

Rockefeller Foundation and Health Demonstration Projects 1920-1940

By Patricia D'Antonio

Ph.D., RN, FAAN
University of Pennsylvania School of Nursing
Philadelphia

dantonio@nursing.upenn.edu

© 2011 by Patricia D'Antonio

On November 10, 1921, New York City's East Harlem Health Center Demonstration Project opened to great fanfare. The project self-consciously characterized itself as a "department store of health and welfare," playing on the success of the urban institution that promised everything that one could imagine buying, in one central location. Similarly, the East Harlem Health Center gathered over twenty three of the neighborhood's health and social welfare agencies into one newly refurbished building for the same kind of "one stop shopping" for coordinated health and welfare services. The concept of "coordination" was key to the success of the demonstration. Public and private agencies would keep control of their budgets and personnel, but the demonstration would test the premise that physical proximity would eliminate costly service duplication, ease access to resources needed by the predominantly Italian community, and, in the end, deliver better health outcomes.¹

A little more than a year later, in December 1922, a sister demonstration, the East Harlem Nursing and Health Demonstration Project, started its work with less attention but no less import. Unlike the Health Center, the Nursing Project would be an effort in "control" rather than cooperation involving the neighborhood nursing services in one half of the East Harlem district. The three private agencies that supported specialized East Harlem nursing services were: Henry Street Visiting Nurse Service (VNS) focused on nursing the sick in their homes, Maternity

Center Association (MCA) for prenatal and home birth services, and the Association for Improving the Condition of the Poor (AICP) supporting tuberculosis nurses. These agencies pooled their resources, personnel, and dollars into one controlling organization that would prove that a generalized nursing service could better serve the needs of the neighborhood for sick nursing and for maternal-child health education.² Negotiations to make the Nursing Project a reality proved more complicated than those involved with the Health Center. Lillian Wald, the internationally renowned founder of the Henry Street VNS, remained profoundly skeptical. She believed that the worth of generalized nursing—a system in which, similar to the VNS, one nurse had responsibility for all the needs of a defined neighborhood—needed no additional proof. Wald finally agreed to participate only after MCA nurses agreed to withdraw their prenatal work from homes to outpatient clinics, leaving all home visiting with the domain of VNS nurses.³

Historians have paid some attention to health demonstration projects like those in East Harlem in the interwar years. The brief accounts that do exist are embedded in the histories of the foundations and private organizations that supported the projects or in the histories of city and state public health departments that looked to them for their policy and practice implications.⁴ The Nursing Project, in particular, has been recognized for its profound success in situating generalized nursing as the ideal norm for all public, as well as private public health nursing.⁵ Yet, a deeper look at both the East Harlem Health Center and the Nursing Project suggests that it is equally useful to think about the processes—not just the outcomes—involved in the coming together and moving apart of the different organizations, disciplinary interests, knowledge domains, and spheres of public and private responsibilities involved in caring for those in need. Furthermore, this is especially timely. The United States stands ready—through the new Patient Protection and Affordable Care Act (ACA) to commit \$11 billion dollars to

bolster and expand the capacity of community health centers to provide comprehensive, high quality, and coordinated care that will target health disparities for low-income individuals, racial and ethnic minorities, rural communities and other underserved areas. An historical understanding not only of what worked and what did not, but also of why and how some projects succeeded and others failed, is essential background as we look towards future ways policymakers and clinicians can improve the health and welfare of all individuals and families, not only the disadvantaged.

Background

Both contemporaries and historians recognized New York City's place as the epicenter of the public health world in the immediate aftermath of the World War I. Under the leadership of Hermann M. Biggs, the city attracted international attention for its school health, immunization, tuberculosis control, and clean milk reform initiatives. They also recognized the City's place at the epicenter of the nursing world. Institutions such as the VNS at the Henry Street Settlement House and Teachers College at Columbia University attracted and trained public health nursing leaders from around the globe.⁶

However, for all its successes, New York City still faced seemingly intractable health issues among its poor working class and immigrant families. These included high infant mortality rates, poor prenatal care, and insufficient attention to the prevention and treatment of tuberculosis. In ways that pre-date what we now describe as the social determinants of health, New York's public health leaders clearly understood the relationships among the conditions in which families lived, the material resources available to them, the access to education available to their children, and their health status. Nevertheless, issues of access and equity to the essential social and health services necessary to allow mothers to raise healthy infants, to help children

achieve in school, and to enable breadwinners to remain productive at work—issues that sound frighteningly similar to those experienced by today’s families from disadvantaged and minority backgrounds—remained highly problematic.⁷

The recently won World War had seemingly proved the power of coordination in effectively and efficiently meeting the extraordinary demands of military and civilian populations; and while most Americans entered a health care system dominated by the private physician-patient relationship, the idea of “coordination” filtered into the post-war health care delivery dialogues about the needs of the poor and the dispossessed. In particular, the American Red Cross had decided that its newly reconfigured peacetime mission would concentrate on the more effective coordination of available social and health services in areas where they already existed, and in the development of new ones in more poorly served parts of the country. It charged local chapters with bringing together community leaders in government, philanthropy, and business to create carefully constructed and coordinated “health centers” that would best serve the needs of defined constituents.

In Boston, for example, the city’s health department took the lead in establishing the Blossom Street Health Unit for the North End’s predominately eastern and southern European immigrant families. With the financial help of philanthropist George Robert White, it brought the city’s private Community Health Association, the Family Welfare Society, the Catholic Charitable Bureau, and the Associated Jewish Philanthropies together within one building, for more effective social service and health care coordination. In another example, on the other side of the country, the vast Los Angeles County decentralized its health department and encouraged more rural areas to test different ways of providing easier social service and health care access to the Mexican and black families they served.⁸

The idea of health centers was not new to New York City. In the late nineteenth century, public health nurses, politicians, and philanthropists joined forces to create local infant welfare stations to promote clean milk and breastfeeding in the battle to decrease infant mortality. In 1914, S.S. Goldwater, the city's Health Commissioner, opened a geographically defined health district in the Lower East Side to try to bring the work of the Health Department closer to the individuals in need. The success of this initiative led Goldwater's successor, Haven Emerson, to extend the concept to the entire borough of Queens, carving it into four new health districts. However, as was so often the case with early twentieth century public health departments, a change in political administration brought a change in both health commissioners and public policy. The new Tammany government of 1918, abetted by health department bureau chiefs who saw their centralized authority diminished by local district administrators, abolished these health districts.⁹ By the early 1920s, a once brilliant New York City Health Department had entered what its historian, John Duffy, describes as the "Years of Travail."¹⁰ Political patronage rather than service delivery became the function of the Department. Demonstration projects, like the East Harlem Health Center and Nursing projects, would serve as bracing antidotes to this malaise.

Bailey B. Burritt, the General Director of AICP, and Homer Folks, a member of the Board of the New York County chapter of the American Red Cross (ARC), took the lead in turning the idea of these projects into a reality. The national offices of the ARC had pledged a building, and, in keeping with the practices of other ARC—sponsored health demonstration projects across the country. The local chapter surveyed the various neighborhoods in the city and it eventually chose East Harlem, a defined geographic district recognized by the city's health department, as the site of the projects. It met criteria because it was a defined local area of

approximately 100,000 people with twenty-three private health and welfare agencies who agreed to cooperate. However, it did not meet criteria because it hardly represented a cross-section of the city of health outcomes and standards of living.¹¹ Yet, the organizers realized, in the socially, ethnically, and racially stratified world of New York City neighborhoods, there seemed no such geographically defined area that could.

