if not antagonistic to, the federally assisted maternity and infancy plan."[146] Monger chaired the committee which outlined Ohio's Sheppard-Towner programs.[147] In Michigan, State Commissioner of Health, Richard Olin left control of Michigan's Sheppard Towner programs with Bureau of Child Hygiene and Public Health Nursing head, Blanche Haines, M.D. She supported the Children's Bureau work and later become the Director of the Division of Maternity and Infant Hygiene for the Children's Bureau in Washington D.C.

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[145]Wilson Smillie, Public Health Administration, p. 262.

[146]Lindenmeyer, p. 108.

[147]Ibid, p. 116.

A second important distinction between the two states is the organizational structure of the administration of the Sheppard-Towner programs. Ohio's maternal and child health program administration was organized hierarchically and shows the differences between men and women's organizational structure. This hierarchical structure left Ohio's women's organizations out of the decision making process and separated women's organizations from the maternal and child health work done by the state. The advisiory committee Monger formed was made up of health professionals and excluded women's organizations.[148] Michigan's program , headed by a female physician who had close ties with the states women's organizations, was organized representatively. The Cooperating Committee which assisted in creating and administering the Sheppard-Towner programs gave women's organizations across the state a voice in the creation of the state's maternal and child health programs. Thirdly, the strength of the Ohio State Medical Association in opposition to the Sheppard-Tower Act in contrast to that of the Michigan State Medical Association probably influenced the structure of the programs in the states. Nationally the AMA was the strongest opponent to the Sheppard-Towner Act. The Ohio State Medical Association 'was the most vocal state organizations which helped shaped the national organizations' official anti-Sheppard-Towner policy."[149] Fourthly, differing activity levels of women's organizations between the states may have contributed to the difference between the two states. As Lindenmeyer points out, "the state's physicians did not want 'lay' women or their organizations to participate in the policy-making process. And interestingly, there is no evidence that women's organizations demanded such participation even though their lobbying efforts had been an essential ingredient at both the national and state level."[150] These differences between Ohio and Michigan help explain why Ohio's Sheppard-Towner programs, created and run without local initative and cut off from the

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[148]Ibid, p. 114-115.

[149]Ibid, p. 110.

[150]Ibid, p. 115.

network of women's voluntary organizations, dwindled in contrast to those in Michigan.[151] Significantly, this comparision shows the importance of public and private networks to the maintenance of maternal and child health programs in the early 20th century. Further state level studies can shed more light on the factors contributing the success or failure of the Sheppard-Towner programs across the nation.

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[151]Ibid, p. 130. Ohio State Health Director, Monger, wanted local communities to take over the responsiblity for programs started with the Sheppard-Towner funds, but in only nine counties and two cities did private, municipal, and county agencies combine to continue these programs.

CHAPTER 4

Maternal and Child Health in Detroit: A Case Study of the Baby Clinic Run by the Detroit Urban League and the Detroit Board of Health, 1900-1930

Creating networks among public and private organizations was not only a strategy of white communities across the state of Michigan; a similar network strategy can be see used by communities in Detroit. The Board of Health of the City of Detroit operated autonomously from the Michigan State Department of Health, consequently the clinics run in Detroit were unconnected to the State Department of Health and must be studied seperately from a state level study. Beginning child health work in 1910, ten years earlier than the State Department of Health, Detroit's Board of Health worked in cooperation with private organizations in the city to establish child health clinics. One such organization was the Detroit Urban League (DUL). Working with the Detroit Board of Health, the DUL ran a Baby Clinic in the Detroit black community which remained unaffected by the Sheppard-Towner Act and its repeal. Since the Board of Health of the City of Detroit was unnconnected to the State Department of Health, it did not receive allocations of the state's Sheppard-Towner funds from the Michigan Bureau of Child Hygiene and Public Health Nursing, therefore its clinics relied and grew on local funds. Thus, as seen on the state level, a network of public and private organizations, white and black, concerned with child health and welfare played a critical role in establishing and maintaining an infant health clinic in the Detroit black community.

A number of factors lay behind the autonomous functioning of the Board of Health of the City of Detroit from the Michigan State Department of Health. First, in 1837, nearly

all of Michigan's population lived in rural areas and Detroit was the only city in the state.[152] In 1890, Michigan, still predominantly rural, had a rural population double that of the state's urban population. In the late 1910s a dramatic demographic shift occurred, the urban population caught and exceeded the rural population.[153] The Michigan Bureau of Child Hygiene and Public Health Nursing was established before the 1920 census figures showed this shift and understandably the Bureau's initial program focused on the rural population of the state. Later attention to rural problems during the Sheppard-Towner years reflects this early design.

By 1930, however, 68.2 % of the people of Michigan lived in urban areas of 2,500 or more. Detroit alone held 43% of the state's population.[154] This population shift left Detroit underrepresented in the state government. This is a second contributing factor to the seperation of Detroit's Board of Health from the State Department of Health. One scholar reflecting on rural and urban representation in the state goverment writes, "It is very apparent that under the old system of apportioning senatorial and representative districts in Michigan many urban dwellers did not have the representation in the legislature to which their numbers and the constitution entitled them. This was because the representatives of the overrepresented rural areas were unwilling to surrender their control of the legislature despite the fact that they were forced to violate the constitution in order the regain control." The senatorial districts were redrawn in 1925, if senate seats had been distributed roughly

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[152]Floyde C. Fischer, The Government of Michigan (Chicago: Allyn and Bacon, Inc., 1965) 101.

