Economic Constraints Impacting the Establishment of Reproductive Public Health in New Mexico, 1919-1940

By Dr. Lena McQuade

Assistant Professor
Women's and Gender Studies Department
Sonoma State University
1801 E. Cotati Ave.
Rohnert Park, CA 92948

mcquade@sonoma.edu

During the summer of 2010, I conducted a weeklong research trip to the Rockefeller Archive Center (RAC), to examine records pertaining to the establishment of a public health department in the state of New Mexico (1919-1937). My primary research objective was to study the role of philanthropic organizations such as the International Health Board of the Rockefeller Foundation and the Commonwealth Fund in funding health projects throughout the state. More specifically, I wanted to closely examine the development of reproductive, maternal, and infant heath services in diverse New Mexican communities. What I found in the archives was ample documentation about the impoverishment of New Mexico and an array of consequences triggered by the under funding of health services. This research into state health funding is integral to my larger manuscript project on the history of infant mortality and reproductive health in New Mexico.

For this research report, I divided the primary source material I surveyed into two sections based on chronology and the funding agency. The first section addresses the work of the International Health Board of the Rockefeller Foundation, which actively funded public health projects in the state from 1920-1929. In the second section, I focus on the matching

health grants provided by the Commonwealth Fund to the state of New Mexico for the purpose of establishing modern health services during the years 1930-1936. In the second section, I also cover unsuccessful attempts by the state public health department to finance formal training for aspiring New Mexican midwives.

To contextualize the data in this research report, it is first necessary to provide a very brief overview of the history of New Mexico as it pertains to health and wellbeing. The land that comprises the present day state of New Mexico was forcefully ceded by Mexico to the United States under the treaty of Guadalupe de Hidalgo in 1848. During the next sixty-four years, until statehood was granted in 1912, the inhabitants of New Mexico were territorial subjects of the United States and as such were not entitled to all the same rights and privileges as U.S. citizens. Most notably for this research project, the inhabitants of New Mexico were precluded from political rights and the ability to control their own territorial government. Scholars argue that racial prejudice about the majority Mexican American and Native American population of the New Mexico territory was central to Congress's repeated denial of statehood. This history of the racialized exclusion of New Mexico had lasting ramifications for health and medical infrastructure.

By 1919, New Mexico was the last state in the nation to establish a public health department and consequently the state missed earlier opportunities to develop organized public health care. Early vital statistics from 1929 reveal that New Mexico's infant mortality rate was more than double the national average and higher than any other state in the nation. The lack of state and federal supported health care in the region also meant that within New Mexico there was a long history of lay practitioners, such as curanderas (healers) and parteras (midwives), addressing the health needs of their own communities. For example, parteras or Spanish-

speaking midwives, delivered upwards of 30% of state births well into the 1930s while nationally midwifery delivery rates had plummeted below 15%. New Mexico's complicated history of race based national exclusion coupled with a long established practice of lay community health work impacted the formation and outcomes of public health programs in the state. This history of New Mexico informs my research on the collaborations between nationally renowned philanthropic foundations and state health entities during the 1920s and 1930s

The International Health Board of the Rockefeller Foundation: Establishing Public Health in New Mexico (1920-1929)

The International Health Board of the Rockefeller Foundation (IHB) was active in helping to fund health programs and build health infrastructure in New Mexico from 1920-1929. Following a model developed in the U. S. south, the IHB became a cooperative funding partner with New Mexico counties and the state to establish health demonstration sites in New Mexico. The goal of these sites was to provide a tangible example of the value of public health work to the various populations of New Mexico. Early health officials in New Mexico hoped that once New Mexicans saw the positive outcomes of organized public health, every county in the state would be interested in funding a full time health department.