The officially defined boundaries of East Harlem stretched from Third Avenue to the East River and East 99th Street to the Harlem River. It was home to what the city recognized as the “largest Italian colony in the western hemisphere.”¹² It grew as late nineteenth century immigrants from Southern Italy sought relief from the traditional yet overcrowded ethnic neighborhoods of the Lower East Side. However, their standards of living hardly improved. Most tenements were dilapidated “old law” buildings with shared outdoor bathrooms and no running water. A few men worked as skilled artisans, but most of them were employed as laborers, factory hands, or petty tradesmen, and one third of its women had to supplement their families’ incomes by working at home making paper flowers or sewing factory-consigned garments.¹³ With the post-war immigration restrictions, their numbers were evenly split between those foreign born and those of foreign parents. East Harlem residents were in desperate need of health services. They and their babies died at rates greater than those of New York City as a whole. In the period between 1916 and 1920, adults in East Harlem suffered a 15.3 (per 1,000) mortality rate as compared to 14.7 in the city; during the same time period, their babies died at rates of 100.6, rather than the 83.2 mortality rate for the city as a whole.¹⁴

Burritt and Folks, as did others involved in health demonstration projects, knew well that outcomes of health coordination and nursing cooperation had to be systematically and statistically assessed, not just simply promise success. The projects’ potential to generate data to

improve access, decrease costs, and develop models of effective care could be used across the country to win important philanthropic support, bolstered from private agencies and public health departments—in New York City, this inevitably meant the Rockefeller Foundation (RF), whose Laura Spelman Rockefeller Memorial (LSRM) had already provided important and continuous support to the Henry Street VNS, the MCA, and the AICP. John Dr. Rockefeller, Sr. (JDR) established the LSRM in 1918 to honor his late wife's commitment to public welfare and to issues affecting women and children.¹⁵ With written assurances that coordinating and cooperating health and welfare agencies would pledge either money or equivalent services, the LSRM agreed to a three-year \$32,000 donation in 1921 that matched that of the private agencies. A second three-year appropriation of \$32,000 in 1922 launched the Nursing Project.¹⁶

Beginning the Demonstrations

In addition to the existing health and welfare services, the initial three year demonstration period saw a dizzying array of health and welfare services coordinated, consolidated, and created. Under the leadership of Kenneth Widdemer, the Health Center's executive director, and with the input of a House Council of representatives of affiliated agencies, the Health Center strengthened its focus on getting adults access to general medical exams as a way to identify potential problems before they became serious diseases; worked together to establish new cardiac clinics to address what was quickly becoming one of the leading causes of adult mortality; collaborated with the city to provide dental services to the district's school children; reorganized TB prevention work to more closely follow children deemed at risk; systematized record keeping; and canvassed the neighborhood families to both learn about their perceived health and welfare needs, and to make them aware of the resources at the Health Center. The data were impressive. The calculated costs per capita rose twenty-seven cents, but the numbers

of individuals served rose 109%. Infant mortality declined 36% by 1923 as compared to the city's decline of 25%, and the death rates from all causes of mortality now mirrored that of the city at large: 1,176 per 100,000 in East Harlem and 1,171 per 100,000 in New York City.¹⁷

The Nursing Project, under the direction of Grace Anderson, formerly head of the Municipal Nursing Service in St. Louis, flourished as well. It launched a well-designed comparative study of the effectiveness of generalized versus specialized nursing, with carefully matched East Harlem neighborhoods organized either to receive care from an array of nurses specializing in maternity, infant welfare, pre-school, and sickness care or to receive care from one nurse who had specialty consultants available to her at the Health Center. It had also reworked its recordkeeping system to also include length of time of nursing visits to enable another study that would compare the costs of different kinds of nursing home visits. In addition, it had plans in place to study the nutritional status of children with pneumonia, as malnourishment was seen as marker of a child at risk. Their work, often invisible in the published reports, substantively contributed to the district's impressive outcomes, and their faces were often seen in the neighborhood: two years of data documented 63,500 visits to individuals and families throughout the district.¹⁸ In 1925, the LSRM approved funding for two more years of both demonstration projects.¹⁹

However, fissures were emerging in the Health Center's plans for cooperation. In 1924, the American Red Cross abruptly announced its withdrawal from the national health center movement and its expectation that local agencies would assume increasing financial responsibilities and administrative costs.²⁰ Furthermore, the agencies themselves were rethinking their commitment to coordination. Some had had to redraw their own long-established practice boundaries to conform to those of the Health Center and others found themselves providing more

resources to the families in East Harlem then they did to those in other neighborhoods of the City. Certainly, as Folks explained to Beardsley Ruml, the new director of the LSRM, in May 1925, there had been some “misgivings” on the part of some participating organizations when plans were first presented to them, but the ultimate success “was even greater than anticipated,” and all agreed to continue past the initial three year commitment.²¹ However, the LSRM had begun to hear otherwise and launched its own survey in early 1926. If there were, as its own internal memos noted, a “spirit of cooperation” among those actually working at the Health Center, this did not hold true when LSRM officials discussed the Center with the leadership of the participating organizations.²²

Issues of privilege and prerogative, colored by class and religious biases, had undermined prospects of real cooperation. Certainly, Lawson Purdy, the director of the City’s Charity Organizing Society (COS), had deep reservations, since it actually cost more, he explained, to keep his organization with the Health Center, because his social workers were “of higher intelligence and better trained” than those from other agencies, and they wasted a great deal of time correcting the mistakes of those agencies’ workers.²³ Lillian Wald, speaking confidentially, felt the Health Center accomplished little, and because the Center made no attempt to charge any fees, was badly organized and contributed to the pauperization of its patients.²⁴ In addition, as Homer Folks did admit, Catholic relief organizations contributed little to the Health Center, placing spiritual values above social welfare work, and they were also, he reported, quite content to have the secular AICP take on their cases.²⁵ Furthermore, Bailey Burritt, when carefully questioned about how the health statistics differentiated the work of nurses from that of other workers in the Health Center, found he could not answer. The numbers, he conceded, were “all jumbled together.”

The case against the Health Center continued to mount. In 1926, Louis I. Harris, the newly appointed City Health Commissioner, announced plans to form the Welfare Council of New York City, an organization that would eventually bring together three hundred thirty-two of the City's largest health and welfare agencies for advice and consultation.²⁶ The medical and policy advisors to the LSRM strongly recommended abandoning East Harlem and supporting the initiatives of the Council as they emerged.²⁷ In all likelihood, Ruml needed little encouragement. Under his leadership, the LSRM increasingly sought to disentangle itself from the local health and welfare projects it had sponsored in the past and move into supporting research in the new social sciences affecting children's health, psychiatry, and race relations.²⁸ In a tactful letter to Homer Folks in April 1927, Ruml explained how the LSRM had stopped funding projects in public health and public health nursing, but that it was aware of the LSRM's historical commitment to New York City.²⁹ The Health Center received bridge funding to mitigate the impact of its closing on the East Harlem community until 1931, when the City took possession of the Health Center and promptly closed it.³⁰ The Nursing Project continued, freed from "jumbled up" measures of its work, could then began its journey toward what it would later call "a new approach" to health work.³¹

From a Nursing and Health Demonstration Project to a Nursing and Health Service

In early 1927, aware that dedicated funding from the LSRM for a demonstration project would stop in December, the leadership of the East Harlem Nursing and Health Demonstration Project convened a "Continuation Committee" of its most important constituents. Chaired by Bailey Burritt, it included Hazel Corbin, the director of the Maternity Center Association; Florence Johnson, the director of nursing service of New York City County's American Red Cross; Margaret Nourse, the President of St. Timothy's League, a new group of lay women

supporting the Project; Marguerite Wales, the director of nursing at the Henry Street VNS; Alta Dines, the AICP's nursing director; Homer Folks, now in his capacity as Secretary of the New York State Charities Aid Association; as well as Grace Anderson, and her assistant, Mabelle Welch, from the Nursing Project. A new constituent, Lillian Hudson, an assistant professor of nursing education at Teachers College at Columbia University (TC), also joined the group. As the Committee reviewed the Project's accomplishments, it became clear that a teaching mission had slowly grown up alongside its service one. In past years, it had hosted increasing numbers of public health nurses from around the country, international nurse fellows supported by the RF, and post-graduate public health nursing students from TC. As it looked to the future, the Project envisioned enlarging its service mission and formalizing its teaching one.