[153]Daniel S. McHargue, Michigan Government in Brief, (Ann Arbor: University of Michigan Press, 1961) 4-5. In 1890 Michigan had approximately 1.3 million rural and .6 million urban people. In 1900, approximately 1.4 million lived in rural regions and .75 million lived in urban areas. By 1910, the population of the urban areas had increased significantly to 1.25 million, while the rural population remained the same at 1.41 million. The 1920 census marked the shift in the balance of the rural to urban population of the state. Michigan now contained 2.25 urban dwellers, while its rural population remained at 1.4 million. By 1930, the urban population had grown by one million to 3.25 million; the rural population remained approximately the same.

[154]Richard T. Ortquist, Depression Politics in Michigan, 1929-1933 (New York: Garland Publishing Inc., 1982) 1.

on a population basis the eight most populous counties would have been entitled to 60 % of the 32 seats.[155] Rural control over the Michigan house and senate left Detroit with little power in influencing state policy to its advantage.

A third factor contributing to the autonomous operation of Detroit's Board of Health may have been the shifting makeup of the urban population in the early 20th century. In 1910 33.6% of the Detroit population was foreign born.[156] In 1925 the foreign born population was comprised half the population of Detroit. [157]Also, from 1910-1920 the black population in Detroit jumped from 1% to 4%. [158] By 1925, blacks made up 6.5% of the Detroit population.[159] The 1918 electoral reform in Detroit gave Detroit a non-partisan government with officials elected by the voters at large, rather than through ward elections. A mayor, nine councilmen, a city clerk and city treasurer now governed the city.[160] This represented a rather dramatic change, as one historian writes: "what had been a rather ethnically balanced political elite at the century outset was by 1920 more solidly Anglo Saxon."[161] Inside Detroit the white population gained control over city politics. A 1922 history of Detroit remarked, "The automobile industry has resulted in a great influx of immigrants from Europe. Probably no other city in the United States has had forced upon it

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[155]McHargue, Michigan Government in Brief, p. 245.

[156]Clarence Burton, William Stockling and Gordon Miller, eds. The City of Detroit, Michigan 1701-1922 (Detroit and Chicago: The S. J. Clarke Publishing Company, 1922) 1508.

[157]Melvin G. Holli, ed. Detroit (New York: New Viewpoints 1976) 21.

[158]Joel D. Aberbach and Jack Walker, Race in the City: Political Trust and Public Policy in the New Urban System (Boston: Little Brown and Company, 1973) 7. The black population was 5, 741 in 1910 and by 1920 had risen to 40,838. The white population in 1910 was 460,025 and in 1920 was 952,840.

[159]Holli ed., Detroit, p. 123.

[160]Dorothy Ketcham, "A Manual of the Government of Detroit," School of Public Affairs and Social Work of Wayne University, Report No. 35 (Detroit Bureau of Governmental Research Report no. 163, 1942) 13.

[161]Martin Marger, The Force of Ethnicity: A Study of Urban Elites (Journal of University Studies-Ethnic Monograph Series, vol. 10, no. 5, Winter 1974) 53-54.

the problem of assimilating and Americanization of the so-called foreign element as had Detroit. The city has been a veritable 'melting pot.' As a result, perplexing problems of health and sanitation have arisen."[162] These perceived 'perplexing problems of health and sanitation" which were "forced" on Detroit by the influx of immigrants, as this 1922 history described, likely were not something the dominant rural population wanted to channel state money into, thus constituents would have supported maintaining Detroit's separate municipal functions.

And lastly, considering the history of Michigan, the autonomous operation of the board of health of its largest city comes with little surprise. Detroit has a long history of local government. In 1815, " as the result of a protest demanding that the control of local affairs be restored to the people, Governor Lewis Cass approved an act of the Territorial legislature which granted a new charter to Detroit, thus restoring local government." [163] In 1837, during the third session of the legislature of the new state of Michigan, a new charter was provided for Detroit. Government of the city was divided into six wards with two aldermen from each on the common city council. The mayor was elected yearly. This allowed Detroit to maintain local government. Twenty years later, in 1857 a new charter enlarged the powers of the common council. In 1908, the Home Rule City Act permitted cities in Michigan great freedom in choosing the type of government which would fit local needs. Cities could choose the form of government, the number of department needed, the officers needed to carry out municipal responsibilities the city council and how it would be elected.[164] One report explains, "Home rule cities operate under a broad grant of authority. They may exercise all municipal powers in the administration and management of municipal property and government whether the powers be enumerated or not and may adopt resolutions and ordinances relating to their municipal concerns subject to the constitutions

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[162]Burton, Stockling and Miller, eds., p. 1179.

[163]Ketcham, "A Manual of the Government of Detroit," p. 1.

