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Prenatal Care in the Rural United States, 1912–1929

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SUMMARY: In 1920, maternal mortality rates in the United States exceeded those of other industrialized nations. To redress this statistic, the federal Children's Bureau set its sights on improving access to prenatal care at a time when 80 percent of American women received none. In 1921, following lobbying by urban, middle-class progressive women working at or in support of the Bureau, the government legislated for prenatal care programs through the Sheppard-Towner Act. To date, historians have focused on how successfully women implemented the act's provisions, paying less attention to whether support for rural mothers reduced maternal mortality rates. Using Children's Bureau pamphlets, documents pertaining to the Sheppard-Towner Act, and letters written to the Bureau from poor, rural women, this article brings government workers, medical professionals, and the women they served into dialogue to analyze the first push to establish prenatal care for underserved American women and the obstacles that stood in the way.

KEYWORDS: prenatal care, Children's Bureau, Sheppard-Towner Act, Progressive Era, rural

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In 1916, Mrs. Phelps was living in rural Wyoming. She was one of many women to write about her fears of childbirth to the Children's Bureau (hereafter Bureau), a federal agency founded four years earlier, primarily to combat infant and maternal mortality. Her correspondence to the Bureau captures a voice brimming with anger and frustration, as she recounts her personal struggles in preparation for childbirth. "I am so worried and filled with perfect horror at the prospects ahead. So many of my neighbors die at giving birth to their children. . . . Will you please send me all the information for the care of my self before and after and at the time of delivery? If there is <u>any thing</u> what I can do to escape being torn again wont you let me know."[1] After having birthed two large babies, Phelps's fear of further trauma is evident in her pleas.

Phelps's concerns did not fall on deaf ears. Julia Lathrop (1858–1932), first chief of the Children's Bureau (1912–21), responded to Phelps that she had read her letter with the "most earnest attention and sympathy. [As they] are not the only letter[s] of that kind which the Bureau has received—it makes very urgent the great question of protecting motherhood."[2] The high infant and maternal mortality rates captured the attention of the middle-class Progressives, who in 1912 secured government support to establish the

[1] Letter from Alice Cutting Phelps to Julia Lathrop, October 19, 1916, box 25, file 4-3-0-3, Central File 1914–20, Children's Bureau Records, Record Group 102 (hereafter CBR, RG 102), National Archives and Records Administration, College Park, Maryland (hereafter NARA), emphasis original. I quote all letters verbatim, capturing the grammatical errors, which are an important part of the textual record.

[2] Letter from Julia Lathrop to Alice Cutting Phelps, October 27, 1916, box 25, file 4-3-0-3, Central File 1914–20, CBR, RG 102, NARA. Julia Lathrop graduated from Vassar College and dedicated her life to social and political reform. She was a major figure in the nation's first juvenile delinquency law in Chicago and played an influential role at Hull House before becoming first chief of the Children's Bureau.

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Children's Bureau for the purpose of conducting research into these areas.[3] During the Bureau's first year, attention focused on child welfare, particularly infant mortality in urban areas.[4] However, with a deluge of letters from pleading mothers, such as Mrs. Phelps, and the results of research in rural locations, attention later turned to maternal mortality.[5] Lathrop explained to Phelps that the Bureau was seeking a solution through its educational pamphlet, "Prenatal Care," and legislative reform that would enable mothers, particularly in rural areas, to secure the medical and nursing care "to which they are entitled."[6] Phelps and

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[3] In the 1920s, women's groups were divided into (1) militant feminists who sought all forms of equality for women, (2) progressive reformers who were the settlement house workers and Bureau staffers who sought social reform but held traditional family values, and (3) anti-suffragists. In 1909, President Roosevelt called the first White House Conference on Children and Youth. Over the next three years progressive reformers, women's clubs, labor unions, and various state labor committees actively endorsed the establishment of a federal department focusing on child welfare.

[4] Kriste Lindenmeyer, *A Right to Childhood: The U.S. Children's Bureau and Child Welfare, 1912–46* (Urbana: University of Illinois Press, 1997), 9, 30, 35. See also Laura L. Lovett, *Conceiving the Future: Pronatalism, Reproduction, and the Family in the United States, 1890–1938* (Chapel Hill: University of North Carolina Press, 2009).

[5] See Elizabeth Moore, "Maternity and Infant Care in a Rural County in Kansas," U.S. Department of Labor, Children's Bureau publication no. 26 (Washington, D.C.: Government Printing Office, 1917); Viola I. Paradise, "Maternity Care and the Welfare of Young Children in a Homesteading County in Montana," U.S. Department of Labor, Children's Bureau publication no. 34 (Washington, D.C.: Government Publishing Office, 1919); Florence Brown Sherbon and Elizabeth Moore, "Maternity and Infant Care in the Two Rural Counties in Wisconsin," U.S. Department of Labor, Children's Bureau publication no. 46 (Washington, D.C.: Government Printing Office, 1919); Helen M. Dart, "Maternity and Child Care in Selected Rural Areas of Mississippi," U.S. Department of Labor, Children's Bureau publication no. 88 (Washington, D.C.: Government Printing Office, 1921); Glenn Steele, "Maternity and Infant Care in a Mountain County in Georgia," U.S. Department of Labor, Children's Bureau publication no. 158 (Washington, D.C.: Government Printing Office, 1923).

[6] Letter from Julia Lathrop to Alice Cutting Phelps, October 27, 1916 (n. 2). See also letter from Mrs. M. T. to Children's Bureau, June 23, 1916, file 4-6-0-3, Central File 1914–20, CBR, RG 102, NARA; Anna Steese Richardson, "Safeguarding American Motherhood," *McClure's Magazine*, July 1915, 35, 77.

her neighbors had to wait five years until the Bureau, and a broader coalition of interested parties, succeeded in coaxing Congress to pass the Sheppard-Towner Maternity and Infancy Act in 1921.[7] The act provided federal funding to participating states that established Bureau-approved prenatal care programs to reduce infant and maternal mortality rates.

The Bureau observed through its research that urban mothers exhibited higher maternal mortality rates than rural women. Historian Richard Meckel suggests that the Bureau nonetheless focused on rural locations because "the causes of maternal mortality were more intractable in those areas of the country where the population was scattered, doctors were few and far between, and public health programs virtually non-existent."[8] Indeed, the Bureau's 1917 report paid special attention to the problem of rural maternal mortality, noting that in sparsely populated regions "the question is not one of good or bad obstetrical care but of the inaccessibility of any care at all."[9] Julia Lathrop explained that "I hope that our community will be so organized that there will be a doctor and nurse stationed at various points," so that no one has to travel long distances.[10]

This article excavates the dialogue between rural women seeking prenatal assistance and the government agency charged with aiding their access to it. I analyze the processes the

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[7] For information on other parties, see Charles Seddon, "The Most Powerful Lobby in Washington," *Ladies' Home J.* 39, no. 4 (1922): 5, 93, 95–96; U.S. Government Publishing Office, "Digitized Bound Congressional Record for the 1920s" (September 26, 2017), https://www.govinfo.gov/features/crecb-1920s-now-available.

[8] Richard A. Meckel, *Save the Babies: American Public Health Reform and the Prevention of Infant Mortality, 1850–1929* (Rochester, N.Y.: University of Rochester Press, 1990), 204. See also Gertrude J. Fraser, *African American Midwifery in the South: Dialogues of Birth, Race, and Memory* (Cambridge, Mass.: Harvard University Press, 1988), 131.

[9] Grace L. Meigs, "Maternal Mortality: From All Conditions Connected with Childbirth in the United States and Certain Other Countries," U.S. Department of Labor, Children's Bureau publication no. 19 (Washington, D.C.: Government Printing Office, 1916), 26.

[10] Letter from Julia Lathrop to Mrs. Roesch, January 13, 1916, box 25, file 4-3-0-3, Central File 1914–20, CBR, RG 102, NARA.

Bureau put in place to promote prenatal care, how rural women exerted agency, and how structural obstacles impinged on that agency. The story of the relationship between the Bureau and rural women's experiences sheds new light on the history of American maternity care, refocusing our attention on the social and material conditions in nonurban areas, where most women lived in the early twentieth century. Further, this article enriches our understanding of the history of prenatal care, which has been relatively neglected in the otherwise well-trodden terrain of the medicalization of American childbirth.[11] I conclude by drawing out the commonalities between past and present with respect to troubling high maternal mortality rates in the United States.

Increased physician oversight of childbirth in the first decades of the twentieth century included greater management of the prenatal period, which had customarily been a time when women generally did not seek medical care. If in need of advice or aid, they would turn to knowledgeable relatives or a midwife. The Sheppard-Towner Act embedded a push for prenatal care within a larger maternal welfare program that invested authority over infant and maternal care in physicians. This dovetailed with the financial benefit to them by making these incursions into what had traditionally been the province of midwives or the period during which women did not normally seek medical assistance.[12] But while these changes

[11] E.g., Richard W. Wertz and Dorothy C. Wertz, *Lying-In: A History of Childbirth in America* (New Haven, Conn.: Yale University Press, 1989); Robyn Muncy, *Creating a Female Dominion in American Reform* (New York: Oxford University Press, 1991); Jacqueline H. Wolf, *Deliver Me from Pain: Anesthesia and Birth in America* (Baltimore: Johns Hopkins University Press, 2009); Charlotte G. Borst, *Catching Babies: The Professionalization of Childbirth, 1870–1920* (Cambridge, Mass.: Harvard University Press, 1995).