The Project had already established an excellent service reputation. It also had the strong support of Mary Beard, a powerful presence in public health nursing and the Assistant Director of the RF's Division of Nursing Education. "It seems to me," she noted in 1927 after visiting the Project with the President of the American University in Beirut, "far and away the best place to observe health work for mothers and babies in New York ... One might easily have spent a week going from home to home with a public health nurse and not have seen so great a variety of health instruction as we saw that morning."³²

Over the next five years it hoped to expand the service to the entire East Harlem district, work toward a more fully integrated nursing service, and offer posture work for pre-school children.³³ It also wanted to fundamentally change the way nurses taught and thought about their patients. Rather than thinking only about the health content needed, nurses now needed to think about the context in which the content would be delivered. They had to use ideas borrowed from mental hygiene to think about the personalities of those receiving their messages;

understand the attitudes that existed among members of the family of which the individual was but one part; and know the “desirable” and “undesirable” traits that might affect the lives of the mother and child in the present and in the future;³⁴ and then nurses could begin their health teaching.

The Project then envisioned another new goal moving forward, that of forging a more permanent and formal relationship with TC for post-graduate education for public health nursing leadership.³⁵ It fell to Folks to convince the LSRM of the wisdom of this expanded vision of the Nursing Project as a service and a teaching site. Not only had the Project provided the definitive data that established generalized nursing as the ideal norm, Folks argued, it had also captured data on the various costs of nursing care. It had expanded its services to include all mothers, infants, and children up to their start of school. It served the RF well as a training site for their nursing fellows from Japan, China, the Philippines, and central and southern Europe. It now wanted to work with the Teachers College to establish a formal Institute of Nursing Education for graduate nurses at the Demonstration.

Nursing and the Rockefeller Foundation

The RF balked.³⁶ Richard M. Pearce, then the RF’s Director of Medical Education for the International Health Division (IHD), had been watching developments in East Harlem with increasing alarm. His division oversaw the development of nursing as well as medical education in countries in which the RF had supported development projects. He worked closely with Beard to identify the women chosen for fellowships to study U.S. public health nursing practices, and as early as 1926 she had mentioned to him that a request for additional support for the Nursing Project seemed “inevitable.” Pearce, careful to acknowledge that he had no authority over the LSRM’s policies, constructed a memo to his RF colleagues clearly outlining what he believed

the IHD's position should be. It had no interest in either the Health Center or the Nursing Project. Granted, he conceded, its role in training public health nurses did involve the educational initiatives supported by the Division of Medical Education (DME), other than the fact that it was completely unrelated to the RF's main objective—undergraduate training for public health nurses. The Nursing Project would propose RF support of a graduate program, and stand in direct contradiction to the RF's practice of only supporting nurse training schools associated with teaching hospitals of medical schools.³⁷

East Harlem's request also came at a turning point in the RF's nursing's policy. The RF had always been clear that its support of nursing was directly connected to its support of medical education and public health, both in the United States and abroad.³⁸ From its initial work on hookworm control in the early twentieth century American south, the RF had developed global programs in medical education, research, and public health. Its commitment to help rebuild the public health infrastructure of war-torn Europe crystallized what, for the RF, was the critical issue related to public health nursing—what kind of education did a public health nurse need for effective practice.

The RF believed that its support of “light-house” nursing schools in the United States, Canada, and Western Europe would point the way. They hoped that these schools, associated with colleges and universities, rather than hospitals, would graduate fully functioning public health nurses in as little as two years. It expected that these “progressive schools” would change fundamental undergraduate nursing courses in ways that emphasized public health as well as bedside nursing practices. Instead, to the frustration of RF officials, these schools either could not or did not do so. Nursing educators of schools at such universities as Yale, Vanderbilt, and, to a lesser extent, Toronto, took the position that public health nurses needed to be—first and

foremost—fully trained nurses exposed to all areas of nursing practice, including: nutrition and medical, surgical, obstetrical, pediatrics, and mental health nursing. Their ostensible model replicated that of medicine—a traditional four years of medical school followed by post-graduate training in newly fashioned and research intensive schools of public health.³⁹

Moreover, by 1927, it had become evident that the RF's administrative structure was too unwieldy. The Rockefeller Institute for Medical Research and four Rockefeller Boards (the Rockefeller Foundation; the General Education Board; the International Education Board; and the Laura Spellman Rockefeller Memorial) seemed to outsiders unrelated, independent, and equally available for grants. Within the RF, so many administrative structures created a “twilight zone” into which applications that were not obviously within the domain of the humanities or the natural and social sciences might disappear without adequate consideration.⁴⁰ In 1929, the reorganization was legally official and the RF now had two boards, the Rockefeller Foundation, which now included the IHD, and the General Education Board. The LSRM was dissolved.⁴¹

Nursing initiatives now lay within the purview of the RF, with those involving U.S. proposals under the direction of Thomas B. Appleget, one of its vice presidents. Those involving international ones were under Pearce, who was as unhappy with the direction of RF funded nursing initiatives abroad, as he was with East Harlem, and consequently had already ordered a complete review. Remember also, that he had warned his staff that the RF's interest in public health nursing education remained at the undergraduate level, conversely, responsibility for graduate nursing education lay with particular governments.⁴²

In 1927, the still existing LSRM remained strongly supportive of the actual work of the East Harlem Nursing and Health Demonstration Project. Moreover, concerns that the pending reorganization might constitute a “public relations disaster” if no provisions were made for the

kinds of charitable philanthropy embodied in the traditional LSRM grants, therefore strengthening the Projects argument for another five-year grant to continue its service mission.⁴³ Nevertheless, despite resolute claims that the service and teaching missions were “inseparable” the RF refused to move to support graduate public health nursing education. To do so would not only be to contradict its stated policies, but it would be an admission that the dream that someone, somewhere, somehow, could create a real undergraduate school of public health nursing was unrealistic. Since this kind of teaching was still seen as experimental, TC refused to underwrite all its costs. The Milbank Memorial Fund, supporting its own demonstration project in the Bellevue-Yorkville section of the city, agreed to fund TC’s Institute at East Harlem.

The Nursing Project, secure in another four years of support from the RF and the pooled resources of the four cooperating nursing agencies, set about to create a formal “family nursing service” that would more fully integrate knowledge from nutrition and mental hygiene into their work. As the representative agency in East Harlem for the HSS Visiting Nurse Service and the Maternity Center Association, it would use the “medical-nursing approach” of these “covering” services as the basis to build the “relationships for the educational work that would continue long beyond the acute need for the initial service.”⁴⁴ In addition, it would develop a “common program of health education” that would be carried into the home by one nurse whose relationship with the family would continue over time.⁴⁵ In 1928, it brought the demonstration part of its work to a close, and renamed itself the East Harlem Nursing and Health Service.

A New Approach to Nursing

There were some substantive differences between the Nursing Project and the new Nursing Service. The nurses’ data on the extent of malnourished children in East Harlem had led first to hiring a nutritionist to work with at risk families, but they quickly discovered they could

reach further into the community if they used the nutritionist as a consultant to their own work with families. This became the model as they worked to also incorporate knowledge from mental hygiene into their practice as they brought experts onto their staff. Rather than reporting their pre-natal and health work with mothers, infants, and children as separate categories, they spoke more directly to their work with families as a whole. By 1931, they had worked out a consistent message to the RF, whom it still wanted to support its new educational initiatives. Grace Anderson, in her summary report to the RF on the work of its Teaching Service, spoke directly to its significant success in the “pooling of professional knowledge and skills in working out the essentials of a family health program for the community.”