[164]Fischer, The Government of Michigan, p. 102.

and laws."[165] Another text further explains, "The home rule enabling act, passed by the state legislature in 1909, made it possible for the electors of all cities and villages in Michigan to frame, adopt, and amend their charters, or to amend an existing charter previously granted by the legislature, and to pass all laws and ordinances relating to strictly internal affairs and municipal concerns, subject to the constitution and the general laws of the state." [166] For example, Detroit had "its own supervision of midwives" when midwife inspection and supervision was initiated throughout the state in 1927 by the Bureau of Child Hygiene and Public Health Nursing.[167] Detroit's long history of independent government and "home rule charters," allowed for legal autonomous operation of the city's Board of Health.

The Board of Health of the City of Detroit was established in 1895. However, this does not mark the beginning of health work in the city, the earliest report of the Board of Health of Detroit dates to 1882 according to a 1922 publication.[168] Only the Board of Health records for the years 1910-1915 can now be located in the Michigan State Public Library, the Bentley Historical Library, the Detroit Public Health Department and the Detroit Public Library. However, these records chronicle the beginnings of maternal and child health care in Detroit. Clues on its later expansion come out of the Detroit Urban League records. The Detroit Urban League's records concerning its Baby clinic offer detailed information on the establishment and operation of this clinic run in cooperation with the Board of Health of the City of Detroit. Further research is needed to assess the operation of other clinics in Detroit.

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[165]Citizens Research Council of Michigan, Governmental Organizations in Metropolitan Southeast Michigan (Detroit: Metropolitan Fund, Inc., 1965) 20.

[166]Ketcham, A Manual of the Government of Detroit, p. 2.

[167]The Fifty-Fifth Annual Report of the State Health Commissioner, p. 127.

[168]Burton, Stockling, Miller, eds., p. 1508.

Detroit's Board of Health began to focus attention on the welfare of children in January of 1910 with the founding its first "Mothers' Clinic." The purpose of the clinic was to instruct "mothers in the care of their babies with a view to reducing the unnecessarily great infant mortality."[169] The Visiting Nurse Association "gave" the services of a nurse, Miss E. E. Gilmour, to attend to the clinics and make home visits. A "well-known woman of this city who requested that her name be withheld from publication" contributed "enough" money to provide the babies with milk and to purchase the necessary equipment for the clinic. The physician in charge of the clinic, Dr. Francis Duffield, volunteered his services. Similar to clinics that would later be run across the state in connection with the Michigan State Department of Health, various individuals and organizations in Detroit worked together to establish and run a clinic. The Board of Health reported that "the results obtained from this experimental work have been so satisfactory that the Board of Health has decided to enlarge upon the work," Five nurses who did school work in the winter were assigned to the baby clinic over the summer.[170]

Three years after the opening of this first clinic, in 1913, the Board of Health founded its Child Health Department.[171] That same year prenatal clinics were established with the Board reporting that "These clinics have prospered and are destined to assume a prominent part in the solution of the infant mortality problem in Detroit, and the improvement in vitality of coming generations"[172]. Two infant welfare stations for educating mothers and caring for sick babies had already been established prior to 1914, one at the Board of Health building and the other at the Children's Free Hospital. Another two infant welfare stations. located at 1257 Dubois Street and 578 Weston Ave., were

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[169] 29th Annual Report of the Board of Health of the City of Detroit, 1910.

[170] 29th Annual Report of the Board of Health of the City of Detroit, 1910.

[171] 32nd Annual Report of the Board of Health of the City of Detroit, 1913.

[172] 33rd Annual Report of the Board of Health of the City of Detroit, 1914.

opened between June 1914 and June 1915. The Wesson Ave. Health Center, located in the Polish section of Detroit, represented the Board of Health concern's with the presence of a rapidly growing immigrant population.[173] By 1922 the number of clinics, according to the Detroit Urban League Board Meeting minutes, were "twelve or fifteen" distributed across the city.[174] While clinics served the surrounding populations and thus remained largely segregated in practice, this segregation was not legally mandated, "mothers were permitted to use the clinics nearest them regardless of color."[175]

Just as the immigrant population-growth declined with the restriction of immigration at the beginning of World War I, the Detroit black community expanded in the wake of migration from the South to northern industrial centers. Over the course of fourteen years one of the largest redistributions of population in this country's history took place. From 1916-1930, over one million blacks left the southern states for northern urban centers of Detroit, Pittsburgh, New York and especially Chicago. In the first two years conservative estimates place the number of migrants at 400,000, at an average rate of 16,000 per month or 500 a day.[176] The majority of the 500,000 southern blacks who

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[173]34th Annual Report of the Board of Health of the CIty of Detroit, 1915.

[174]Minutes for the DUL Board Meeting, April 1922; DUL-MHC Box 11.

[175]Minutes for the DUL Board Meeting, April 1922; DUL-MHC Box 11.