[12] Abraham Flexner, *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching* (New York, 1910), 6.

were afoot in urban areas, they were slow to make inroads in rural regions, which remained largely beyond the physician's reach in the first quarter of the twentieth century.

A central concern of the Progressive Era women's movement was educating women for motherhood and the rise of prenatal care was part of this effort. Valuing medical opinion and biomedical knowledge, middle-class Progressives believed maternal care required instruction, not just instinct.[13] There is a rich body of scholarship on the Bureau's mothering and maternal education policies, which historians have pinpointed as targeting working-class and immigrant women.[14] Although class- and race-based assumptions hampered the effectiveness of advice, historians have largely focused on the Bureau's successes, such as organizing health conferences (i.e., community health fairs) for mothers, distributing educational pamphlets, and interviewing women as part of their research agenda.[15] To date, scholars have yet to analyze the literature on prenatal care and the responses of the poor, rural women the material was meant to assist. The educational and socioeconomic issues impeding

[13] The Progressive Era was a period of social activism and political reform that extended from the 1890s to the 1920s. Reformers were generally educated, middle-class women.
[14] See Sheila M. Rothman, *Woman's Proper Place: A History of Changing Ideas and Practices, 1870 to Present* (New York: Basic Books, 1978); Emily K. Abel, "Benevolence and Social Control: Advice from the Children's Bureau in the Early Twentieth Century," *Soc. Serv. Rev.* 68, no. 1 (1994): 1–19; Linda Gordon, "Putting Children First: Women, Maternalism, and Welfare in the Early Twentieth Century," in *U.S. History as Women's History: New Feminist Essays*, ed. Linda Kerber, Alice Kessler-Harris, and Kathryn Kish Sklar (Chapel Hill: University of North Carolina Press, 1995), 63–86; Rima D. Apple, "Constructing Mothers: Scientific Motherhood in the Nineteenth and Twentieth Centuries," *Soc. Hist. Med.* 8, no. 2 (1995): 161–78.
[15] E.g., Wertz and Wertz, *Lying-In* (n. 11), 210; Molly Ladd-Taylor, *Raising a Baby the Government Way: Mothers' Letters to the Children's Bureau, 1915–1932* (New Brunswick, N.J.: Rutgers University Press, 1986), 210; Muncy, *Creating a Female Dominion in American Reform* (n. 11), 110.

rural women from accessing prenatal care remain unclear. The Bureau offered good advice, but to women often without the means to follow it.

To reconstruct this experience of rural prenatal care in the early decades of the twentieth century, I rely on the Bureau's "Prenatal Care" pamphlets, documentation on Bureau-approved state-level Sheppard-Towner programs, and a large collection of correspondence between female staff at the Children's Bureau and the women they served. Bureau staff received over 125,000 letters each year from mothers like Phelps.[16] They confided intimate details of their reproductive lives, laying bare the fear, loneliness, and frustration that often accompanied childbirth when facing poverty, delinquent husbands, harsh rural life, as well as the indifference of the medical profession.[17] Though the gender, class, and location are usually apparent, identifying the author's race is trickier. Most of the letters come from northern rural women, a description that fits relatively few African Americans. As none of the letter writers self-identify as Black, it seems likely that most of the authors were white, although one cannot discount the possibility that some were African American or of another race and have not explicitly self-identified as such. To compensate for a dearth of material clearly authored by rural Black mothers I read the voices that come through Bureau letters written by Black public health activists, white public health nurses, as

[16] Nine boxes containing letters to and from the Children's Bureau were chosen at random in the period prior to the enactment of the Sheppard-Towner Act (1914–20) and seventeen boxes during the period of the Sheppard-Towner Act (1921–30). Boxes were selected from sections 4-1 (Eugenics and Hereditary), 4-2 (Maternity), and 4-3 (Rural Maternity Care). The number of letters in each box varied, but averaged 77 across the boxes chosen. All letters in each box were analyzed for this article. Letters from Black public activists were located within these boxes.

[17] Nancy Pottishman Weiss, "Mother, the Invention of Necessity: Dr. Benjamin Spock's *Baby and Child Care*," *Amer. Quart.* 29, no. 5 (1977): 519–46.

well as concerned white citizens. To this I add the memoirs of two African American lay midwives that engage explicitly with the concerns of Black mothers.

White middle-class progressive women working for the Bureau, and who engaged in civic activities related to the social and moral welfare of the poor, responded to women's letters. They yield a wealth of information about the ideas and administrative methods of the staff. Although sympathetic, the letters seem to reveal that the Bureau had a shallow understanding of the needs that lower-class women had gone to great pains to express. However, Bureau responses unmask what appears to be staff frustration, as well as the tenuous position of the Bureau, and the limitations of the department in meeting the maternal needs of rural women.

Taking an intersectional approach to my analyses of varied and complex sources, I organize this article into two parts. The first section sets the stage for an overview of early twentieth-century medical and midwifery education, maternal mortality, and the role of middle-class progressive reformers in the establishment of the Children's Bureau and Sheppard-Towner Act. The second section details the impact of obstacles that stood in the way of the Bureau's efficacious implementation of its prenatal agenda, including (1) harsh working conditions for farm women, (2) the inaccessibility for women of doctors and medical facilities, (3) socioeconomic constraints, and (4) racial discrimination in maternity care.

The Children's Bureau, the Sheppard-Towner Act, and American Maternity

In the early twentieth century, childbirth had been regarded as a private matter, outside the purview of state and federal regulation. Medical students received little or no training in

childbirth, and obstetrics, as a distinct specialty, had not yet been developed.[18] Most women had home births and relied on a family doctor or midwife. Although 50 percent of doctors attended home births as part of their practice, only 5 percent of U.S. women gave birth in hospital at the turn of the century.[19] Most medical students therefore had little opportunity to encounter clinical cases and learned the management, examination, and manipulation of labor only once on the job.[20] J. Whitridge Williams, a Johns Hopkins University educator and author of a landmark obstetrics textbook, credited this lack of attention to doctors relegating it to so-called woman's work, as it had historically been overseen by midwives.[21]

Rural areas, in particular, faced a shortage of hospitals and skilled doctors, who were often stretched across a large and thinly populated territory.[22] The majority of rural women saw a doctor or midwife only at the onset of labor; poor rural women more likely to receive maternity care at home from lay midwives.[23] Midwives fell into three categories based on their training: lay midwives, doctor-apprenticed midwives, and school-trained midwives.[24]

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[18] The specialty of obstetrics did not develop until 1929.

[19] George W. Kosmak, "The Sheppard-Towner Bill," *JAMA* 76, no. 19 (1921): 1319; Wertz and Wertz, *Lying-In* (n. 11), 71, 133. The small number of women who gave birth in hospital were generally poor, unmarried urban women who attended lying-in hospitals.

[20] Kenneth M. Ludmerer, *Learning to Heal: The Development of American Medical Education* (New York: Basic Books, 1985), 33.

[21] J. Whitridge Williams, "Medical Education and the Midwife Problem in the United States," *JAMA* 58, no. 1 (1912): 1–7.

[22] For a discussion on accusations of the incompetence of country doctors, see Borst, *Catching Babies* (n. 11), 132.

[23] C. A. Ritter, "Why Pre-natal Care?," *Amer. J. Gynecol.* 70 (November 1919): 523–34; Robert Morse Woodbury, "Maternal Mortality: The Risk of Death in Childbirth and from All Diseases Caused by Pregnancy and Confinement," U.S. Department of Labor, Children's Bureau publication no. 158 (Washington, D.C.: Government Printing Office, 1926), 83–86; Wertz and Wertz, *Lying-In* (n. 11), 85, 87; Borst, *Catching Babies* (n. 11), 123.

[24] See Borst, *Catching Babies* (n. 11), 13–36. As with medical schools, a lack of standardization in the rigor and length of training plagued midwifery education. No

The lines between these groups were not always clear and the term "midwife" did not always denote any particular training or legal status. The lay midwife primarily tended to women from underserved communities, especially white and Black rural women. Their work was an extension of a woman's traditional domestic skills, often voluntary, and closely resembling patterns of "gender-specific mutual aid" among women.[25]

The majority of pregnant women received no prenatal care at this time, as doctors focused on the treatment of sick patients rather than preventive health care.[26] Poor access to prenatal care and the concomitant high maternal mortality rates troubled Progressive reformers. Lillian Wald (1867–1940) wrote in 1903 that "if the Government can have a department to look after the Nation's farm crops, why can't it have a bureau to look after the Nation's child crop?" implying that rural women are also worthy of special attention from the government.[27] In response, settlement house workers, such as Lathrop, Wald, Florence Kelley (1859–1932), Jane Addams (1860–1935), and Grace Abbott (1878–1939), lobbied for a federal agency to research infant and maternal mortality rates. After six years of intensive lobbying, President William Taft signed legislation in 1912 establishing the U.S. Children's Bureau. It was soon realized that the United States ranked well below other industrially developed countries when it came to infant and maternal mortality. For example, in 1915, the overall U.S. infant mortality rate was 100 per 1,000 live births, compared to 68 in Australia

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governing body regulated midwifery schools; most schools were independent, for-profit ventures controlled by male doctors.