Only in East Harlem could observation and practice be directly correlated with theoretical instruction in education, psychology, sociology, nutrition, mental hygiene, and social case work. Its students from around the globe learned about family relationships in class and focused on improving them in practice. Unlike what was available at Henry Street, it provided its students with a “social laboratory” in which new experiences were translated into new principles and practices.⁴⁶ This required not only a change in focus, but also one in methods: traditional public health nursing checklists had evolved into narrative Family Data Sheets transcribed by stenographers; and health clinics and conferences at the Center became ones where a mother would bring all her children at one time rather than sequentially to identified infant or pre-school health screenings. However, most of all, it meant more aggressively promoting the mental hygiene aspects of the new nursing role to a wider audience.

The 1920s and 1930s had witnessed a resurgence of the mental hygiene movement that offered a potentially new knowledge base—that of psychoanalytic theory—that leading nurse educators hoped would buttress nursing’s claims to specialized knowledge and independent

practice. Two threads consistent with the mental hygiene movement ran through East Harlem's new approach to family nursing.

First, there was no longer any notion of a “normal” family. The pervasive idea of “adjustment” as a signifier of mental health and illness now meant that “to be normal is to have a problem of adjustment to work out.”⁴⁷ All families needed mental hygiene help. In fact, to be “normal” was to be in need of advice “about innumerable things from a friendly person in whom one has confidence.”⁴⁸ Additionally, patients, sometimes termed pupils, would necessarily have that confidence in one who nursed the sick when she returned to tell an expectant mother about infant care feeding and the best weaning practices that would encourage both excellent nourishment and emotional independence. One well-publicized metric of the Nursing Service's success, in fact, lay in convincing Italian mothers to stop breast feeding at their infants' six month birthday. The Italian mothers' tradition of lengthy breast feeding, it believed, was based only on economic insecurity and superstition, and was a significant cause of malnutrition. Their metric of success—after intensive education, fifty percent of the Italian mothers had stopped breast feeding their babies by eight months of age.⁴⁹

The second thread consisted of the intense scrutiny expected by the nurse of herself as well as the family in her care. To be more “objective”—to have the capacity to deal with a family's situation without allowing her judgment to be affected by emotions, assumptions, biases, or pre-conceived notions—she had to constantly examine her own thoughts and feelings. She had to learn how to be more passive by waiting for her patient to tell her what she needed, rather than actively assuming what she needed to be taught.⁵⁰ Indeed, the nurse had to be open to the pain as well as the joy of her own emotional life, so that she could accept that of others.⁵¹ One important role of the mental hygiene consultant, Pease concluded, was helping the nurse

perform a sometimes painful self-examination,⁵² but the stakes seemed high. As Pease concluded her speech to public health nurses in Canada in 1934, the public health nurse directly affects the process of family building. In a successful family, “people who have known love and security and a chance to be independent in their first years are not likely to become insane or neurotic as adults, and because happy people do not commit crimes nor does a contented nation make war.

Homer Folks also carried the message to the RF as the chair of the Nursing Service’s Board of Trustees. As he wrote Thomas B. Appleget, the RF vice president, to whom the Service now reported, the Service was now a successful “family service”—and its success lay in its specific recognition “that public health nursing is a complex undertaking which must derive many of its techniques from specialists in other fields.” The teaching and supervisory staff at the Service now included nutritionists, mental hygiene specialists, social case workers, teachers, and physicians. Mindful of the concern about where and how a public health nurse should be educated, he also noted the strategic position of a fully trained nurse. Through calls from a mother looking for prenatal care for herself or home nursing for a sick child, such a nurse reached “a cross-section of the community—families that would not be known to other agencies.”⁵³ He emphasized this in 1932, calling attention to the increasing interdisciplinary nature of the family service. “The Nursing and Health Service has disregarded the barriers that exist between professional groups,” he wrote, “and has brought experts in nutrition work, in mental hygiene, in social work, and in education into a close working relationship with nurses and physicians to the end that a more complete service may be rendered to the people of the community.”⁵⁴

The RF was, in fact, very interested in interdisciplinarity and by the late 1920s began funding an increasingly coherent program of research that focused on the “science of man” and

called for “fearless engineering” to integrate the social sciences with the biological, medical, and natural sciences. The results eventually lay the foundation for a new field of science, molecular biology,⁵⁵ but however fearless, this program of research centered on a particular vision of science that assumed the reductionist stance that one could isolate and measure discrete variables likely to have the most significant impact. As Ellen Lagemann has argued this inherently gendered stance blinded RF officials to alternative modes of inquiry that might focus on a more inclusive, comprehensive, and responsive attempt to employ a more multifaceted approach. RF officials supported new definitions of “research,” yet they dismissed all other research as “propaganda” by well-meaning but pre-professional (usually) women.⁵⁶

RF officials remained unmoved by the Nursing Service’s pleas. In December, Folks, Burritt, Anderson, and Welsh had a “protracted discussion” about the long-term future of the Service when current funding ran out in 1933. They considered two possible options: changing its location or formalizing a relationship with an educational institution. They rejected both, and decided to be quite daring. They decided to remain independent and asked the RF for a commitment of ten years of funding. It fell to Folks to deliver the message again in January 1932. Appleget was clearly alarmed and he noted in his diary that Folks wanted to preserve the integrity of the Service by suggesting that the RF take on the renewal of its commitment and that of the Milbank, with no end in sight until the final endowment of the project at the end of an eight year period. Diary entries were circulated among key RF officers to keep everyone aware of new and continuing initiatives. Appleget made sure his diary entry documented the fact that he gave Folks no possible encouragement that such a request would be considered. A more considered response came in May. The RF would not endow the Service or provide any funding for the educational component, but it did acknowledge the value of its work and that a complete

withdrawal of support would be a “hardship” on the people it served.⁵⁷ The RF agreed to an additional, and tapering, four years of funding, and began helping in the search for an alternative institution that might support the Service and allow it to continue.⁵⁸

A Changing Landscape

“Hardship” scarcely captured the conditions in the early years of the Great Depression and the accompanying unemployment that hit the East Harlem community early and hard.⁵⁹ An impressionist 1931 survey of New York City’s nurses and social workers reported “unusual and disturbing reports of suffering” and families delaying health care to pay rent and purchase food.⁶⁰ Also, the Depression had taken its toll on private voluntary agencies that could not meet overwhelming and legitimate needs for economic relief. In a complete reversal of numbers attending its opening in 1922, ninety-eight percent of East Harlem families needing relief were supported by first state and later federal dollars; only two percent were receiving support from private agencies at that time.

On the other hand, those same federal dollars undercut the Service’s own community focus. Fiorello LaGuardia, a child of East Harlem, and at that time mayor of New York City (NYC), was committed to both public health (his first wife and their child died of tuberculosis) and to the new federal construction dollars available through the Work Projects Administration. Under his watch NYC secured millions of dollars to expand dental screening programs, pre-school health exams, add public health nurses to the Health Department rosters, build hospitals, and to eventually bring neighborhood health centers to twenty identified districts in NYC. In 1935, one of the first such centers was built in LaGuardia’s own community of East Harlem.⁶¹

The Welfare Council that the LSRM had been urged to support had also emerged as a powerful research and advisory body to NYC. The Council’s 1929 report, *A Health Inventory of*

New York City, presaged the changing health care landscape. Constructed by the well-known health care reformer, Michael Davis, the inventory noted the problematic nature of public and private care coordination that spurred the development of health demonstration projects across the United States in the early 1920s. It also noted changes that he felt bode well for the future: the rise in the numbers of hospitals whose own outpatient clinics took health prevention and care coordination more seriously; the sharp increase in the numbers of individuals across NYC using these clinics; the “dissolving” boundaries between private medical practice and public health promotion.⁶² Davis was less enthusiastic than most about the plans to carve the city into health districts. The entrance of hospitals as increasingly important institutions in the health care area, he believed, had a “radical” effect on the delivery of home health care services and lessened the need to think about placing health centers in areas well served by these institutions and their growing outpatient departments.