[176]Carole Marks, Farewell- We're Good and Gone: The Great Black Migration, (Indiana University Press: Bloomington and Indianapolis, 1989) 1. See also Richard Thomas, Life for Us Is What We Make It, Chapter 2. For other books on Detroit see: Sidney Glazer, Detroit: A Study in Urban Development (New York: Bookman Associates, Inc., 1965) For other books on black Detroit see: The State of Black Detroit: Building From Strength (Detroit: The Detroit Urban League, 1987); Detroit: Race and Uneven Development (Philadelphia: Temple University Press, 1987) For books on the Great Migration see: Joe William Trotter jr. ed., The Great Migration in Historical Perspective: New Dimensions of Race, Class, and Gender (Indiana University Press, 1991); Joe William Trotter, Jr., Black Milwaukee: The Making of an Industrial Proletariat, 1915-1945 (Urbana: University of Illinois Press, 1985); Peter Gottlieb, Making Their Own Way: Southern Blacks' Migration to Pittsburgh, 1916-1930 (Urbana: University of Illinois,Press, 1987); Kenneth L. Kusner, A Ghetto Takes Shape, Black Cleveland, 1870-1930, (Chicago: The Universtiy of Chicago Press, 1967); Homer C. Hawkins and Richard W. Thomas, eds. Blacks and Chicanos in Urban Michigan (Lansing: Michigan History Division, 1979); Florete Henri, Black Migration Movement North, 1900-1920 (New York: Doubleday, 1976); James R. Grossman, Land of Hope: Chicago, Black

relocated northward came in two major migration waves: one in 1916-1917 in response to the increasing demand for labor, and the other in 1924-1925 when the full effect of decreased foreign immigration due to the Immigration Act of 1921 was felt.[177] An increase in jobs available at Ford, Dodge, Chrysler, Chevrolet and Packard automobile plants served also as a major pull factor.[178]

In 1910 the Detroit black population was 5,741. By 1920, the population had risen to 40,838, a startling net increase of 35,097 (611.3 percent). The percentage growth rate for Detroit exceeds by nearly double the next closest contender for percent increase, Cleveland, Ohio whose black population increased by 307.8 percent. By 1930, 120,066 blacks resided in Detroit. Rapid population growth along with job opportunities at the lowest rungs of the work force, poor housing, segregation and overcrowding combined with hard work, long hours and insufficient food, clothing and rest to magnify health problems in the community.[179]

The Detroit black community, severely challenge by the rapid growth and change during these years and after survived and progressed through what historian, Richard Thomas, calls the "process of black community building." In this process of black community building certain individuals, classes, institutions and organization played key roles at various stages of the community building process.[180] Denied government solutions because traditional access to political power remained in the control of the white

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Southerns, and the Great Migration (Chicago: University of Chicgo Press, 1989); George W. Grohn, The Black Migration: The Journey to Urban American (New York: Weybright and Alley, 1972); Darlene Clark Hine, "Black Migration to the Urban Midwest: the Gender Dimension, 1915-1945," The Great Migration in Historical Perspective: New Dimensions of Race, Class, and Gender, Joe William Trotter, jr. ed. (Indiana University Press, 1991).

177 Thomas, Life for Us Is What We Make It:, p. 27; Hine, "Black Migration to the Urban Midwest," p. 128.

178Marks, Farewell, p. 122; Hine, "Black Migration to the Urban Midwest," p. 128.

179Marks, Farewell, p. 146-147; Thomas, Life for Us is What We Make It, Chapter 4.

180 Thomas, Life for Us is What We Make It, p. xii.

male middle- and upper-classes, black welfare activity, especially before the New Deal consisted to a great extent of private black institutions providing for black people in their communities what the white state did not.

While black men headed most organizations and played leadership roles denied to women, black women also played a important role in the community building process. Black women maternalists concentrated their efforts on race uplift work directed at men, women and children, rather than solely on women and children.[181] Working in hotels as cooks and waitresses, in the new steam laundries as ironers, in garment and lampshade factories and in food processing and meat packing plants as common laborers and more commonly as personal servants and domestics working black women contributed vital financial support to black families and by extension to the black community. [182] As Thomas argues, since black women tended to be the mainstay of black churches, their meager wages contributed greatly to the growth and development of those institutions that formed the heart of the community building process in black Detroit.[183] Darlene Clark Hine also argues for the importance of black women in sustaining black communities: "A study of the history of the early twentieth century black women's club movement is essential to the understanding...the critical roles they played in creating and sustaining new black social, religious, political, and economic institutions." Black women's considerable contribution to the founding and development of the Urban League is one such example.[184]

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[181]Gordon, Pitied But Not Entitled, p. 141; Boris, "The Power of Motherhood: Black and White Activist Women Redefine the Political," p. 213-246; Evelyne Brooks Higginbotham, "African-American Women's History and the Metalanguage of Race," Signs 17 (Winter 1992) 271; Gordon, "Black and White Visions of Welfare: Women's Welfare Activism, 1890-1945," p. 559-590; Mink, The Wages of Motherhood.

[182]Hine, "Black Migration to the Urban Midwest," covers the gender differences in migration and employment patterns of blacks during the Great Migration.

[183]Ibid, p. 28, 34.

[184]Hine, "Blacks Migration to the Urban Midwest," p. 130.