[25] Ibid., 5.

[26] Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Cambridge, Mass.: Harvard University Press, 1992), 516.

[27] Quoted in Dorothy E. Bradbury and Martha M. Eliot, "Four Decades of Action for Children: A Short History of the Children's Bureau, 1903–1946," U.S. Department of Labor, Children's Bureau publication no. 358 (Washington, D.C.: Government Publishing Office, 1956), 1.

and 76 in Sweden. In terms of maternal mortality, the ratio was 61 per 10,000 live births in the United States and 43 in Australia and 29 in Sweden.[28]

The Bureau sought to bring these shameful mortality rates more in line with other industrially developed countries. However, according to historian Kriste Lindenmeyer, the Bureau's primary project was infant mortality because it seemed to be the least controversial topic politically, and so attention was often centered on babies.[29] It was not until Bureau staff began to receive thousands of letters from disgruntled women sharing their childbirth experiences that Lathrop extended its focus on maternal mortality. Field workers in seven rural locations and across five states interviewed hundreds of women.[30] The Bureau's studies corroborated their complaints, leading them to conclude that rural mothers received little or no prenatal care.[31] Inspired by a successful New York City program a decade earlier, the

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[28] Settlement houses were established in poor urban districts where volunteers provided services to the underprivileged. Lathrop noted the connection among Kelley, Wald, and Addams in a letter from Julia Lathrop to Graham Taylor, December 13, 1927, file Julia Lathrop to Graham Taylor, July 26, 1918–June 1932, Graham Taylor Papers, Newberry Library, Chicago. On women reformers, see Eleanor Stebner, *The Women of Hull House: A Study in Spirituality, Vocation, and Friendship* (New York: State University of New York Press, 1997); "The Children's Bureau Act of 1912," 42 U.S.C. §§ 191–193 (1940); "The Promotion of Welfare and Hygiene of Maternity and Infancy for the Year Ending June 30, 1929," U.S. Department of Labor, Children's Bureau publication no. 203 (Washington, D.C.: Government Printing Office, 1931), 139.

[29] Lindenmeyer, *Right to Childhood* (n. 4), 37.

[30] Locations included Kansas (1917), Montana (1919), Wisconsin (1919), Mississippi (1921), and Georgia (1923). See Moore, "Maternity and Infant Care in a Rural County in Kansas" (n. 5); Paradise, "Maternity Care and the Welfare of Young Children in a Homesteading County in Montana" (n. 5); Sherbon and Moore, "Maternity and Infant Care in the Two Rural Counties in Wisconsin" (n. 5); Dart, "Maternity and Child Care in Selected Rural Areas of Mississippi" (n. 5); Steele, "Maternity and Infant Care in a Mountain County in Georgia" (n. 5).

[31] Julia Lathrop, "Fifth Annual Report of the Chief, Children's Bureau to the Secretary of Labor," U.S. Department of Labor, Children's Bureau publication (Washington, D.C.: Government Printing Office, June 30, 1917), 16–20; Dorothy Kirchwey Brown, "The Case

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Bureau lobbied the federal government to support access to prenatal care for all expectant mothers.[32] The result of this effort led to the introduction of the Sheppard-Towner Act and a step toward combatting infant and maternal mortality through federally funded and state-run programs in rural areas.[33]

After the passage of the act, the Bureau expanded its distribution of its educational pamphlet, "Prenatal Care," an initiative it had launched already in 1913. Lathrop's colleagues had pressed for the pamphlet to be written by a physician, but Lathrop chose Mrs. Max West, a widowed mother, to draft it. Although West was advised by Dr. John Slemmons, who had written a more detailed book in the field, Lathrop argued that "we can keep the thing simpler"

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for Acceptance of the Sheppard-Towner Act" (Washington, D.C.: National League of Women Voters, 1922), 27. For a complete statistical analysis, see Woodbury, "Maternal Mortality" (n. 23), 83–86.

[32] In 1907, New York established the Bureau of Child Hygiene under the direction of Dr. Josephine Baker. A pre- and postnatal care program was trialed in selected urban districts, in which physicians and public health nurses monitored women. Of the mothers "under care during the prenatal period, the death rate . . . is just exactly one-half of those not supervised." Quoted in Brown, "Case for Acceptance of the Sheppard-Towner Act" (n. 31), 14–15, quotation on 29. See also Julius Levy, "Maternal Mortality and Mortality in the First Month of Life in Relation to Attendant at Birth," *Amer. J. Pub. Health* 13, no. 2 (1923): 88–95. Prenatal care work was also undertaken on an individual level. For example, philanthropist Mrs. William Lowell Putnam chaired the Department of Public Health and the Committee on Prenatal and Obstetrical Care of the Women's Municipal League of Boston. The first experiment in prenatal care, considered a great advance in preventive medicine, was conducted under Putnam's supervision from 1909 to 1914.

[33] "Sheppard-Towner Maternity and Infancy Protection Act of 1921," 42 U.S.C. §§ 161–175 (1921); Skocpol, *Protecting Soldiers and Mothers* (n. 26), 495. Connecticut, Illinois, and Massachusetts never accepted the cooperation offered by the federal government under the Sheppard-Towner Act because it violated states' rights. See *Commonwealth of Massachusetts v. Mellon*, 262 U.S. 447 (1923). See also "Illinois Needs No Federal Nurse," *Chicago Daily Tribune*, April 25, 1923; Mrs. William Lowell Putnam, "The Sheppard-Towner Bill," *JAMA* 76, no. 18 (1921): 1264–65.

coming from a mother.[34] The Bureau sent "Prenatal Care" free to women on request, and it was probably the first written material on basic hygiene and pregnancy they ever saw.[35] Thirty-eight pages long, the first four editions of "Prenatal Care" appeared between 1913 and 1924 and remained unrevised until after the Sheppard-Towner era concluded in 1929. For many women, it demystified childbirth and provided instruction about the importance of monitoring critical symptoms, such as headaches, that expectant mothers often dismissed.[36] The pamphlet advised women on general maternity care, such as hygiene, nutrition, and exercise. Women were instructed on the importance of bathing, eating vegetables, meat, and dairy, wearing loose-fitting clothes, and getting rest and light exercise. Even without access to prenatal care, these activities could promote a healthy pregnancy.

State-level Sheppard-Towner programs followed up on the pamphlet's advice with a range of activities designed to reinforce its message to mothers and midwives alike. Educational programs, including health conferences, classes for expectant mothers, and the creation of maternal health clinics, promoted the same messages about hygiene, diet, and exercise.[37] Fourteen states set as a priority the instruction, supervision, and licensing of midwives.[38] Others employed public health nurses to visit pregnant women in the home to offer "advice and instruction in diet, hygiene, clothing, fresh air, exercise, rest, care of the

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[34] Letter from Julia Lathrop to Lillian Wald, October 26, 1912, box 59, folder 1, Edith and Grace Abbott Papers, Special Collections Research Center, University of Chicago Library. See also "Public Protection of Maternity and Infancy," Pub. L. No. 2366, § Committee on Interstate and Foreign Commerce (1921).

[35] "Prenatal Care" was the first federal pamphlet available to pregnant women. However, in 1915 information could also be obtained from New York, Indiana, and North Carolina state health departments, from an insurance company, and through agricultural extension courses. However, this information was regional and did not reach a large audience.

[36] E.g., Letter from Mrs. M. T. to Children's Bureau, June 23, 1916 (n. 6).

[37] Lindenmeyer, *Right to Childhood* (n. 4), 103.

[38] Wertz and Wertz, *Lying-In* (n. 11), 208–9.

breasts, skin and teeth."[39] With access to limited doctors in rural areas, some states, such as New York, established health clinics throughout rural districts to provide hygienic advice.[40] In southern states, public health nurses supervised Black midwives. Doctor Felix Underwood, executive officer of the Mississippi State Board of Health, highlighted that "two major activities were stressed, cleanliness of equipment, and personal and home hygiene of the midwife and prospective mother; and calling a physician for any abnormality."[41] Public health nurses provided basic hygienic advice and discouraged African American midwives from using practices not medically endorsed. Authorities supplied a list of approved tools of the trade and routinely inspected midwife bags for contraband, such as herbal teas.[42]

Although public health nurses provided some medical services, their role in prenatal care was primarily educational and "to persuade the woman . . . a good physician is essential," especially if there were any concerns or complications.[43] Furthermore, no reform

[39] "Department of Health, City of New York, Annual Report" (New York, 1920), 149. In the early twentieth century, public health nurses were generally trained in social welfare; they provided hygienic advice and educated people on disease prevention. By the 1930s there were nearly 20,000 public health nurses in the United States. Rothman, *Woman's Proper Place* (n. 14), 139; Susan L. Smith, *Sick and Tired of Being Sick and Tired* (Philadelphia: University of Pennsylvania Press, 1995), 71.