Even the families that the East Harlem Nursing and Health Service were committed to serve were changing. Due to immigration restrictions, by the mid-1930s sixty percent of the population of the East Harlem Nursing district was born in the United States and only thirty percent had been born abroad; and the Service had noticed a decreasing demand for Italian translators.⁶³ Birth rates to young parents had plummeted more than fifty percent and families were growing smaller in size, a trend abetted by a neighborhood birth control clinic, and noted with approval as the East Harlem nurses felt that the children received additional and improved attention. Infant mortality had fallen to fifty-six per one thousand, as compared with seventy-four in 1923. However, maternal mortality remained more intractable because its prevalence remained the same as in 1923.

Equally significant, almost overnight, hospitals had replaced homes as the preferred site of births, and physicians had replaced lay midwives as the preferred attendant. Up until 1927, eighty-five percent of births had been in home, and by 1934, sixty-five percent occurred in hospitals. “Young mothers,” Anderson reported to her governing board, “look upon hospital care quite differently than did their foreign-born parents.”⁶⁴ East Harlem’s one outpatient medical clinic had closed by 1933, as doctors’ care now came through hospitals, hospital-based outpatient clinics or private practice. Now, the East Harlem nurses’ first responsibility when called for a pre-natal visit was to ensure that mothers registered at the hospital in which they hoped to deliver, as soon in their pregnancy as possible, and afterward they would begin their own work.

The Fight to Save East Harlem

The fight to save the East Harlem Nursing Service, in general, and its teaching mission, in particular, fell to Mary Beard, who, after the reorganization, became the RF’s Associate Director of the IHD, now the only Division within the RF that had any interest in nursing. The IHD had been continuously supporting women who might assume leadership positions in the countries where the RF had made an investment in medical sciences and public health by awarding fellowships to study in the United States. The East Harlem Nursing Service, along with Vanderbilt’s, Yale’s, and the University of Toronto’s School of Nursing had been consistently part of the fellowship experiences. The support of the IHD was critical.

At the outset, Beard called a dinner meeting of the Board of Directors at the women only Cosmopolitan Club on March 13, 1935. The discussion extended past midnight, but the strategy for approaching Frederick Russell, the head of the IHD, was finalized (Pearce had retired in 1930). Granted, Beard wrote Russell two days later, explaining that the RF had no interest in

graduate education for public health nursing leaders, but that sustaining the work of the East Harlem Nursing and Health Center was “one of those decisions which sometimes have to be made which are exceptions to the rules.”⁶⁵ It stood “head and shoulders” above other teaching centers, and was a far superior developed practice field for public health nursing than, she emphasized, *any of the schools of nursing* in which the RF was interested, including the University of Toronto, a RF nursing favorite. It broke new ground in working to prevent mental illness through its family health teaching and had “become the very kind of practice field which the IHD is attempting to foster all over the world.”

“Public health nurses,” Beard continued, “cannot be educated without such a teaching field.” Although, keenly aware of the RF’s aversion to fund any project that lacked independent sustainability,⁶⁶ she tried to broker a compromise. At present, Beard argued, there were no schools of nursing in the NYC sufficiently independent of hospital or medical school control that could absorb the graduate program at East Harlem. However, in five years, she predicted, there would be. At the time, Teachers’ College and East Harlem represented the only counterweights to traditionally structured schools of nursing, but in five years, and with an additional \$90,000 grant from the RF, East Harlem could join the ever strengthening Presbyterian and the New York Hospital Schools in their quest to offer post-graduate public health nursing education.⁶⁷

Russell was, in fact, sympathetic to Beard’s appeal and aware of the importance of the teaching service.⁶⁸ However, Appleget, the RF’s vice president, was not so impressed. The RF officers debated the merits of all possibilities, including an affiliation with a proposed School of Public Health Nursing at Cornell, but this seemed “ambitious and complicated” and not an option for the foreseeable future. On June 24, 1935, after repeated queries from Folks about the length of the deliberation, Appleget informed him that there would be no additional RF support.

The RF would stay with its tradition and with the time-limited appropriation promised in 1932. The last grant of \$10,000 would begin as planned, on December 1, 1935, and end on November 30, 1936. Appleget found himself unable to make any exceptions no matter how worthy.⁶⁹

Beard found it “most distressing” that this decision would leave the Service with only the pledged income from the four organizations that provided financial or in kind nursing resources to it—certainly more than half of its budget, but leaving initiatives in mental health, nutrition, and parental education “crippled.”⁷⁰ In December, she re-approached the RF suggesting \$5000 to maintain these services in 1937 and 1938, until a plan was developed to possibly transfer the East Harlem teaching staff to a new city health center run by the New York Hospital—Cornell Medical Center.⁷¹ The RF agreed to an additional year⁷² and Beard then resigned from its Board. “I feel I can serve East Harlem better,” she wrote to Folks in January 1936, “by resigning from the Board than if I continue to be a member of it.”⁷³

The Directors and staff of East Harlem refused to see this as the end of their grand experiment. By 1937, they had prepared extensive materials to publicize their work. *The East Harlem Nursing and Health Service: Fifteen Years of Cooperative Endeavor: Should it go on?*—carefully laid out the steps taken to achieve their “new approach to health work.”

Over the past fifteen years the Service had:

- met the needs of the community for sick and maternity nursing
- developed new services such as health work for pre-school children
- experimented with the organization of nursing services
- integrated knowledge from nutrition and mental hygiene into all aspects of health work
- brought the skills of a family case-worker to bear on common problems and
- trained a new generation of practitioners from across the globe.

They had battled what they saw as the illiteracy, old-world customs, and fatalistic indifference of southern Italian immigrants, and now pointed with pride to how the now adult children they served brought their own children to the Service. They felt that they had confronted what they believed other agencies knew, but never publically admitted—the often ignored fact that the families most in need of services were often the least likely to benefit from them, and now more “consciously” selected parents most responsive to teaching and guidance. While they continued to attend to all families who experienced episodes of illness or the birth of a new child, “maximum help” was given to families of “more ability.” They believed that there was now the complete acceptance of the nurse as a “general practitioner” maintaining high standards of work that integrated the specialized services of sickness nursing, maternal and infant nursing, and tuberculosis nursing. The path had not been an easy one, but through constant experimentation, a “new approach” to family health work had been achieved that integrated the work of the visiting nursing of the seriously ill and new mothers with the approach of the “health” nurse that—using new knowledge from nutrition and mental hygiene—would continue to reduce the need for sickness care. The East Harlem Nursing service drew a sharp distinction between its “new” work and that of a previous generation of public health nurses. Its work was based on the individual needs of individual families not on initiatives that would affect the community as a whole.