The National Urban League was founded in New York City in 1911 through the merger of three related organizations: The Committee on Urban Conditions Among Negroes in New York, the National League for the Protection of Colored Women, and The Committee for Improving Industrial Condition Among Negroes. Black men and women worked together for racial uplift in this organization. Detroit founded its local chapter of the Urban League in 1916 in response to the influx of southern black migrants. Although established and run by black men and women to serve the needs of the Detroit black community, the Detroit Urban League was supported by a network of white and black organizations. The Association Charities, a collaboration of Catholic and Protestant ethnic self help agencies, gave financial assistance in establishing the DUL. The Employers Association of Detroit paid the salary of the employment secretary. The vast majority of black workers who arrived in Detroit received their first jobs from those firms in the Detroit business community which worked with the DUL. The Jewish Welfare League also assisted, agreeing to allow the DUL to use a building they owned for just the cost of maintenance as a community center. The Detroit Recreation Commission operated the building. These supporting organizations represented white-controlled resources who work across racial and ethnic lines.

Aid also came from black community organizations. The Detroit Study Club, a group of 25 middle class black women and the Willing Workers, a relief society of middle class black women assisted the DUL. More substantial aid came from four of the largest black churches in Detroit, such as the Second Baptist Church. Other organizations, like the Young Negro Progressive Association and the Colored Mothers Club, cooperated with the DUL. With the help of this network of white and black organizations, the DUL found jobs and housing for migrants, set up programs like the Domestic Training School to prepare

rural black women for domestic employment in Detroit, established community centers, a children's summer camp, ran health programs and a baby clinic.[185]

The Detroit black community obtained its infant clinic in much the same way as white communities around the state later would: through networks of people from different organizations working together for the purpose of improving maternal and infant health. Even before the founding of the DUL, the black community had already established a connection with the Detroit Board of Health to address the health needs of its community. The Detroit League on Urban Conditions Among Negroes reported in 1916, that Dr. Vaughn of the Board of Health was collecting the vital statistics for the black population in Detroit.[186] That same year the Director of the Joint Committee of the Detroit League on Urban Conditions Among Negroes enlisted the aid of the nurses of the Board of Health. Miss Ross, Chief Nurse of the Board of Health, "promised their active cooperation in health among the colored people to the Director."[187]

Later, the Detroit Urban League maintained and expanded this link between the Board of Health and the black community. With death rates in black communities consistently higher than those in white communities across the country, health was always a top concern of the DUL [188] In 1910, the white death rate was 14.5 per 1000; the non

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185See Thomas, Life for Us Is What We Make It, Chapter 3. For books on the NUL see: Guichard Parris and Lester Brooks, Black in the City: A History of the National Urban League (Boston: Little, Brown, and Company, 1971); Nancy J. Weiss, The National Urban League: 1910-1940 (New York: Oxford University Press, 1974). For books on the DUL see: John C. Dancy, Jr., Sands Against the Winds: The Memoirs of John C. Dancy (Detroit: Wayne State Univsity Press, 1966); John M. T. Chavis and William McNitt, A Brief History of the Detorit Urban League (Ann Arbor: Michigan Historical Collection, 1971).

186"Monthly Report of Detroit League on Urban Conditions Among Negroes" June 1916, DULP-MHC, Box 11.

187"Report of Director to Monthly Meeting of Joint Committee of Detroit League on Urban Conditions Among Negroes" December 12, 1916, DULP-MHC, Box 11.

188 Marks, Farewell, p. 146-147; Thomas, Life for Us Is What We Make It, p. 104; Dancy "History of National and Local Urban League" Historical File Detroit Urban League Papers, Michigan Historical Commission, Ann Arbor Mich. (Here after cited as DULP-MHC) Box 69.

white 21.7. In the 1920, the white rate was 12.6; the nonwhite 17.7 per 1000. Children, especially infants were worse off than their parents. Between 1915 and 1919, 92.8 white babies died per 1000, while 150 black babies per 1000 died before their first birthday.[189] With high infant death rates between 1915 and 1919, (149.7 black infants died compared to 92.8 white infants) the improvement of infant health in the black community was a prime focus of the DUL from its inception.[190]

When the DUL established its settlement house in 1919, later named the Columbia Community Center, its first proposed activity was a "Clinic and Day Nursery."[191] The clinic, which opened in July, was operated in conjunction with the Board of Health as the 1919 minutes suggested, "The Children's Clinic which was planned by the Board of Health held its first session today at which time one mother and child presented themselves."[192] A later history, written by John Dancy, further clarified this relationship. He reported, "A community center was organized on Columbia Street with a Baby Clinic under the direction of the Board of Health." [193] The rapid expansion of the infant clinic, seen in the Community Center and DUL Board meeting reports, further verifies the importance placed on improving infant health in the black community. This follows the state trend of increased infant welfare activity during this period. That first month, the physician and two nurses in the clinic cared for 53 babies.[194] The minutes of the Columbia Community Center board meeting reported in September of 1919, that "The clinic has registered 164 babies during the month of August. Since this feature was added

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[189]Marks, Farewell ,p. 146-147. Thomas, Life for Us Is What We Make It, p. 104.

[190]Thomas, Life for Us Is What We Make It, p. 104.

[191]"Minutes of Settlement Board Meeting," June 13, 1919, DULP-MHC, Box 8.

[192]"Meeting of Settlement House Committee," July 11, 1919, DULP-MHC, Box 8.

[193] Dancy, "History of National and Local Urban League," Historical File DULP-MHC, Box 69.