[40] Letter from Anna Rude to Nellie Leando, September 22, 1920, box 25, file 4-2-0-3, Central File 1914-20, CBR, RG 102, NARA. See also Skocpol, *Protecting Soldiers and Mothers* (n. 26), 510; Smith, *Sick and Tired of Being Sick and Tired* (n. 39), 71.

[41] Felix J. Underwood, "The Relation of the Midwife to the State Board of Health" (1931), box 8416, folder 34, RG-51/Series 2036: Midwife Program Files and Photographs, Public Health Nursing Division, Mississippi Department of Archives and History, Jackson. See also Felix J. Underwood, "Manual for Midwives" (Jackson: Mississippi State Board of Health, 1921). The "Manual for Midwives" was disseminated to other states and remained virtually unchanged for over half a century.

[42] Underwood, "Manual for Midwives" (n. 41); Edna Roberts and Rene Reeb, "Mississippi Public Health Nurses: A Partnership That Worked," *Pub. Health Nursing* 11, no. 1 (1994): 57–63; Smith, *Sick and Tired of Being Sick and Tired* (n. 39), 104.

[43] Brown, "Case for Acceptance of the Sheppard-Towner Act" (n. 31), 27.

measures upgraded or improved accessibility to health care or increased the number of hospital beds.[44] The Bureau's approach to prenatal care did, however, serve as a catalyst for the American Medical Association's (AMA) interest in the potentially lucrative arena of preventive health care. Immediately following the introduction of the Sheppard-Towner Act, physician Fred Adair encouraged doctors to expand their expertise in prenatal care, but this shift did not reflect the suitability of their training for this work or lead to medical advancements at this time.[45] In due course, physicians came to assume greater oversight, not just of the birth itself but of the prenatal period. The Sheppard-Towner Act was the impetus for laying the foundations of prenatal care within a larger maternal welfare program that placed physicians at the helm.

Under pressure from the AMA, and with the endorsement of the Bureau, northern states began to regulate midwifery practice following the introduction of the Sheppard-Towner Act, with Massachusetts banning it outright. States required formal instruction and licensing despite "few places to obtain training."[46] Abbott recognized that immigrant midwives, who often serviced northern rural communities, were well trained in Europe, but she believed there was no point to establishing midwifery schools in the United States

[44] Sheila M. Rothman, "Women's Clinics or Doctors' Offices: The Sheppard-Towner Act and the Promotion of Preventive Health Care," in *Social History and Social Policy*, ed. David J. Rothman and Stanton Wheeler (New York: Academic Press, 1981), 175–201; Rothman, *Woman's Proper Place* (n. 14), 136.

[45] Fred L. Adair, "The Physician's Part in a Practical State Program of Prenatal Care" (Washington, D.C.: Government Printing Office, 1926); Wertz and Wertz, *Lying-In* (n. 11), 145–46; Skocpol, *Protecting Soldiers and Mothers* (n. 26), 516; Jeffrey P. Baker, "When Women and Children Made the Policy Agenda—The Sheppard-Towner Act, 100 Years Later," *New Engl. J. Med.* 385, no. 20 (2021): 1827–29.

[46] Borst, *Catching Babies* (n. 11), 67.

because midwives "are little used at the present by women of native parentage."[47] With new legislative requirements most immigrant midwives did not seek licensure and midwifery numbers declined. This is in part because midwifery was an avocation for many immigrant women, the limited number of available training places, and the requirement to take the exam in English, which proved an insurmountable hurdle for many women.[48] Despite some country doctors filling the void, they tended to work only within a limited geographical area.

Amid this AMA-led attack on midwifery in the Sheppard-Towner era, the Bureau retreated from an earlier commitment to researching the socioeconomic bases of poor maternal health, instead directing women to a medical model of health and offering services to blunt the force of these inequities. Bureau-approved state programs encouraged women to consult their doctor regularly. Despite the costs and lack of availability, the Bureau advocated giving birth in a hospital "since any emergency which may arise is most easily met in a hospital."[49] In 1915, Abbott wrote that "a well-trained doctor to attend every woman during childbirth is ideal."[50] "Prenatal Care" pamphlets claimed that compared to midwife-assisted births, physician-assisted hospital births were safer, cheaper, more convenient, and in demand by women compared to midwife-assisted home births.[51]

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[47] Grace Abbott, "The Midwife in Chicago," *Amer. J. Sociol.* 20, no. 5 (1915): 684–99, quotation on 685.

[48] Some women requested the exam to be written in their native language. Borst, *Catching Babies* (n. 11), 67, 154.

[49] Letter from Viola Anderson to Hilda M. Hemsil, February 1, 1926, box 4, file 4-4-3-2, Central File 1925–28, CBR, RG 102, NARA.

[50] Abbott, "Midwife in Chicago" (n. 47), 693–94.

[51] Mrs. Max West, "Prenatal Care," Care of Children Series no. 1, U.S. Department of Labor, Children's Bureau publication no. 4 (Washington, D.C.: Government Printing Office, 1913), 21.

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In the face of AMA and Bureau advocacy for physician-led prenatal and perinatal care, the shift from home to hospital proceeded apace, but unevenly. By 1936, six years after the Sheppard-Towner Act had expired, hospital births in urban areas reached 71 percent, but only 14 percent of babies born in rural areas were delivered in hospitals.[52] Good rural hospital services were lacking, with small towns often building "cottage hospitals" reliant on "philanthropic agencies."[53] Although larger towns benefitted from small, privately owned hospitals supported by patient fees, most doctors were not specialists, so general patients were treated alongside obstetric cases, and "the trusting public suffered."[54] Patients requiring expert medical and surgical care were required to go to city hospitals, though patients often refused to be transferred because of distance and cost.[55]

The Bureau had, of course, no ability to lift the socioeconomic, geographical, and other barriers that stood in the way of rural women. The "Prenatal Care" pamphlet and Sheppard-Towner programs provided advice on maintaining a healthy pregnancy, but rural mothers like Mrs. Phelps were often told, "We can not give you much assistance in your real problem, namely, securing proper attention at childbirth."[56] The Bureau directed women to the path of health, but there was no guarantee of access. Women's letters to the Bureau, with

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[52] Lindenmeyer, *Right to Childhood* (n. 4), 199.

[53] Borst, *Catching Babies* (n. 11), 156. See also letter from Dr. Hazel Dell Bonness to Dr. Blanche Haines, September 10, 1925, box 3, file 4-1-1, Central File 1925–28, CBR, RG 102, NARA.

[54] G. R. Egeland, "An Economically Built Small Hospital," *Mod. Hosp.* 19, no. 5 (1922): 387–90, quotation on 387. See also Dorothy Dunbar Bromley, "What Risk Motherhood?," *Harper's Monthly Mag.*, June 1, 1929, 11–22.

[55] Roswell T. Pettit, "The Diagnostic Hospital of a Small Community," *Mod. Hosp.* 17, no. 3 (1921): 195–99.

[56] Letter from Mrs. Max West to Alice Cutting Phelps, October 24, 1916, box 25, file 4-3-0-3, Central File 1914–20, CBR, RG 102, NARA. See also letter from Julia Lathrop to Mrs. Roesch, January 13, 1916 (n. 10).

demands for support, suggest that they took Bureau advice offered seriously. Women queried Bureau staff about the pamphlet's contents, often seeking further information, advice, and clarification or simply expressing their frustration and criticizing the validity of staff responses. Their pleas underscore the limits of instructional advice detached from real-world conditions. Formulaic staff responses at first glance seem insensitive to the challenges women faced, but they were clearly doing the best they could with the highly constrained resources they had at their disposal. The obstacles rural women encountered were well beyond the abilities of Bureau staff to remediate.

Socioeconomic Conditions for Expectant American Mothers

In the early twentieth century, the majority of Americans lived in rural areas, building their lives around farming, logging, or mining. In places like Montana, homesteads were built on prairies where families managed the herding of sheep and cattle, and the cultivation of flax, potatoes, and wheat. In contrast, parts of the Deep South and Midwest were largely forested, and loggers cleared the land for dairy farming and the cultivation of potatoes, corn, rye, wheat, and barley.[57] Although they describe geographically dissimilar areas, Bureau reports suggest that families contended with similar challenges, including isolation, poverty, limited public infrastructure, and severe weather. Women had to be resourceful to adapt.

The sexual division of labor and the subordination of women in urban homes were "routinely challenged" on rural homesteads.[58] Although traditional gender roles were

[57] Sherbon and Moore, "Maternity and Infant Care in the Two Rural Counties in Wisconsin" (n. 5), 17, 56; Steele, "Maternity and Infant Care in a Mountain County in Georgia" (n. 5), 8; Paradise, "Maternity Care and the Welfare of Young Children in a Homesteading County in Montana" (n. 5), 23–24.