Their data indicated that it was succeeding. Over the fifteen years it worked with families, malnutrition in children declined from twenty-six percent of all children it saw, to less than four percent in 1936. Infant mortality declined from seventy-one deaths in 1923 to fifty-six in 1935. With its successful immunization initiatives, diphtheria deaths had almost disappeared, and the measles death rate had declined significantly. The Service added careful caveats to this

data. Many other agencies, it acknowledged, worked in the District, and the constant and consistent availability of federal relief dollars put more food on families' tables than the inconsistent earnings of wage workers before 1929. Still, in their minds, the best data was less tangible. It took pride in the changed relationships that existed between its nurses and their families; in parents' increasing ability to work through many problems on their own; and on the Service's prominence as a "laboratory" for the training of public health nurses.⁷⁴

There was still much to be done. They "deplored" the fact that a move into administration was the only way nurses could increase their salaries, and wanted to create a new "senior field worker," so that their best and most experienced nurses could remain in "direct family health service." They wanted their student service relieved of its "most serious handicap—the pressure of bedside nursing." Under the terms of its agreement with Teachers College, the students "cannot carry the acute work," and, with the commitment of the Service to generalized nursing, "the burden of this falls on the advisors."⁷⁵ They wanted to strengthen its mission of experimentation and publication, and their colleagues in the wider public health nursing world agreed. All of the letters of support it marshaled in support of its continued existence spoke to this unique function of the Service. Katherine Tucker, the Director of the Department of Nursing Education at the University of Pennsylvania, wished the Service to turn to studies of school nursing—an area of practice she believed in which there was little *evidence* based on real study and experimentation.⁷⁶ Marguerite Wales, a consultant in nursing education to the W.K. Kellogg Foundation, noted that nowhere else have specific problems in public health benefited from the group thinking of experts, not just thinking about, but actually working to solve problems, and as a result its publications were avidly read by nurses across the globe.⁷⁷

Nevertheless, ultimately, the fight failed. As Appleget reminded Folks in his final appeal for continued funding in November 1937, the IHD only worked with sustainable governmental agencies, not voluntary ones like East Harlem. Its uniqueness, in fact, was its problem. It was neither a city health service nor was it an affiliated unit of the “great medical centers.” It was providing a “notable community service” that made it renowned but also vulnerable. East Harlem had been, in his mind, “rather stubborn in its independence.” It had been and kept itself free from relationships with hospital based schools of nursing whose inevitable and insatiable demands for service would have compromised its ability to identify, experiment with, and solve what it saw as problems uniquely within the domain of public health nursing. However much it wanted a partnership with the City’s Department of Health it had steered clear of the politics of public health. As Katherine Tucker pointed out in her letter of support, it had fewer “entangling alliances” and never suffered from “the periodic upheavals that usually occur in most community services.”⁷⁸ This, Appleget acknowledged, led to the excellent work of the Service—and to the question of survivability once the RF stopped the last remnants of its support in 1937.

The East Harlem Nursing and Health Service limped along with rising deficits for the next few years, until acceding to the inevitable. A personal and rather terse letter from Margaret Nourse, the President of St. Timothy’s League, and long time supporter of the Service, to the RF in January 1941, acknowledged that “your generosity and real interest in this project entitles you to know of the imminent shutting down of this teaching centre (sic).”⁷⁹ An innovative and interdisciplinary Nursing Service and, as Nourse inadvertently emphasized, teaching service, that had hoped to transform the practice and curricular landscape of public health nursing, now shared the fate of the earlier Health Center and had come to a close.

Conclusion

In 1934, New York City's Department of Health commissioned a study on "Some Special Health Problems of Italians in New York City," in conjunction with two newly planned federally- funded neighborhood health centers in East Harlem and in Mulberry Bend Park, the second largest concentration of Italian and Italian American residents in the City's lower east side. By all mortality measures, the residents of East Harlem experienced "distinctly better" rates than those in Mulberry Bend Park. The reason seemed self-apparent. It was because of the "the intensive health work carried on in the district by the East Harlem Health Center" that had persisted even after the Rockefeller funded health demonstration project had closed. The shadow of that past project extended further. "There is every reason to believe," the report concluded, that the new downtown health center would "improve health conditions in that district to a considerable extent." No longer would its residents die needless deaths from pneumonia, tuberculosis, venereal diseases, and diabetes.⁸⁰

Though at another 1934 meeting of the East Harlem Council of Social Agencies, Grace Anderson of the East Harlem Nursing and Health Service declared that if the poor were to receive the help they needed the City would have to move beyond merely creating health centers. It needed to provide the same subsidies to home nursing as it currently did to health centers and municipal hospitals. These subsidies for "home relief," she argued, were as "legitimate a charge to the taxpayer as hospitals."⁸¹ Anderson was not alone in this wish. She only echoed the hopes of leading public health nurses across the United States. However, these kinds of subsidies never materialized. Rather, Anderson's hope of municipal funding to preserve sick nursing and health promotion in the home reflected health care as progressive public health nurses wanted it to be—constructed within intimate personal relationships forged in homes and not in the more

impersonal ones found in the increasingly central hospitals and health care centers that increasingly dominated the health care landscape.⁸²

What can we learn from the histories of these two demonstration projects as the United States stands ready to bolster and expand the capacity of community health centers to provide comprehensive, high quality, and coordinated care to under resourced communities like those of East Harlem? Health care needs cannot be separated from the needs of constituent communities. These communities might be narrowly defined as the funders of demonstrations or more broadly defined as the people served. The demonstration projects in East Harlem succeeded when they joined with constituents around the need to create meaningful knowledge about how to care for those at home and in the community. They failed when narrower, disciplinary interests and needs took center stage.

However, as the experiences of the East Harlem Health Center Demonstration Project shows, the notion of “constituent communities” need not remain static. The RF may have changed its focus and direction away from the direct provision of health and welfare services, but the City’s Health Department stood ready and waiting for the moment when the private funding of these services gave way to the overwhelming need for public dollars in the 1930s. It also shows the limits of voluntary cooperation. The notion of “coordinated care” cannot work unless there is an ultimate arbiter of who can do what with whom.

The nurses at the East Harlem Nursing and Health Service must be commended for what they did along with like-minded colleagues—opened public health nursing to interdisciplinary areas of knowledge long before such was popular. They introduced mental health concepts into the practice of nursing long before they became engrained in nursing school curricula. They broadened their care to be more inclusive of families rather than individuals, but they should not

be condemned for what they did not do. As historian Karen Buhler-Wilkerson points out, the 1920s and 1930s were periods of “self-analysis” for public health nursing, but their reports all focused inward on the needs of the discipline rather outward on the needs of the community. Susan Moore, the associate editor of the *Nation’s Health*, the monthly newsletter of the American Public Health Association, termed these reports “uninspirational.”⁸³

Still, as we look forward to the ACA’s call for demonstration projects, we can remember the experiences in East Harlem as lessons about what might be most important. At both the Health Center and the Nursing Service, long term influences may have been as, if not more, important than the shorter term’s metrics of success or failure. NYC ultimately adopted the neighborhood health center model as its way to battle the new public health threats of cancer, hypertension, and accident prevention. In nursing, education for public health practice remained that which mirrored medicine: undergraduate students studied a broad range of topics; graduate students specialized.

There are some cautionary lessons as well. Disciplinary needs—be it the Health Center’s role to advance a national agenda or the Nursing Service’s role as a teaching center—cannot be separated from the needs of constituent communities. The East Harlem demonstrations succeeded when it joined with constituents around the need to create meaningful knowledge about how to care for those at home and in the community. They failed when they could no longer engage their supporters, their community, and their patients in their own particular mission.

Editor’s Note: This research report is presented here with the author’s permission but should not be cited or quoted without the author’s consent.

Rockefeller Archive Center Research Reports Online is a periodic publication of the Rockefeller Archive Center. Edited by Erwin Levold, Research Reports Online is intended to foster the network of scholarship in the history of philanthropy and to highlight the diverse range of materials and subjects covered in the collections at the Rockefeller Archive Center. The reports are drawn from essays submitted by researchers who have visited the Archive Center, many of whom have received grants from the Archive Center to support their research.

The ideas and opinions expressed in this report are those of the author and are not intended to represent the Rockefeller Archive Center.