One of the first identified obstacles to establishing public health in New Mexico was the low economic valuation of much of the state and subsequently a lack of state funds to support full time public health services. In 1919, the state legislature passed legislation creating a State Board of Health and appropriated $13,000 for its operation. This appropriation was used to fund several statewide health positions, including an epidemiologist, sanitary engineer, bacteriologist, and two assistant health officers; however, this funding was insufficient to support county health officers and public health nurses. In February of 1920, the state legislature passed an additional

health law that permitted county officials the option of levying a special tax, not to exceed one-half mill on the dollar of the valuation of property, to fund local health work. Even if local municipalities enacted this optional special health levy, the economic value of New Mexican counties was so low that the levied funds would still fall below the minimum required to operate a successful county health program. For example, even in the six most economically favorable counties in the state, the maximum levy would only yield $6,000 to $9,000 per year, which fell below the minimum amount of $12,000 recommended by the IHB to operate an effective county health unit.[1]

Recognizing these financial constraints to the development of effective statewide public health, Clinton Anderson, the Executive Secretary of the New Mexico Public Health Association, wrote to George Vincent, the Chairman of the IHB of the Rockefeller Foundation, requesting funds to establish health demonstration units in New Mexico. These health demonstration units would be located in several counties and staffed by a health officer and public health nurses who would focus on improving sanitation and preventing the spread of communicable diseases such as tuberculosis. The IHB responded favorably to this request and agreed to work cooperatively with the state and local county governments in New Mexico to fund public health. The IHB offered to provide an amount not to exceed $10,000 yearly to be used to supplement local health funds for public health demonstration projects. Local health officials believed that once New Mexicans saw the value of these health projects, the state and local counties would continue appropriating increasing funds for public health. The IBH funds for New Mexico were envisioned to be an initial boost to local health funding that New Mexicans would shortly be able to support on their own.[2]

What I found most interesting in the initial documents between New Mexico's public

health representatives and the IHB were the connections that these entities drew between New Mexico and the southern states in the U.S. The IHB initially saw its work in New Mexico as an extension of the work already done in the south. In the south, the IHB supplemented local county health budgets, which enabled more health services and eventually lead to increased state funding. Where IHB projects had been undertaken in the south, states were now fully funding their own health budgets—a model that the IHB hope to replicate in New Mexico. Despite these initial similarities, early correspondence evidences a discussion of what health officials believed to be some important differences between New Mexico and the southern states. Most notable were descriptions about the specific racial demographics of state, the prevalence of Spanish, as well as the geography and economics of the state. According to New Mexico public health official Anderson, convincing New Mexicans of the "value" of health differed from the IHB work in the south and was particularly challenging, he wrote, because:

> "our problem here is much more difficult than the problem in North Carolina since a large portion of the population is uninterested in general sanitation and disease prevention work. About one-half of the population is of Spanish-American descent and the problem of educating these people to a realization of what might be done by a full time health department is unusually hard."[3]

In this representative quote, there is much to analyze in terms of how early pubic health officials constructed meanings about race and health in this new state. This early assessment of healthcare in New Mexico evidences the ways public health was entangled with emerging definitions and descriptions of race and ethnicity in this new state.

Debates over racial meanings in New Mexico were not simply abstract concepts but literally impacted the bodies and health of New Mexicans. Take for example an early discussion about the possibility of hookworm in New Mexico. The first report to the IHB about funding health projects in New Mexico noted that a survey for hookworm disease in the state had not yet

been made. Despite the lack of any scientific inquiry into the possible existence hookworm, the report concluded that the "impression prevails" that the disease does exist in the "southern section of the state where the population is made up largely of Mexicans." Without conducting any scientific investigation, the bodies of Mexican Americans living in the southern part of the state were already imagined to harbor "filth-born" disease. These prevailing impressions about people of Mexican decent in New Mexico persisted even though the same report later concluded that "hookworm disease is assumed to be of minor importance" in the state.[4] In terms of racial construction, these early descriptions reveal the ways the bodies and health of Mexican-origin people may have been seen as analogous to another group of racially excluded subjects—African Americans in the south. There is much further analysis to be done about the role of public health in the construction of racial difference and racism in New Mexico.

The records of the IHB's work in New Mexico also illuminate the financial constraints that shaped the development of public health in the state. Coinciding with the start of the IHB's funding in the early 1920s, New Mexico suffered a long and severe drought. This drought impacted nearly every economic sector in the state including livestock (cattle and sheep) as well as dry farming. This agricultural downturn was coupled with railroad strikes and drop in the price of copper, which closed several mines and mining communities in the state. These economic hardships created what one New Mexico public health official called an "insistent and widespread demand for curtailment in government expenditures."[5] As a result of this pressure and a decline in tax revenues, the legislature of the state of New Mexico failed to appropriate adequate funds for county health work. This threatened the cooperative funding relationship between the IHB and the state of New Mexico since the state had difficulty matching its share of public health budgets. Even in the face of these economic challenges, the IHB continued to fund

health work in New Mexico, although, it had to scale back its expectations about the legislature of New Mexico taking over the entire responsibility for health funding in the near future.