[58] Barbara Handy-Marchello, *Women of the Northern Plains: Gender & Settlement on the Homestead Frontier, 1870–1930* (Saint Paul: Minnesota Historical Society Press, 2005), 6.

maintained if the husband worked as a laborer on a neighboring farm, the financial viability of owner-occupied farms required the wife to toil alongside her husband.[59] The isolation and hard work were demanding both physically and psychologically, but also afforded women the opportunity to live in ways that transgressed the gender norms of urban life.[60] Rural women made crucial contributions to the financial viability of their homes and communities.[61] However, it also meant an arduous work week, averaging sixty-three hours.[62]

The seasonal nature of agriculture and restricted incomes meant that most women, in addition to doing the housework, had to contribute to manual labor. "Prenatal Care" advised women to avoid "exhausting forms of activity," suggesting that they would "derive greater benefit from sitting quietly out in the fresh air."[63] However, pregnancy did not guarantee rest or the availability of someone else to take over the heavy chores.[64] Few had the financial resources or help to allow them to set aside, even temporarily, their domestic responsibilities, and most pregnant women had to "work up to the last minute" of their pregnancy, as one woman put it in a 1914 letter.[65] Writing to the Bureau in 1915, Mrs. W. M. similarly lamented that there was no consideration for a woman's condition and "we were expected" to

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[59] E.g., Paradise, "Maternity Care and the Welfare of Young Children in a Homesteading County in Montana" (n. 5), 53–60.
[60] Handy-Marchello, *Women of the Northern Plains* (n. 58), 6.
[61] Beverly J. Stoeltje, "'A Helpmate for Man Indeed': The Image of the Frontier Woman," *J. Amer. Folk.* 88, no. 347 (1975): 25–41.
[62] U.S. Department of Agriculture, "Yearbook of Agriculture 1928" (Washington, D.C.: Government Printing Office, 1929), 620.
[63] West, "Prenatal Care" (n. 51), 11.
[64] Paradise, "Maternity Care and the Welfare of Young Children in a Homesteading County in Montana" (n. 5), 59; Sherbon and Moore, "Maternity and Infant Care in the Two Rural Counties in Wisconsin" (n. 5), 13; Handy-Marchello, *Women of the Northern Plains* (n. 58), 65.
[65] Letter from Mrs. John Spien to Children's Bureau, October 28, 1914, box 25, file 4-2-2-4-1, Central File 1914–20, CBR, RG 102, NARA.

work.[66] Women explained that their "bodies suffered from the strain of overwork," especially when they resumed their chores so soon after giving birth.[67] A lack of birth control also meant successive pregnancies, which took a toll on women's health.[68] As Mrs. H. P. wrote in 1921, "I am so tired! If I could only rest a while, but I don't see any chance. I have had my children so fast and have had so much to do."[69] Irrespective of the demands on farming women, "Prenatal Care" advised expectant mothers to have "a morning bath" and "to spend at least two hours of each day in the open air . . . resting while they sew, read or chat."[70] In direct response, Mrs. F. G. wrote "if any of your advice covers what an ordinary farm wife can carry out I would like to have it. . . . [I] get up at 5 a.m. hustle breakfast for 5, wash dishes help milk feed pigs clean up bakeing-scrubbing washing . . . where could I have time for a bath every morn?"[71] Rural women hoped that Bureau advice and Sheppard-Towner programs would "help us poor Country people," but little of it seemed transferable from middle-class urban life. They were receptive to the advice but pushed back with demands for guidance that suited their social and material reality.[72]

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[66] Letter from Mrs. W. M. to Children's Bureau, March 29, 1915, file 4-5-0-3, Central File 1914–20, CBR, RG 102, NARA.
[67] Handy-Marchello, *Women of the Northern Plains* (n. 58), 65.
[68] Many letters sent to the Bureau highlighted women's desperation and pleas for assistance in birth control. E.g., letter from Mrs. Roy Fonner to Children's Bureau," May 15, 1919, box 24, file 4-0-2, Central File 1914–20, CBR, RG 102, NARA; letter from Mrs. E. S. to Children's Bureau, January 13, 1928, file 4-4-1-3, Central File 1925–28, CBR, RG 102, NARA.
[69] Letter from Mrs. H. P. to Dr. Sherbon, July 28, 1921, file 4-10-6-0, Central File 1921–24, CBR, RG 102, NARA.
[70] West, "Prenatal Care" (n. 51), 11.
[71] Letter from Mrs. F. G. to Miss Gertrude B. Knipp, October 6, 1917, box 25, file 4-2-0-3, Central File 1914–20, CBR, RG 102, NARA.
[72] Letter from Mrs. L. W. to Children's Bureau, March 13, 1922, file 11-2-2, Central File 1921–24, CBR, RG 102, NARA.

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Bureau pamphlets and letters capture the staff's normative middle-class values, which set the pattern for a federal social welfare policy.[73] Lathrop asserted that society should aim to implement these values to alleviate the economic injustices between the rich and poor, and thus reduce class animosity.[74] Bureau officials believed that their shared identity as women with those they served superseded any class differences. However, they were aware that their advice, though valuable for improving infant and maternal outcomes, did not work for many women because of their living conditions. Staffer Dorothy Mendenhall described the advice given to poor, rural women as "absurd."[75] Writing in 1916, Mrs. Max West concurred, but suggested that "the problems that follow in the train of poverty and ignorance can be answered by the spread of education, and the satisfactory adjustment of social and economic conditions."[76] Unable to effect socioeconomic transformation, the Bureau had to focus on education alone to extend middle-class norms and practice of prenatal care. As an unsigned letter from the Bureau to one rural mother put it in 1918, staff "realize[d] how little the Bureau can do. . . . In the meantime, we can only try to make it better understood."[77] In the face of meaningful political power and control of the government purse strings, Bureau staff settled for spreading word of best prenatal care practices without regard for their ability to actually implement this advice.

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[73] Molly Ladd-Taylor, *Mother-Work: Women, Child Welfare, and the State, 1890–1930* (Chicago: University of Illinois Press, 1994), 91; Lindenmeyer, *Right to Childhood* (n. 4), 2.
[74] Julia Lathrop, "Presidential Address—Child Welfare Standards: A Test of Democracy," in *Proceedings of the National Conference of Social Work* (Atlantic City, N.J., 1919), 5–41.
[75] Quoted in Mrs. Max West, "The Prenatal Problem and the Influence Which May Favorably Affect This Period of the Child's Growth," *Amer. J. Obstet. Dis. Women Child.* 73, no. 3 (1916): 416–24, quotation on 422.
[76] Ibid., 422–23.
[77] Letter from Children's Bureau to Mrs. Charles Lanyon, March 6, 1918, box 25, file 4-2-0-3, Central File 1914–20, CBR, RG 102, NARA.

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Federal and state governments, which did have the means to bridge the gap between middle-class urban women and the rural poor, were slow to develop much needed infrastructure in rural areas where vast distances impeded women's access to health care. Doctors typically saw a patient for the first time during labor, despite the encouragement to seek prenatal care. In the absence of any serious symptoms, pregnant women spared themselves the costly and arduous trip to the doctor.[78] In a representative remark, one South Dakota resident complained to Bureau staff in 1928, toward the end of the Sheppard-Towner era, about the continued lack of accessibility to a "good local physician." Heavily pregnant and in despair, she explained that the nearest physician was fifty-two miles away.[79] Some women traveled several days in uncomfortable conditions; the long trip often left them exhausted, leaving them "very weary" when labor finally began.[80]

Poor roads compounded the problem of distance.[81] One survey identified a father who advised Bureau staff that to provide better maternal care, "first get the county commissioners to put in roads that would make it possible for us to receive medical care . . . when the water

[78] Letter from Alice Cutting Phelps to Julia Lathrop, October 19, 1916 (n. 1); letter from Mr. L. M. Ranes to Children's Bureau, October 25, 1933, box 498, file 4-6-2-2, Central File 1931–40, CBR, RG 102, NARA; letter from Mary Roesch to Children's Bureau, January 4, 1916, box 25, file 4-3-0-3, Central File 1914–20, CBR, RG 102, NARA; letter from Mrs. John Q. Adams Jr. to Children's Bureau, July 3, 1928, box 10, file 4-4-2-2, Central File 1925–28, CBR, RG 102, NARA.

[79] Letter from Mrs. John Q. Adams Jr. to Children's Bureau, July 3, 1928 (n. 78).

[80] Paradise, "Maternity Care and the Welfare of Young Children in a Homesteading County in Montana" (n. 5), 48; Borst, *Catching Babies* (n. 11), 123.