[194] "Minutes of Settlement House," July 13, 1919, DULP-MHC, Box 8.

the Board of Health has found it necessary to add another colored nurse on its staff, it now having three colored nurses." At this time the clinic ranked 10th out of fifteen clinics in the Detroit area in number of attendance. [195] By March of 1920, less than a year since the clinic was begun, the Board reported that "The Clinic is growing so rapidly that the Board of Health has petitioned to use the place every day during the week instead of the three days they now have. We are having daily attendance averaging twenty-five babies."[196] By October, the Clinic operated every day, and with "very fine results."[197] By March of 1921, the large number of babies coming in each month necessitated the addition of another physician and nurse at which point the Baby Clinic now operated with two physicians and three nurses.[198]

Like so many other infant clinics in the state operated by private voluntary organizations at this same time, the DUL bore the cost of running the clinic. The DUL received its funds through the Employers Association and the majority of their funds from the Community Union.[199] From the initial proposal for a clinic, the board worked on funding the clinic as the 1919 Settlement Meeting minutes suggested when they reported that "the Director is to see Dr. Ross in re to the expense." [200] During the first year of operation the Board of Health "asked that we secure a new stove for the kitchen so as to increase the heating in that room. The present gas stove cannot adequately keep the room at

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195 "Columbia Community Center Minutes," September 25, 1919, DULP-MHC, Box 8.

196 "Columbia Community Center Board Meeting Report" March 25, 1920, DULP-MHC, Box 8.

197 "Report of Urban League," October 14 1920 DULP-MHC, Board of Directors Minutes and Reports, Box 11.

198 "Report of the Community Center," March 24, 1921, DULP-MHC, Box 8.

199 "Special Urban League Board Meeting," November 3 1919, DULP-MHC, Box 11.

200 "Minutes of Settlement Board Meeting," June 13, 1919, DULP-MHC, Box 8.

the temperature best suited for the babies." [201] The House Committee in May of 1922 requested a teachers table for the clinic at a cost of $18.00. Dancy was consulted and agreed with the purchase.[202] That same year Mr. Dancy requested the House Committee place new shelves in the Baby Clinic, which they provided at a cost of $5.50.[203]

The DUL clinic continued to run in this manner during the Sheppard-Towner years. When the Sheppard-Towner Maternity and Infancy Act was signed into law November 23, 1921, unlike the white small town and rural communities of Michigan which experienced a boost in growth of clinics aided by the expanded Bureau of Child Hygiene and Public Health Nursing, the Detroit black community saw no changes which could be attributed to the Sheppard-Towner funds directly. As Lindenmeyer's study showed, Ohio used Sheppard-Towner funds to address maternal and infant health in the Cleveland black community. Michigan did not do so.

Even without assistance from Sheppard-Towner funds the DUL continued to expand its maternal and child health programs and clinic. In addition to establishing and running the Baby Clinic in cooperation with the Detroit Board of Health, the DUL held other activities to promote improved infant health in their community, such as open houses at the Community Center at which the clinic ran demonstrations on infant care as part of the Annual Negro Health Week 1920- 1923.[204] In July 1923, the DUL bought the Chestnut Street house and moved its community center to the new building. The health clinic was still of central importance and was one of the first of the DUL Community Center activities resumed. The committee reported, "Baby Clinic and several activities are now in operation, but before all clubs and organizations can function in the new building some decorating and

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201"Columbia Community Center Board Meeting Report," November 18 or December 4, 1919 DULP-MHC, Box 8.

202"Report of House Committee" May 11, 1922, DULP-MHC, Box 8.

203"Report of House Committee," September 14 1922, DULP-MHC, Box 8.

204"Director Reports," DULP-MHC, Box 8 and Box 11.

minor repairs will have to be made."[205] Throughout the Sheppard- Towner years the clinic saw over 1,000 babies each year.[206] In 1925 1,432 babies made over 6,000 visits to the clinic.[207] By 1927, the clinic expanded its hours of operation to six days a week.

The Baby Clinic in the Chestnut Street Community Center, like many clinics across the state, continued unaffected by the repeal of the Sheppard-Towner Funds in 1929.[208] In 1930 the center's annual report stated: "Our Community Center has gone along in the even tenor of its way. It has served not only the neighborhood, but the city at large..." The center enabled the education department of the Board of Health to provide nurses to lecture to black mothers on child care and to expectant mothers on prenatal care. [209] Minutes from the "Detroit Urban League Board of Trustees" reported in 1933 a near record number of babies; 1500 had visited the clinic.[210] The clinic was still in operation in 1936 when Dancy wrote a history of the Detroit Urban League, having at that point cared for over 20,000 children.[211]

While Detroit black community's infant clinic and infant clinics in Michigan's towns and rural communities were organized and funded by local organizations with the support of public health departments, important distinctions must be made. The Board who

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205"House Committee Report" 1923 DULP-MHC, Box 8.

206"Annual Report of Director of Detroit Urban League" 1924-1934, DULP-MHC, Box 11.

207"Annual Report of Director of Detroit Urban League" January 14, 1926, DULP-MHC, Box 11.

208"Annual Report of Trustees of Detroit Urban League," 1929-1935, DULP-MHC, Box 11.