Despite the many obstacles, the IHB was able to help establish an early public health infrastructure in the state and to provide funds for the salaries of the first health officers in the state. The public health department was also able to increase its health outreach to schools and communities. Midwifery and infant care were part of these early public health projects. For example in 1922 newly hired public health nurses taught several midwifery classes held throughout the state with attendance ranging from two to fourteen attendees. A total of twenty-nine midwives in San Miguel County and eighteen in Torrance County were given individual instructions on best health practices.[6] Perhaps one of the most important functions of the IHB in New Mexico was the improvement of the birth and death registration process. The intensive statewide campaign to reach the 90% birth and death reporting rate required to bring New Mexico into the U.S. Census Registration Area was accomplished by 1929. This required building infrastructure to ensure that doctors and midwives were accurately reporting births and deaths and that various sub-registrar offices were tabulating this data on a county and statewide level. The beginning of New Mexico's admission into the U.S. Census also marked the end of the IHB's funding of public health in the state.[7]

The Commonwealth Fund: Building a County Nursing Program in New Mexico (1929-1936)

When the funding from the IHB of the Rockefeller Foundation ended in 1929, the state of New Mexico still lacked the financial resources necessary to independently operate a statewide public health program. Late in 1929, the Director of Public Health in New Mexico, G. S. Luckett, wrote to the Commonwealth Fund (CF) requesting funds to continue developing the

public health department's capacity in the state. The CF, run at the time by Edward Stephen Harkness, was a philanthropic enterprise dedicated to fostering health and welfare programs. In his first petition to the CF, Luckett asked for funding to support a mobile health unit that could travel to remote locations in the state as well as for financial backing for educational health classes to be taught at the Normal Schools in New Mexico. These specific requests were based on the rural and geographically varied nature of the state as well as the identified need to train more New Mexicans in public health. The CF denied this initial request explaining that the Foundation's public health grants were strictly for building rural health units that would employ a health officer, a sanitary officer, two public health nurses, and a clerk for each county in qualifying states. The CF grants would cover 50% of the costs of operating a rural health unit with the other 50% to be matched by local and state governments. This funding model had proved successful in other rural states but was more challenging to adapt to the needs of New Mexico.

Luckett wrote a second request to the CF explaining what he dubbed the "peculiar conditions" of New Mexico. These conditions, he elaborated, included a population that was 50% of Spanish descent with a 300 plus year history of inhabitation in the region. Luckett explained, "they have had their babies and buried their dead for nearly 300 years without outside help or interference." Additionally, the state of New Mexico had the fifth largest landmass in the nation; the state was larger than all of New England and New York State combined. Finally, the low taxable values in the state and the economic standing of the population prevented the majority of counties from supporting their own public health services. All of these conditions made it impossible for the state of New Mexico to meet the funding requirements for the CF rural health grants, which, Luckett argued, the state needed if it was to further their public health

program.[8]

Luckett's description of the financial situation in New Mexico sheds further light on the economic constraints in the state. He explained that in 1930, a local health officer, part time, cost $1,200 to $1,500 and maintenance of a nurse ranged from $2,700 including $900 for travel. The total for this bare-bones county public health team would cost $3,900 to $4,200 per year. To raise $4,200 based on the half mill levy established by the New Mexico legislature would require a county valuation of $9,200,000. Of the 31 counties in the state, 14 had this valuation or above, leaving 17 counties that could not afford basic health services without drawing additional funds from the local schools (which had a small budget for nursing services) or from financial support outside of the state. Luckett estimated that 8 of the poorest counties would not be able to maintain the costs of a nurse any time in the near future. To give an estimate of how many people were impacted by this lack of health services and thus could benefit from CF funding, Luckett stated that 38% of the state population lived in these 17 poorest counties.[9]