[81] Paradise, "Maternity Care and the Welfare of Young Children in a Homesteading County in Montana" (n. 5) 17–20; Sherbon and Moore, "Maternity and Infant Care in the Two Rural Counties in Wisconsin" (n. 5), 26–27.

is high, and we can not cross, we are cut off from the world."[82] Some doctors would not risk their safety by traveling "over bad roads," especially during inclement weather.[83] It was not uncommon for women to phone multiple doctors before getting one to agree to come.[84] Women such as Mrs. M. A., who lived not too far from a doctor, still found it "quite a distance when roads are bad."[85] Women who could not manage the trip often relied on their husbands to fetch the doctor, sometimes leaving their laboring wives unattended to travel in adverse weather conditions "over the very worst roads one ever saw."[86] Although the new Federal Road Act of 1916 provided funds to upgrade rural roads, the need was great, and roads in many areas remained in poor condition.[87] Some states levied a five-dollar tax on rural families for road maintenance, but "no one 'worked' the roads" and so they remained unsealed.[88]

To offset the inaccessibility of physicians, some states employed public health nurses with Sheppard-Towner funds. Though well intentioned, they bore the heavy burden of responsibility for vast, poorly connected areas. Between 1921 and 1927, clinics set up in

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[82] Paradise, "Maternity Care and the Welfare of Young Children in a Homesteading County in Montana" (n. 5), 19. See also S. Josephine Baker, "Why Do Our Mothers and Babies Die?," *Ladies' Home J.* 39, no. 4 (1922): 32, 174.
[83] Letter from Mrs. Matilda B. Burnside to Children's Bureau, March 30, 1928, box 4, file 4-4-3-2, Central File 1925–30, CBR, RG 102, NARA. See also C. M. Schuldt, "The Need of Maternity Service in Rural Districts," *Wisconsin Med. J.* 19 (1920): 576.
[84] Letter from Mrs. Matilda B. Burnside to Children's Bureau, March 30, 1928 (n. 83).
[85] Letter from Mrs. M. A. to Children's Bureau, October 19, 1921, file 4-4-3-3, Central File 1921–25, CBR, RG 102, NARA.
[86] Letter from Alice Cutting Phelps to Julia Lathrop, October 19, 1916 (n. 1). See also Paradise, "Maternity Care and the Welfare of Young Children in a Homesteading County in Montana" (n. 5), 28.
[87] Paradise, "Maternity Care and the Welfare of Young Children in a Homesteading County in Montana" (n. 5), 17.
[88] Steele, "Maternity and Infant Care in a Mountain County in Georgia" (n. 5), 6.

South Dakota were able to visit each town only once or twice, making it nearly impossible for women to receive continuity of care. Supply shortages and local opposition by doctors also impeded care.[89] A nurse in Nevada had no equipment except a pair of scales, and her health conferences organized as part of the state's Sheppard-Towner program were so poorly promoted that few people attended.[90] One maternity care advocate in Wisconsin was "so thoroughly disgusted" with resistance from the local medical fraternity that she felt there was no point continuing.[91] Some states, such as Minnesota, that did set up health conferences required women to receive permission from their local doctor before being examined by a public health nurse, and the assessment report was required to be sent to him for follow-up with any treatment.[92] If a woman did not have a local doctor or could not afford one, she was unable to see the public health nurse.

Supply problems, poverty, and cost meant that, despite living on farms, many women were unable to afford the balanced diet advised in the "Prenatal Care" pamphlet.[93] Mrs. M. M., whose husband worked as a farmhand, struggled to survive on her husband's low wages. In a 1920 letter to the Bureau, she complained that "a man cant feed 6 children properly on $4 a day, pay rent, water, and clothe them, besides there is his wife & himself to feed & clothe."[94] One 1919 Bureau report revealed that despite a family living on a dairy farm, the "whole milk supply was [carted] off . . . leaving almost no milk for the family's

[89] Clara Edna Hayes, "Sheppard-Towner Work in South Dakota," *Med. Woman's J.* 34, no. 6 (1927): 145–47.
[90] Ladd-Taylor, *Mother-Work* (n. 73), 186.
[91] Letter from Lucile Blachly to Blanche Haines, July 1, 1927, file 11-30-1, Central File 1925–28, CBR, RG 102, NARA.
[92] Rothman, "Women's Clinics or Doctors' Offices" (n. 44), 189.
[93] West, "Prenatal Care" (n. 51), 8–11.
[94] Letter from Mrs. M. M. to Children's Bureau, July 29, 1920, file 4-6-0-3, Central File 1914–20, CBR, RG 102, NARA.

use."[95] Unskilled workers, in particular, often struggled to survive in insecure jobs on poor wages. In Kansas, Mrs. E. S. acknowledged, "We rent a farm & find it hard . . . to provide food & clothe for us all."[96] Writing from Colorado in 1921, Mrs. J. S. disclosed that she and her family could not "have vegetables or poultry because it takes all of our work to run the ranch to pay the rent."[97] Other women complained that they lived in areas where they simply could not access certain foods, such as fruit, vegetables, eggs, and milk.[98] With the demands of their families paramount, many women neglected themselves.[99] Mrs. Bentcliff told staff that prior to giving birth she was "obliged to go without food myself so my other 2 little girls [would] not go hungry."[100] As a result, women suffered from poor nutrition, which had the potential to negatively impact their pregnancy.[101]

Financial constraints similarly impinged on women's ability to afford the Bureau's recommendation of "the care of a competent physician."[102] Almost 85 percent of people

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[95] Sherbon and Moore, "Maternity and Infant Care in the Two Rural Counties in Wisconsin" (n. 5), 68.

[96] Letter from Mrs. E. S. to Children's Bureau, January 13, 1928 (n. 68).

[97] Letter from Mrs. J. S. to Children's Bureau, June 6, 1921, file 4-10-6-1, Central File 1921–24, CBR, RG 102, NARA.

[98] See Letter from Mrs. N. W. to Children's Bureau, February 2, 1916, file 4-3-1-4-3, Central File 1914–20, CBR, RG102, NARA; letter from Helen Bentcliff to Children's Bureau, February 28, 1916, box 25, file 4-2-0-2, Central File 1914–20, CBR, RG 102, NARA; letter from Mrs. A. McColgan to Children's Bureau, May 28, 1918, box 25, file 4-3-0-3, Central File 1914–20, CBR, RG102, NARA.

[99] Ransom S. Hooker, ed., *Maternal Mortality in New York City: A Study of All Puerperal Deaths, 1930–1932* (New York: Oxford University Press, 1933), 91.

[100] Letter from Helen Bentcliff to Children's Bureau, February 28, 1916 (n. 98).

[101] Meckel, *Save the Babies* (n. 8), 170.

[102] Letter from Mrs. Max West to Alice Cutting Phelps, October 24, 1916 (n. 56). "In 1917, midwives charged from $7 to $10, a fee that included daily visits for five days or more. Doctors charged from $20 to $30 and the patient had to hire a nurse for all subsequent attention, which in effect doubled the fee. In 1930, the charge for midwives had risen from $25 to $30 but as high as $65 for doctors." Wertz and Wertz, *Lying-In* (n. 11), 211.

employed in 1923 earned less than $2,000 annually (the equivalent in 2020 of $30,400), with 38 percent living on a wage of less than $1,000. Physicians' fees were often prohibitively expensive, compounded by mileage charges for additional travel to far-flung rural areas.[103] Writing in 1916, Mary Roesch explained that "my [h]usband is only making [$]1.35 a day . . . how am I going to get 35 dollar to have a doctor?"[104] As women often gave birth in quick succession, many families struggled to pay off prior childbirth bills before having another baby.[105] Mrs. A. G. explained to Bureau staff in a 1921 letter, "We owe $125 in doctor bills . . . and dread any more."[106] Those who required treatment or medication had to show that they could pay for them. Those with outstanding debts were often refused care.[107]

Inpatient maternity care was also out of reach for most women. The "Prenatal Care" pamphlet suggests that the total cost of hospital births was less than home births. But such assertions failed to account fully for a hospital stay's impact on the household economy.[108]

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[103] S. Josephine Baker, "The High Cost of Babies," *Ladies' Home J.* 40, no. 10 (1923): 212–13; Irvine Loudon, "General Practitioners and Obstetrics: A Brief History," *J. Roy. Soc. Med.* 101, no. 11 (2008): 531–35; "Maternal Deaths: A Brief Report of a Study Made in 15 States," U.S. Department of Labor, Children's Bureau publication no. 221 (Washington, D.C.: Government Printing Office, 1933), 9; letter from Mrs. John Spien to Children's Bureau, October 28, 1914 (n. 65); letter from Mrs. A. G. to Children's Bureau, August 10, 1921, file 4-10-6-0, Central File 1921–24, CBR, RG 102, NARA; letter from Mrs. L. G. to Children's Bureau, April 11, 1922, file 11-40-2, Central File 1921–24, CBR, RG 102, NARA.

[104] Letter from Mary Roesch to Children's Bureau, January 4, 1916 (n. 78). See also letter from Mrs. A. Allen to Children's Bureau, July 29, 1918, box 25, file 4-2-0-3, Central File 1914–20, CBR, RG 102, NARA.

[105] Letter from Mrs. W. S. to Children's Bureau, January 30, 1918, file 9-4-4-1, Central File 1914–20, CBR, RG 102, NARA.

[106] Letter from Mrs. A. G. to Children's Bureau, August 10, 1921 (n. 103).

[107] Letter from Susie Goodman to Children's Bureau, June 13, 1916, box 25, file 4-3-0-3, Central File 1914–20, CBR, RG 102, NARA; letter from Mrs. A. Allen to Children's Bureau, July 29, 1918 (n. 104).

[108] West, "Prenatal Care" (n. 51), 21; letter from Viola Anderson to Hilda M. Hemsil, February 1, 1926 (n. 49).