209"Minutes of the Detroit Urban League Board Meeting," May 14, 1929; Annual Report for 1929; DULP-MHC, Box 11.

210 "Annual Report of Trustees of Detroit Urban League" January 29, 1934, DULP-MHC Box 11.

211 Dancy, "History of National and Local Urban League," DULP-MHC, Historical File Box 69.

governed the Columbia Community Center and arranged the DUL infant clinic consisted of men and women.[212] The Board, while headed by males, was also made up of women. In the following three years other women's names appeared and reappeared on the Board members lists, in addition to the original six.[213] These women were actively involved in the functioning of the community century. For example, for the 1919 open house, a committee made up of Miss Lee, Miss Postales and Miss Holgate with Mrs. Hunton and Mrs. L. B. Johnson made the arrangements. They "decided that the Clinic put on some sort of demonstration for baby care, that the music school have a musical program, and that the Domestic Training school add some program in keeping with their work."[214] Even though the Community Center Board was a mixed group of men and women, in contrast to the women's clubs who arranged the clinics in the white communities, both the board and the women's clubs drew on networks of people in private and public organizations to appropriate community resources for maternal and child health work. Both groups established networks to effect change from outside the traditional power structure.

Another important distinction, the Detroit Clinic unlike the maternal and child health clinics in the white communities did not provide maternal health care. In 1927, the Detroit Board of Health urged the DUL to operate a prenatal clinic so "that some of the pressure

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212"Minutes of Settlement Board Meeting" June 13, 1919, DULP-MHC, Box 8. In 1919, the Settlement Board Meeting, after electing Mr. Butzel as Chair, Mr. Talliaferro as Vice Chair and Mr. Dancy as Secretary, proposed the founding of a children's clinic in its new settlement house. Miss Gulley, Mrs. Hosner, Miss Westmorland, Mrs. Graine, Miss Postle, Mrs. DuPorte along with Dr. Lundy, Mr. Butzel, Mr. Johnson made up the present members of the first Settlement Board meeting, as must have Mr. Talliaferro and Mr. Dancy as mentioned above.

213"Minutes of Settlement Board Meeting" June 13, 1919,Columbia Community Center Minutes Sept. 25 1919; Minutes of the Columbina Community Center Board Meeting October 23, 1919, Minutes of Community Center Board Meeting February 24, 1921, DULP-MHC, Box 8. New names appearing were: Mrs. Hunton, Miss Holgate, Mrs. Lee, Mrs. Bakeman-Johnson, Miss Henderson, Mrs. Cary, and Mrs. Krolik.

214"Minutes of the Columbia Community Center Board Meeting," October 23, 1919, DULP-MHC, Box 8.

might be taken off its downtown central station."[215] Not willing to increase attention to health at the expense of other programs this request for more space in the Community Center building was rejected. The House Committee feared that expanding the clinic would force out other activities and turn the Community Center into a settlement house.[216] The DUL did not take on the added responsibility of a prenatal clinic, so the pregnant women of the black community must have continued to seek care at the downtown central station prenatal clinic run by the Detroit Board of Health. How this decision was reached is unclear from the minutes. Undoubtedly the existance of a prenatal clinic which black women had access to lessened the Board's concern about this issue. Other factors undoubtedly contributed to this decision. One, the mixed gender of the Board members of the Community Center would lead to less focused concern over solely female health issues. Two, black women during this period concentrated their reform efforts on race uplift rather than primarily on concerns of women, such as prenatal care.[217] This racial difference between Black and white women reformers is important to consider and adds further weight to the importance of the racial difference between the members of the Board governing the Baby Clinic and the white women's clubs who organized local clinics outside of Detroit. The Board worked for racial uplift and consequently directed work for the improvement of health of men, women and children in their communities, in comparison to white women's clubs who worked addressed largely women and children's health issues.

215"Minutes of DUL Meeting," September 21 1927 DULP-MHC, Box 11.

216"Minutes of DUL Meeting," October 21, 1927 DULP-MHC, Box 11.

217Gordon, Pitied But Not Entitled, p. 141; Boris, "The Power of Motherhood: Black and White Activist Women Redefine the Political," p. 213-246; Evelyne Brooks Higginbotham, "African-American Women's History and the Metalanguage of Race," Signs 17 (Winter 1992): 271; Gordon, "Black and White Visions of Welfare: Women's Welfare Activism, 1890-1945," p. 559-590.

While these distinctions are important, the similarity between the organizational structures behind the clinics run across the state is most striking. The cooperation of the DUL with the Board of Health, and the DUL's work with other white and black organizations points to the importance of establishing networks of people among public and private organizations as a strategy to serve the health needs of the Detroit black community women and children. This network was an important part of the community building process in black Detroit and provided needed education and care for black mothers and their children in Detroit from 1919-1930.