ENDNOTES:

- ¹ Homer Folks, Forward, in Kenneth Widdemer, *The House that Health Built*, New York: Garland Publishing, 1925, p. 7.
- ² Grace Anderson, "An Urban Nursing and Health Demonstration." *American Journal of Nursing* 30: 12 (1930), pp. 1531-1532.
- ³ RAC, LSRM, Box 1, Folder 12, Series 3.1, "Health Center to be Established by the Red Cross and Co-operating Organizations."
- ⁴ For examples, see Daniel M. Fox, "The Significance of the Milbank Memorial Fund for Policy: An Assessment at its Centennial." *The Milbank Quarterly* 84: 1 (2006), pp. 5-36; Elizabeth Toon. "Selling the Public on Health: The Commonwealth and Milbank Health Demonstrations and the Meaning of Community Health Education." In Ellen Lagemann, editor, *Philanthropic Foundations: New Scholarship, New Possibilities*. Bloomington: Indiana University Press, 1999, pp. 119-130; and George Rosen, "The First Neighborhood Health Center Movement: Its Rise and Fall." *The American Journal of Public Health* 61 (1971), pp. 1620-1635.
- ⁵ Karen Buhler-Wilkerson, *No Place Like Home: Nursing and Home Care in the United States*. Baltimore, Maryland: The Johns Hopkins University Press, 2010.
- ⁶ Patricia D'Antonio, *American Nursing: A History of Knowledge, Authority, and the Meaning of Work*. Baltimore, Maryland: The Johns Hopkins University Press, 2010.
- ⁷ John Duffy, *The Sanitarians: A History of American Public Health*. Chicago: University of Illinois Press, 1992.
- ⁸ Ira V. Hiscock, "The Development of Neighborhood Health Services in the United States." *The Milbank Memorial Fund Quarterly*, 13: 1 (1935), pp. 30-51.
- ⁹ Duffy, *The Sanitarians*, pp. 214-215.
- ¹⁰ John Duffy, *History of Public Health in New York City, 1866-1966*. New York: Russell Sage Foundation, 1968, pp. 272-276.
- ¹¹ Kenneth Widdemer, *A Decade of District Center Health Pioneering: East Harlem Health Center*. New York: East Harlem Health Center Widdemer, 1932, p. 30.
- ¹² Russell Leigh Harmon, *The Tenants of East Harlem*. Berkeley: The University of California Press, 2006, p. 24; see also Joseph Cosco, *Imagining Italians: The Clash of Romance and Race in American Perceptions*. New York: State University Press of New York, 2003, who reports that eighty percent of the 4.5 million Italian immigrants to the U.S. were from the south and thirty-three percent settled in New York City.
- ¹³ Harmon, *The Tenants of East Harlem*, pp. 25-28; Widdemer, *A Decade of District Center Health Pioneering*, p. 17.
- ¹⁴ Widdemer, *A Decade of District Center Health Pioneering*, p. 17.
- ¹⁵ Raymond B. Fosdick, *The Story of the Rockefeller Foundation*. New York: Harper & Brothers, 1952.
- ¹⁶ RAC, LSRM, Box 1, Folder 12, Series 3.1, letter from Bailey Burritt to W.S. Richardson, April 20, 1921; June 6, 1922.
- ¹⁷ Widdemer, *House that Health Built: A Report of the First Three Years' Work of the East Harlem Health Center. The East Harlem Health Center Demonstration: An Anthology of Pamphlets*. New York: Garland, 1925, pp. 35-95.
- ¹⁸ Widdemer, *House that Health Built*, pp. 46-47.
- ¹⁹ RAC, LSRM, Box 1, Folder 12, Series 3.1, Governing Board Resolution, May 11, 1925.
- ²⁰ RAC, LSRM, Box 1, Folder 12, Series 3.1, Letter Homer Folks to LSRM, March 4, 1924.
- ²¹ RAC, LSRM, Box 1, Folder 12, Series 3.1, Letter Homer Folks to Beardsley Ruml, May 12, 1925.
- ²² RAC, LSRM, Box 1, Folder 10, Series 3.1, Memorandum of an Interview with Homer Folks, November 22, 1925.
- ²³ RAC, LSRM, Box 1, Folder 10, Series 3.1, Interview with Lawson Purdy, January 5, 1926.
- ²⁴ RAC, LSRM, Box 1, Folder 10, Series 3.1, Interview with Lillian Wald, January 5, 1926.
- ²⁵ RAC, LSRM, Box 1, Folder 10, Series 3.1, Memorandum of Interview with Homer Folks, November 22, 1925.
- ²⁶ On the Welfare Council charge, see Duffy, *History of Public Health in New York City, 1866-1966*, pp. 306-307.
- ²⁷ RAC, LSRM, Box 1, Folder 10, Series 3.1, Evolution of the East Harlem Health Center to the East Harlem District Center, January 14, 1926.
- ²⁸ Fosdick, *The Story of the Rockefeller Foundation*, p. 128.
- ²⁹ RAC, LSRM, Box 1, Folder 10, Series 3.1, Beardsley Ruml to Homer Folks, April 19, 1927. Other projects in health care the LSRM had supported (in addition to the VNS, MCA, and AICP) included New York City's Judson Health Center and ensuring the survival of the Lincoln Hospital Training School for Nurses, acknowledged by the LSRM to be among the best training schools for black nurses.