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Rural women who chose to give birth in regional maternity homes had to factor in the cost of travel and accommodation before and after the birth; they also needed to hire help to take on their duties at home while they were away. In practice, few could afford a hospital birth without accruing debt. Bureau staff understood the financial constraints of a hospital birth for rural women, and so included instructions and a supply list in "Prenatal Care" for a doctor to deliver the expectant mother at home. The pamphlet recommended that a "visiting nurse" be employed to provide postnatal support or, at the very least, hired help to undertake household chores.[109] One cannot know how these women felt on reading advice they could not implement, but one can imagine that it may have left some feeling anxious about being unable to afford the recommended resources for a home birth.[110] They may have also felt angry at being advised to do something that was not possible. In particular, the Bureau's own research indicated that visiting nurses and hired help were "scarce and often difficult if not impossible to secure."[111]

Unconvinced that government entitlements were a solution, Bureau staff tried to connect women to welfare agencies when they could not resolve their issues, but the reality on the ground frequently did not support this approach.[112] Although Abbott and pioneer nurse Mary Breckinridge wrote of the inadequacies of private charities and the need for social workers on the ground, Bureau staff continued to refer the poor to private philanthropic

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[109] See West, "Prenatal Care" (n. 51), 22–24.
[110] Letter from Mrs. John Spien to Children's Bureau, October 28, 1914 (n. 65).
[111] Moore, "Maternity and Infant Care in a Rural County in Kansas" (n. 5), 26; Sherbon and Moore, "Maternity and Infant Care in the Two Rural Counties in Wisconsin" (n. 5) 37; Dart, "Maternity and Child Care in Selected Rural Areas of Mississippi" (n. 5), 37.
[112] Camilla Stivers, "Unfreezing the Progressive Era: The Story of Julia Lathrop," *Admin. Theory Praxis* 24, no. 3 (2002): 537–54; Stebner, *Women of Hull House* (n. 28), 150; Janet Golden, *Babies Made Us Modern: How Infants Brought America into the Twentieth Century* (Cambridge, Mass.: Cambridge University Press, 2018), 52.

groups because of the lack of established social workers.[113] They told women to seek out local charities, even as they were limited or absent in most communities.[114] Madeleine Doty, an influential journalist and civil libertarian, critiqued that "mothers would be given instruction by [Bureau] staff but no help." The government directed women to the road of health, but "if a woman hadn't the money, she must die without aid, clutching to the knowledge of what ought to have been done and hadn't to save her life."[115]

The limits of the Bureau's effort to improve infant and maternal outcomes through the promotion of prenatal care in rural areas is reflected in a 1933 Bureau report. This document reveals that in the final two years of the Sheppard-Towner Act, 59 percent of white rural women had had no prenatal examinations.[116] There was an overall increase in maternal mortality rates for white women with the rate increasing from around 60 per 10,000 live births in 1915 to 63 in 1929, and for rural women an increase from approximately 55 in 1915 to 62 in 1929.[117] However, for African American women living in the South the results were even more dire.

Racism compounded the economic disadvantage that expectant rural mothers faced. In 1920, 85 percent of African Americans lived in the South, predominantly in rural areas. A

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[113] Muncy, *Creating a Female Dominion in American Reform* (n. 11), 82–83.
[114] Letter from Ella Oppenheimer to Mrs. Howard Cayford, May 15, 1934, box 498, file 4-6-2-0, Central File 1931–40, CBR, RG 102, NARA; letter from Grace Abbott to Mrs. S. D., September 1921, file 4-10-6-1, Central File 1921–25, CBR, RG 102, NARA; Abbott, "Midwife in Chicago" (n. 47), 696; Lela B. Costin, *Two Sisters for Social Justice: A Biography of Grace and Edith Abbott* (Urbana: University of Illinois Press, 1983), 109.
[115] Madeleine Z. Doty, "The Maternity Bill," *Suffragist* 8 (January/February 1921): 353–54, quotation on 354.
[116] "Maternal Deaths" (n. 103), 15.
[117] "Promotion of Welfare and Hygiene of Maternity and Infancy" (n. 28), 135–38; Harold F. Dorn, "Maternal Mortality in Rural and Urban Areas," *Pub. Health Rep. (1896–1970)* 54, no. 17 (1939): 684–90.

decade later, despite thousands of Black people moving to northern industrial cities during the first Great Migration (1916–1940), 79 percent still lived in southern rural regions in 1930.[118] From the late nineteenth century to the Civil Rights Movement in the 1960s, states in the South implemented racial segregation under what were known as the Jim Crow laws, which denied Black people access to health care, among other services.[119] There were very few Black doctors, nurses, and hospitals.[120] White doctors often refused to treat Black women, whether out of racial prejudice or concerns about payment.[121] Mrs. A. Allen, a white woman living near an African American community, wrote to Bureau staff in 1918, asking rhetorically, "Cant you see why so many ignorant colored mammies are called in? Cant afford a Dr or nurse."[122] Those few who could pay found health facilities closed to them because of Jim Crow.[123] Black women relied primarily on "granny midwives" who were typically very skilled, but lacked formal training.

Although nationally the Bureau promoted physician-assisted births, southern states developed Bureau-approved programs that assigned Black women to the care of lay midwives. Historians Bruce Bellingham and Mary Mathis assert that the Bureau "withheld from African Americans . . . hygienic socialization to medical management of pregnancy and

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[118] U.S. Department of Commerce, Bureau of the Census, "Negroes in the United States 1920–32" (Washington, D.C.: Government Printing Office, 1935), 1–8.
[119] See *Plessy v. Ferguson*, 163 U.S. 537 (1896). This decision was overturned only in 1954 by *Brown v. Board of Education of Topeka*, 347 U.S. 483 (1954).
[120] Margaret Charles Smith and Linda J. Holmes, *Listen to Me Good: The Life Story of an Alabama Midwife* (Columbus: Ohio State University Press, 1996), 115.
[121] Onnie Lee Logan, *Motherwit: An Alabama Midwife's Story* (San Francisco: Untreed Reads, 2014), 105–6; Smith, *Sick and Tired of Being Sick and Tired* (n. 39), 106, 113.
[122] Letter from Mrs. A. Allen to Children's Bureau, July 29, 1918 (n. 104).
[123] Herbert M. Morais, *The History of the Negro in Medicine* (New York: Publishers Company, 1967), 122.

obstetric patient education."[124] Similarly, historian Gertrude Fraser writes that the Bureau "subscribed to a point of view that contributed to the oppression of African American women" by eliminating midwives and controlling their reproductive lives, all while offering "less than the full benefits of medical science."[125] But while Bureau policy promoted different types of caregivers to different racial communities, favoring greater professionalism for those tending to white women, the situation cannot be reduced to one of white indifference to the plight of Black women. The Bureau's second chief (1921–1934), Grace Abbott, was a founding member of the National Association for the Advancement of Colored People. In a meeting on child hygiene, she recognized that the latitude and flexibility allowed by the Sheppard-Towner Act "to meet local needs" offered an opportunity to provide some meaningful support to African American women despite the obstacles created by Jim Crow laws.[126]

Although the care offered by Black midwives and supported by the Bureau was not always enough, there was rarely an alternative. In an emergency, many southern white doctors refused to serve Black women at home, putting them in danger. White doctors felt no inclination to treat poor African Americans who could not pay upfront.[127] As Eliza Grant, a Black mother exclaimed, "Lord if niggers had to pay what white folks pays for dere babies

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[124] The authors argue that the Sheppard-Towner programs constructed a "racially dualist system by officially incorporating nonmedical providers . . . to service African American mothers." Bruce Bellingham and Mary Mathis, "Race, Citizenship, and the Bio-politics of the Maternalist Welfare State: 'Traditional' Midwifery in the American South under the Sheppard-Towner Act, 1921–29," *Soc. Politics* 1, no. 2 (1994): 157–89, quotation on 164.
[125] Fraser, *African American Midwifery in the South* (n. 8), 129.
[126] "Transactions of the Thirteenth Annual Meeting of the American Child Hygiene Association, Washington, DC., October 12–14, 1922" (Albany, N.Y.: J. B. Lyon, 1925), 194.
[127] Smith, *Sick and Tired of Being Sick and Tired* (n. 39), 6, 20.

gittin' here de niggers just wouldn't git here."[128] But money was not the only impediment. Black midwife Onnie Lee Logan explained that, too often, white doctors did not treat Black people, because "they didn't care. . . . I cain't remember a doctor go in a place in my whole time in the country to deliver a Black baby. . . . Cause if they sent for him the baby would [be] . . . walkin befo he got there."[129] Although all midwives were required to call a doctor in case of an emergency, historian Pete Daniel explains that many white "doctors regarded [Black midwives] as a nuisance."[130] In one particular case, Daniel describes a midwife seeking assistance from a local doctor for a complicated birth. Forced to knock for fifteen minutes, she was verbally chastised and left waiting while the doctor delayed his departure. By the time they reached the mother, she had died.[131] Faced with such racial animus and indifference, the Bureau aimed its efforts in rural Black communities to registering granny midwives and raising their knowledge about hygienic practices. Historian Molly Ladd-Taylor argues that the Bureau received endorsement from Black civic leaders "by focusing on the 'midwife problem' rather than on the economic and social causes of poor health," which underpinned Black mortality.[132]