The 17 counties in this request for funding varied greatly in terms of population and geography. For example, Roosevelt County, located in the central most eastern part of the state bordering Texas had an assessed valuation of just over 8 million dollars in 1929 and a population close to nine thousand. The county demographic was described as "wholly English speaking, native whites," largely settlers from West Texas working in farming. Sandoval County, located in the northwestern quadrant of state bordering the more prosperous Bernalillo and Santa Fe Counties, had an assessed valuation of over four and half million with a population, in 1920, of 8,863. The population in this county was "90% Spanish speaking and Indian" with grazing, lumbering and mining listed as the chief occupations. The Atchison, Topeka & Santa Fe Railroad traversed both Roosevelt and Sandoval County. The poorest county, Catron, located in

the center of the state along the western border with Arizona had a valuation of 2.2 million with an estimated population of 2,500. There were no hospitals or doctors listed as working in this large county that covered 6,500 square miles. The nearest doctor was more than 100 miles over mountains often blocked by snow. The population of the county was "largely native, Spanish speaking," with an "admixture of settlers from outside" who found their principle business in stock-raising.[10] These descriptions provide an important window into the varied racial and ethnic makeup of the economically poorest counties in the state.

The CF responded favorably to Luckett's second petition for funding. They found that the health needs of New Mexico fell outside of the special programs for public health that traditionally received funding, but nevertheless, the officials felt that the situation in New Mexico was "tremendously interesting" and afforded an opportunity to do greatly needed health work.[11] The CF agreed to partner with New Mexico, funding "modern health service" in seventeen of New Mexico's poorest counties for the 1930 and 1931 fiscal years. The grant for the first year, $43,450, was the largest single donation ever made to New Mexico for health work. Under the agreement, the CF would pay for between one-third to the entire salary, travel expenses, and equipment costs of one public health nurse for each of the 17 counties. In addition, the CF would meet the costs of the salaries and traveling expenses of a director of county health work, supervising nurse, and clerical assistant. For its part, counties and the state of New Mexico were required to increase their portion of health financing each year until public health in the state was entirely self-funding.[12]

The Commonwealth Fund had some hesitations about becoming involved in New Mexico. Namely, they questioned whether the health unit in each county would eventually be able to be self-funding. They also questioned how much a lone nurse per county could actually

accomplish considering the vast distances she would have to travel to reach small rural communities.[13] Luckett acknowledged these concerns replying that the typical work of a county nurse would be to spend the summer months almost entirely on infant and maternal hygiene and the school year focusing on assessing the health of school children. He continued to make his case explaining: "we find that the people in the rural districts respond very eagerly to anything of the sort and are far more willing to cooperate with the nurse than they are in the more sophisticated centers."[14] Interesting for my own research is the fact that infant and maternal health care is listed as key areas to be addressed through this funding. I also find the contradictory descriptions of rural New Mexicans—on the one hand depicted as "uninterested" in health and sanitation and other described as "responding eagerly" to public health—to be an area for much further analysis.

In 1931, J. Rosslyn Earp became the new Director of Public Health in New Mexico. An Englishman with a BA and MA from Cambridge and his doctorate from the University of London, Earp came to New Mexico with impressive health credentials. Like many other health professionals who moved to the southwest in the 1930s, Earp arrived in New Mexico as a health seeker with an active case of tuberculosis. This disease would periodically impair his abilities to work throughout his tenure in the state. In addition to the challenges of his own illness, Earp began his job directing public health during another drought that resulted in a severe economic downturn in the state. In 1930 the value of farm products was only 44% of what it was during the previous year. Mines, the third largest industry in the state, were also operating at a loss. Coal mining was down due to competition from cheaper fuels, copper and zinc mining were being reduced due to low valuation, and the prospect of oil extraction from wells in New Mexico looked bleak due to the low cost of crude oil.