CONCLUSION

The Depression brought concerns over maternal and child health to public policy debates again and as Muncy argued, "women in the child welfare corps were ready with the suggestions they had carried across the hostile terrain of the 1920s."[218] The Social Security Act of 1935 included each of the programs suggested by the Abbott-Lenroot team of the Children's Bureau and much of their broader agenda. Title V of the Social Security Act restored the Children's Bureau's Maternity and Infancy health work and allowed the Children's Bureau to expand through programs for crippled children and those neglected by their parents. In addition, the Social Security Act established Aid to Dependent Children, old-age pensions and unemployment insurance.[219] However, Aid to Dependent Children was put under the new Social Security Board, a federal program unconnected to the network of organizations throughout the country working on infant health and welfare, rather than under the Children's Bureau, the unofficial head of this informal network. In addition to circumventing the established networks, Aid to Dependent Children focused on and benefited only those in poverty and, as a result, did not attempt to benefit all women and children as the Children's Bureau programs had.[220] These two significant changes marked a new era in child and maternal health in the United States, and the decline of community networking.

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[218]Muncy, Creating a Female Dominion, p. 150.

[219]Muncy, Creating a Female Dominion, p. 152; Ladd-Taylor, Mother-Work, p. 190.

[220]Muncy, Creating a Female Dominion, pp. 153-154.

Scholars mark the decline of women's organizational networks active influence on child health programs with repeal of the Sheppard-Towner funds in 1929. However, even after repeal of the Sheppard-Towner funding in 1929, Michigan women's organizations remained active and continued to cooperate with the Bureau of Child Hygiene and Public Health Nursing. In doing so they were vital to the continuation of maternal and child health programs begun during the Sheppard-Towner years. This demonstrates that the decline in women's active influence did not occur at the same rate or in the same way across the country women's organizations continued the work they had begun before Sheppard-Towner after the federal funds were withdrawn.

Most importantly, this study shows the centrality of private and public networks to the success of health programs in Michigan. White women's voluntary organizations worked with the Michigan State Department of Health to establish successful maternal and child health programs across Michigan outside of Detroit. Similar networks operated within Detroit as seen used by the DUL. People from various public and private organizations, black and white, working together contributed to success of the DUL Infant Clinic. These networks gave politically marginalized groups, white women and black men and women, a means to address health needs in their communities.

This study leads me to a number of areas for future research. The success of the informal networks constructed by white women and also by black men and women may be one reason that support for the continuation of Sheppard-Towner Act waned and warrants further study. The degree to which the Director of the Michigan Department of Health supported the work of the Bureau of Child Hygiene and the Children's Bureau in comparison to the dynamics of this relationship in other states may shed light on the resulting organizational differences between states. Further comparison of women's club activity among states and their connection to the expanding roles of the state public health department is needed. Comparisons between community efforts to improve infant health in black urban and black rural communities will reveal valuable information concerning race

and public health. Studies addressing the political dynamics between the city and state governments in regards to allocating funds for maternal and child health work will provide further information into the politics of the development of maternal and child health policy. Many questions arise concerning the voices of the women served by these programs and further research using community newspapers and newsletters can shed light on their perceptions, reactions and desires. Research on the nursing associations involvement with maternal and child health programs, their relationship with the women they served and their role in the rising professionalism of public health are broad topics that would important to the development of maternal and child health policy during the early 20th century, as is research on the professionalization of medicine during this period. More case studies of rural and urban communitiy clinics other that the DUL clinic are also important.

Research on Michigan's maternal and child health programs after 1930 is neccessary in providing insight into the creation of our current state maternal and child health program and for pointing to directions for the future. As a society we must readdress the issue of maternal and child health. Today one percent of all infants die under the age of one.[221] Yet other countries have lower rates and critics of current American policy and programs argue that the United States has failed to reduce infant mortality adequately and evenly because it has not adopted comprehensive national health and maternal support systems.[222] For the period between 1980-1990 a dismal decline in child and maternal health was reported by the Children's Defense Fund. Statistics from the National Center for Health Statistics show that compared with 1980 statistics, American infants in 1990 were less likely to be born to mothers who received early prenatal care, more likely to be born to mothers who received later or no prenatal care. In 1990 one in four infants were born to mother who did not receive early prenatal care. Four in 10 infants born to black mothers did not receive early prenatal care. One in nine babies born to

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[221]Meckel, Save the Babies, p. 1.

[222]Meckel, Save the Babies, p. 3.

black mother received late or no prenatal care, compared with one in 20 white babies. In 1990 infants were more likely to be born at low birth weight. Low-birthweight infants are much more vulnerable to death and disability than infants born at normal weight. The overall infant mortality rates were lower in 1990 than in 1980, but the rate of improvement in that decade was slower than the two previous decades. Even with this improvement, in 1991 the U.S. infant mortality rate was 21st compared to nations world wide, behind countries like Canada, Hong Kong, Singapore, and Spain. And a baby born in the U.S. was more than twice as likely to die before its first birthday as a baby born in Sweden. U.S. black babies were more likely to die in their first year of life than a baby in 34 other nations, including Jamaica, Cuba, and Sri Lanka.[223] The U.S. must focus its attention on caring for its mothers and infants. Ultimately understanding the past can help clarify the issues at hand and uncover possible consequences of different courses of action and help guide us in establishing sound, well thought out maternal and child health policy that addresses and remedies these relatively high rates of infant and maternal morbidity and mortality.

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[223]Children's Defense Fund. Decade of Indifference: Maternal and Child Health Trends 1980- 1990 (March 1993) 1-3.

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