-
- ³⁰ RAC, RF, Record Group (RG) 1.1, Box 1, Folder 7, Series 235, Letter from Homer Folks to Thomas Appleget, October 13, 1931.
- ³¹ RAC, RF, RG 1.1, Box 2, Folder 16, Series 235, "Fifteen Years of Cooperative Endeavor: Should it go on?"
- ³² RAC, RF, RG 1.1, Box 1, Folder 9, Series 235, undated note from Mary Beard, circa November 29, 1927.
- ³³ RAC, LSRM, Original Appeal, April 1927.
- ³⁴ RAC, LSRM, Box 1, Folder 13, Series 3.1, "Outline of Family Case Study."
- ³⁵ RAC, LSRM, Box 1, Folder 13, Series 3.1, Committee on Continuation, March 3, 1927; Original Appeal, April 1927; Memorandum.
- ³⁶ RAC, LSRM, Box 1, Folder 13, Series 3.1, Memorandum of Interview, April 26, 1927.
- ³⁷ RAC, RF, RG 1.1; Box 1, Folder 9, Series 235; Richard M. Pearce, Concerning East Harlem Nursing and Health Demonstration Center.
- ³⁸ RAC, RF, RG 1.1, Box 19, Folder 137, Series 700, Report on Foundation Cooperation on Nurse Training in Europe, December 5, 1923. Elizabeth Crowell supported this position, albeit from a different perspective. As she wrote to Edwin Embree in 1923, training schools had to be associated with the clinics and teaching hospitals of medical schools so that a new generation of physicians would acquire an appreciation of good nursing from the very beginnings of their career. Elizabeth Crowell to Edwin Embree, September 5, 1923. For Crowell's work in Czechoslovakia, see Elizabeth Vicker's "Frances Elizabeth Crowell and the Politics of Nursing in Czechoslovakia after the First World War," *Nursing History Review*, 7 (1999), pp. 67-96.
- ³⁹ See Elizabeth Fee, "The Welch-Rose Report: Blueprint for Public Health Education in the America, 1992, available at www.deltaomega.org/WelchRose.pdf, retrieved January 10, 2012; Greer Williams, "Schools of Public Health: Their Doing and Undoing." *Milbank Memorial Fund Quarterly*, 54: 4 (1976), pp. 489-527.
- ⁴⁰ RAC, RF, RG 3.1, Box 19, Folder 137, Series 900, Addendum, January 4, 1927.
- ⁴¹ See Fosdick, *The Story of the Rockefeller Foundation*, pp. 137-138.
- ⁴² RAC, RF, RG 1.1, Box 19, Folder 137, Series 100, Richard Pearce to Elizabeth Crowell, July 13, 1927.
- ⁴³ RAC, RF, RG 3.1, Box 19, Folder 137, Series 900, Addendum, January 4, 1927.
- ⁴⁴ RAC, RF, RG 1.1, Box 2, Folder 13, Series 235, East Harlem Nursing and Health Service, 1937, p. 14.
- ⁴⁵ RAC, RF, RG 1.1, Box 2, Folder 16, Series 235, The Story of the East Harlem Nursing and Health Service, 1937. The Story acknowledged that "people change slowly," and that one needed a long period of time "to gain their confidence through appreciation of their experiences, their felt needs, and their objectives."
- ⁴⁶ RAC, RF, RG 1.1, Box 1, Folder 13, Series 235, The Teaching Service of the East Harlem Health Demonstration Service, April 1, 1928 to October 1, 1931. This source also reports that one black nurse from Philadelphia was at the Service and would be returning to practice tuberculin nursing.
- ⁴⁷ Sybil Pease, "Mental Hygiene Functions of the Public Health Nurse." *Annals of the American Academy of Political and Social Science* 149 (1930), p. 182.
- ⁴⁸ Sybil Pease, "New Frontiers in Public Health Nursing." *Canadian Nurse* 25 (1933), p. 527.
- ⁴⁹ "The Infant Service Report of the East Harlem Nursing and Health Demonstration Project." 1928, p. 22. Reprinted in Susan Reverby, *The East Harlem Health Center Demonstration: An Anthology of Pamphlets*. New York: Garland, 1985.
- ⁵⁰ Sybil Pease, "The Interview in Public Health Nursing." *Public Health Nursing* 25 (1933), p. 137.
- ⁵¹ Pease, "Mental Hygiene Functions of the Public Health Nurse." p. 182.
- ⁵² RAC, RF, RG 1.1, Series 235, Box 2, Folder 14, Report of the Consultant in Mental Hygiene and Social Work. Some of the "Highlights." 1928-1934, p. 20.
- ⁵³ RAC, RF, RG 1.1, Box 1, Folder 9, Series 235, Homer Folks to Thomas Appleget, October 5, 1931.
- ⁵⁴ RAC, RF, RG 1.1, Box 1, Folder 10, Series 235, Homer Folks to Thomas Appleget, April 20, 1932.
- ⁵⁵ Lily Kay, "Rethinking Institutions: Philanthropy as an Historiographic Problem of Knowledge and Power." *Minerva* 35 (1997), pp. 283-293.
- ⁵⁶ Ellen Lagemann, *The Politics of Knowledge: The Carnegie Foundation, Philanthropy, and Public Policy*. Illinois: The University of Chicago Press, 1992, pp. 67-70.
- ⁵⁷ RAC, RF, RG 1.1, Box 1, Folder 10, Series 235, Thomas Appleget to Homer Folks, May 10, 1932.
- ⁵⁸ RAC, RF, RG 1.1, Box 1, Folder 9, Series 235, East Harlem Nursing Service, May 9, 1932.
- ⁵⁹ RAC, RF, RG 1.1, Box 2, Folder 14, Series 235, Community Service in 1934, p. 27.
- ⁶⁰ Lillian Brandt, *An Impressionistic View of the Winter of 1930-1931*. New York: Welfare Council, 1932.
- ⁶¹ Duffy, *The Sanitarians*, p. 260.

-
- ⁶² Michael Davis and Mary C. Jarrett, *A Health Inventory of New York City: A Study of the Volume and Distribution of Health Services in the Five Boroughs*. New York: Welfare Council of New York, 1929, pp. 36-39.
- ⁶³ RAC, RF, RG 1.1, Box 2, Folder 14, Series 235, East Harlem Nursing and Health Service: A Progress Report 1934.
- ⁶⁴ RAC, RF, RG 1.1, Box 1, Folder 11, Series 235, "Meeting of the Board of Directors, February 28, 1935.
- ⁶⁵ RAC, RF, RG 1.1, Box 1, Folder 11, Series 235, "Note to Dr. Russell," March 15, 1935.
- ⁶⁶ This included the Henry Street Settlement and VNS—deeply worried it had no sustainable endowment. Finally gave it a modest one, and cut off yearly appropriations, a common move on the part of the RF and the projects it sponsored.
- ⁶⁷ RAC, RF, RG 1.1, Box 1, Folder 11, Series 235, "Note to Dr. Russell," March 15, 1935.
- ⁶⁸ RAC, RF, RG 1.1, Box 1, Folder 11, Series 235, "Excerpt from TBA's Diary," April 22, 1935.
- ⁶⁹ RAC, RF, RG 1.1, Box 1, Folder 11, Series 235, Appleget to Folks, June 24, 1935.
- ⁷⁰ RAC, RF, RG 1.1, Box 1, Folder 11, Series 235, Mary Beard's Diary, November 12, 1935.
- ⁷¹ RAC, RF, RG 1.1, Box 1, Folder 11, Series 235, Mary Beard, "The East Harlem Nursing and Health Service," December 11, 1935.
- ⁷² RAC, RF, RG 1.1, Box 1, Folder 10, Series 235, Excerpt from Appleget's diary, May 3, 1937, when he refers to RF 2, final contributions tapering out in 1937.
- ⁷³ RAC, RF, RG 1.1, Box 1, Folder 12, Series 235, Mary Beard to Homer Folks, January 16, 1936.
- ⁷⁴ RAC, RF, RG 1.1, Box 2, Folder 16, Series 235, "The East Harlem Nursing and Health Service: Fifteen Years of a Cooperative Endeavor: Should it go on?" 1937.
- ⁷⁵ RAC, RF, RG 1.1, Box 2, Folder 13, Series 235, The East Harlem Nursing and Health Service, 1937.
- ⁷⁶ RAC, RF, RG 1.1, Box 2, Folder 16, Series 235, Katherine Tucker to Grace Anderson, March 10, 1937.
- ⁷⁷ RAC, RF, RG 1.1, Box 2, Folder 16, Series 235, Marguerite Wales to Grace Anderson, March 19, 1937. Wales mentioned a recent RF funded trip to central Europe where former RF Fellows eagerly read East Harlem reports. Other letters of support came from Elizabeth Gordon Fox, Executive Director of the Visiting Nurse Association of New Haven (RAC, RF, RG 1.1, Box 2, Folder 16, Series 235, Fox to Anderson, April 1, 1937); Lillian Hudson of Teachers' College (RAC, RF, RG 1.1, Box 2, Folder 16, Series 235, April 12, 1937); and Amelia Grant, Director of the Bureau of Nursing in the Department of Health (RAC, RF, RG 1.1, Box 2, Folder 16, Series 235, Grant to Anderson, May 10, 1937).
- ⁷⁸ RAC, RF, RG 1.1, Box 2, Folder 16, Series 235, Katherine Tucker to Grace Anderson, March 10, 1937.
- ⁷⁹ RAC, RF, RG 1.1, Box 1, Folder 12, Series 235, Margaret Nourse to Raymond Fosdick and Thomas Appleget, January 15, 1941.
- ⁸⁰ Leonard Covello Papers, Historical Society of Pennsylvania, MSS 40, Box 65, Folder 17.
- ⁸¹ Leonard Covello Papers, Historical Society of Pennsylvania, MSS 40, Box 71, Folder 1.
- ⁸² Karen Buhler-Wilkerson, *No Place Like Home*, p. 712.
- ⁸³ Karen Buhler-Wilkerson, *No Place Like Home*, p. 172.