Despite their aspirations, Bureau policies toward African American midwives reflected the agency's privileging of certain knowledge and practices to be held by (mostly

[128] Eliza Grant, in the Federal Writer's Project Papers, 1936–40, no. 3709, 1938, Southern Historical Collection, Wilson Library, University of North Carolina at Chapel Hill.
[129] Logan, *Motherwit* (n. 121), 56, 60. See also Smith and Holmes, *Listen to Me Good* (n. 120), 20, 104.
[130] Pete Daniel, *Standing at the Crossroads: Southern Life since 1900* (New York: Hill & Wang, 1986), 86.
[131] Ibid. See also Smith and Holmes, *Listen to Me Good* (n. 120), 68, 110.
[132] Molly Ladd-Taylor, "'Grannies' and 'Spinsters': Midwife Education under the Sheppard-Towner Act," *J. Soc. Hist.* 22, no. 2 (2000): 260.

white) physicians only.[133] According to Alabama midwife Margaret Charles Smith, authorities in the 1920s "refused to train them" in critical techniques, such as taking a patient's blood pressure, a vital skill required in prenatal care.[134] Restricting midwives from performing essential procedures, including internal examinations, limited midwives' toolkit and undercut their authority. Most midwives were experienced at performing a version or external rotation of the unborn child, but adherence to new medical policies in the Jim Crow South meant critical delays because midwives were now required to send for a doctor to perform this procedure, though he might not arrive in time, or even at all.[135] This obstructed the Bureau's goal of improving maternal mortality rates because despite their good intentions, the political system did not allow for this realization. Licensing and practice restrictions also reduced the pool of midwives. In Mississippi, illiterate midwives were often denied a license even though they "were among the best midwives."[136] As a consequence, there was a 35 percent reduction in the number of licenses issued.[137] In this way, "Sheppard-Towner agents inadvertently dismantled a necessary component of health care in poor areas," without substituting a viable alternative in African American communities.[138] Despite the Bureau's push for prenatal care among women, 83 percent of rural Black women still had had no prenatal examinations by the final two years of the Sheppard-Towner Act.[139] The

[133] Fraser, *African American Midwifery in the South* (n. 8), 129.
[134] Smith and Holmes, *Listen to Me Good* (n. 120), 144.
[135] "Minutes of Executive Committee Meeting," April 14, 1921, box 8416, folder 24, RG-51/Series 2036: Midwife Program Files and Photographs—Public Health Nursing Division, Mississippi Department of Archives and History, Jackson.
[136] Felix J. Underwood, "The Relation of the Midwife to the State Board of Health" (Jackson: Mississippi State Board of Health, 1937), 5.
[137] Ibid., 2.
[138] Ladd-Taylor, "'Grannies' and 'Spinsters'" (n. 132), 270.
[139] "Maternal Deaths" (n. 103), 15.

reduction in midwives and lack of prenatal care may have had an effect on African American maternal mortality rates, which increased from around 108 per 10,000 live births in 1921 to 120 in 1929.[140]

The health needs of African Americans, underserved by the state and federal governments, gave middle-class Black activists the determination to take control of Black health and construct their own public health network. Although Black middle-class mothers could generally afford some care and had access to a small number of available Black hospitals, local, state, and national social movements "made coordinated efforts to improve the status of African Americans by developing, amongst other things, better health" by organizing community activities, promoting health education, and setting up health clinics.[141] In 1922, Black leader Robert Moton contacted the Bureau's Grace Abbott requesting continued "cooperation . . . for health improvement. Whatever you may do to call this matter to the attention of the general public and also to those under your supervision will be greatly appreciated."[142] In Mississippi, the Bureau provided additional funds for a Black female doctor, Ionia Whipper, to oversee the supervision and training of Black midwives because Bureau leaders thought a Black health professional would be more effective.[143] This evidence suggests that the Bureau was neither blind nor indifferent to the needs of Black mothers. But as historian Susan Smith rightly observes, "African Americans were not a political priority

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[140] "Promotion of Welfare and Hygiene of Maternity and Infancy" (n. 28), 135; U.S. Department of Commerce, Bureau of the Census, "Historical Statistics of the United States, 1789–1945" (Washington, D.C.: Government Printing Office, 1949), 46.
[141] Smith, *Sick and Tired of Being Sick and Tired* (n. 39), 10, 36, 52–54, 56.
[142] Letter from Robert Moton to Grace Abbott, December 15, 1921, box 225, Central File 1921–24, CBR, RG 102, NARA.
[143] Letter from Grace Abbott to Salina Shaw, December 9, 1930, box 367, Central File 1929–32, CBR, RG 102, NARA; letter from Dr. Blanche Haines to Helen Bond, June 20, 1927, box 279, Central File 1925–28, CBR, RG 102, NARA.

for government officials" and women's pregnancy needs were not met with any general improvements.[144]

Conclusion

Until the 1920s, physicians demonstrated no significant interest in managing prenatal care. Following the introduction of the Sheppard-Towner Act and the Bureau's initiative to advance prenatal care, doctors began to support its medicalization. This move reflected not medical or scientific advances but economic opportunism in the face of a changed political environment.[145] The Bureau and the medical establishment promoted the notion that a doctor "knows best." Particularly in rural areas, many women lacked the resources to follow this advice. With restrictions placed on midwives and a refusal to promote advanced midwifery training as a cheaper, practical alternative to physician-assisted care, many rural women faced inadequate support. Interlocking oppressions of class, location, and race limited rural women's opportunities to access care that fit recommendations based on urban, white, middle-class norms.

Bureau staff were not in a political position to influence the types of systemic changes rural women needed. They faced a politically assertive medical establishment and had little influence over state and federal government departments that oversaw infrastructure investments. The first female federal department often found itself in conflicts with the Public Health Service, which was run by medical men. One might speculate that an effort to avoid conflict and turf wars led to a more quiet, nonconfrontational style of advocacy from the Bureau, whose staff may have felt vulnerable in the face of hostility to their agenda and

[144] Smith, *Sick and Tired of Being Sick and Tired* (n. 39), 58.
[145] Borst, *Catching Babies* (n. 11), 91.

their very presence. With 125,000 letters a year pouring in, a small budget, and reliance on volunteer labor, Bureau staff were likely to be time poor and emotionally stretched thin. Staff did what they could within the limits of their remit and power.

In the words of historian Shelia Rothman, the Bureau and the medical profession "in the 1920s created the system, and the problems, with which we are struggling today."[146] The Bureau unintentionally contributed to the development of a medicalized and largely privatized medical system that opposed "any plan embodying the system of contributory insurance . . . which provides medical services . . . regulated by any state or Federal government."[147] This led to health care inequality among disadvantaged groups, and adversely effected infant and maternity care outcomes among women compared to European nations that adopted some form of compulsory national health insurance. Although maternal deaths have significantly declined since the 1920s, the United States still has the highest rates as compared to other industrialized nations, with this ratio increasing in recent years. In 2017, the United States had a rate of about 1.9 deaths per 10,000 live births, while Sweden and the United Kingdom had rates of 0.4 and 0.7, respectively.[148] The status of midwifery in the United States lags behind those of other countries. In the United Kingdom, midwives deliver half of all babies, while in the United States midwives attend almost 10 percent.[149] It is estimated that five million women currently are unable to access maternity care in over a

[146] Rothman, "Women's Clinics or Doctors' Offices" (n. 44), 177.
[147] "Minutes of the Seventy-First Annual Session of the American Medical Association," *JAMA* 74, no. 19 (1920): 1317–28, quotation on 1319.
[148] Max Roser and Hannah Ritchie, "Maternal Mortality Ratio," Our World in Data, n.d., https://ourworldindata.org/maternal-mortality.
[149] "Frequency and Trends," Birth by Numbers, n.d., https://www.birthbythenumbers.org/midwifery/.

thousand U.S. counties, with rural, Black, and low-income women particularly vulnerable.[150] Preventive care and a push toward midwifery-based care provide no financial benefit for physicians.[151]

Bureau policies and practices brought prenatal care for the first time to the forefront of American conversations about pregnancy and childbirth. A century later, a long road continues to stretch ahead to bring rural women, especially in African American communities, the care they deserve. One lesson from this history is clear: education alone is not enough. The socioeconomic and political contexts in which didactic approaches are deployed shape women's ability to adopt behaviors that lead to better health outcomes. Evidence from the Bureau's effort demonstrates that it is not that women are unreceptive to the advice so much as structural obstacles related to race, class, gender, and geography need to be mitigated. And, of course, such deep changes are much more difficult to achieve than disseminating good advice—a necessary but insufficient step to lowering infant and maternal mortality.

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[150] Natalie A. DiPietro Mager et al., "Routine Healthcare Utilization among Reproductive-Age Women Residing in a Rural Maternity Care Desert," *J. Commun. Health* 46 (2021): 108–16.

[151] For a discussion on prenatal care and the lack of scrutiny over the number of scheduled prenatal visits, see Alex F. Peahl and Joel D. Howell, "The Evolution of Prenatal Care Delivery Guidelines in the United States," *Amer. J. Obstet. Gyn.* 224, no. 4 (2021): 339–47.

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