Earp gathered data from the Taxpayers Association of New Mexico detailing the taxable land in each county. Out of the 78 million acres of land in New Mexico only 30 million were subject to direct tax. The non-taxed lands included National forests, Indian reservations and public domain lands. Of the 30 million acres of taxable land, about 80% was grazing land. In the seventeen counties funded by the CF, six had over 50% of their entire land area untaxed because of national forests, Indian reservations, and public lands. Another four counties had at least 30% of their land untaxed. These large areas of untaxed land meant that the counties had a hard time coming up with enough tax revenue to fund social services. The Taxpayers Association further claimed: "the condition of the livestock market and the prices for cattle are not such as to indicate large profit in the livestock industry and that is practically the only kind of industry for which our lands in New Mexico are available."[15] The State Tax Commissioner ruled that no counties could increase their budgets and must, if possible, reduced them by 10%. In other words, there was little prospect that New Mexico would be able to meet the funding benchmarks established by the CF to retain public health services.[16]

Given these bleak economic prospects, representatives from the CF visited New Mexico in early 1932 to assess the viability of future philanthropic involvement in the state. In their summary of this trip they noted the positive health work underway in the state. For example, public health nursing, financed by the CF, was found to have "decided value in the conservation of child life in this state, which has the highest infant death rate in the country." While there were some areas of health improvement, the CF noted that of the seventeen counties currently being funded only eight had the financial resources to eventually take over county health work and an additional six counties had the potential to take over health work in the future. Three counties had no prospect for "permanent success" and the CF decided to drop their support of

these counties. Overall, the CF found that the New Mexico public health department was doing "an excellent job on very limited resources." Based on this assessment, the CF awarded New Mexico $30,000 for the 1932-1933 fiscal years to be matched by $24,900 from county and state budgets.[17] From the records, it appears that while the economic depression of the early 1930s certainly had an impact on public health in the state, the CF felt that its support was yielding positive results.

Impediments to Financing Formal Midwifery Training for New Mexicans

In addition to learning more about the larger economic picture impacting public health philanthropy in New Mexico, I also gathered further information about midwives in the state. From the records, it appears that while the local public health department and the CF were concerned about maternal and infant health, the economic constraints in the state and prevailing negative attitudes about midwives ultimately prevented the establishment of more organized midwifery training. An early letter between the New Mexico Director of Public Health, Earp, and the CF is indicative of midwifery's lower priority in the hierarchy of addressing public health needs. Earp explained, "my plans for providing New Mexico with trained midwives progress slowly amidst many other concerns."[18] Earp and others were well aware of New Mexico's high rate of infant mortality. Over the course of his tenure in New Mexico, Earp came to realize that, while ideal, it would be impossible for all pregnant women to deliver under the care of a physician. The cost of medical services coupled with the rural geography and lack of paved roads meant that many women would continue to rely upon midwives. While he disagreed in principle, Earp believed that the economic reality in New Mexico was such that midwives would be necessary for years to come. He advocated formal training for a select segment of young, rural, Spanish-speaking midwives in the state. Ultimately, Earp failed in this

endeavor and, from the records, it appears that no New Mexican women were able secure formal training in midwifery from outside the state.

Early in 1932 Earp learned that Bellevue Hospital in New York would train midwives free of charge provided they could pay seventy-five dollars for equipment and travel. From the records, it appears that Earp was interested in this opportunity to train Spanish-American, New Mexican midwives. He sought out CF assistance to cover the seventy-five dollar travel and equipment costs and attempted to reach local New Mexican women who might be interested in this program of midwifery training.[19] He encountered obstacles in both endeavors. The CF replied to Earp's request for midwifery funding stating that in light of the local circumstances in New Mexico (and I assume this meant the poverty, lack of doctors, and rural geography) that training local midwives might work. However, the CF declined funding this endeavor and noted that Earp would "face opposition to the idea from most effete Easterners."[20] Unable to procure funding from the CF, Earp hoped to raise funds within the state for this purpose.

In addition to the search for funding, Earp continued to seek out local candidates for midwifery training. The archival records of the CF contain correspondence between Earp and two local New Mexican women who expressed an interest in midwifery training. These letters are very important as they represent some of the only voices of New Mexican women in this collection. The earliest correspondence was between Earp and Miss Leonides G. Lucero of Sandoval, New Mexico. The original letter from Lucero is unfortunately not in the records, however, Earp's reply was available. Apparently Lucero wrote to Earp requesting midwifery training. In his reply Earp wrote "I am interested in your family history and in your anxiety to follow your mother's profession."[21] From this response, it is possible to deduce that in Lucero's original request she described her interest in further midwifery training through referencing her

family's history and her mother's work as a midwife. The fact that she mentioned her family shows that she thought this was pertinent and valuable information that bolstered her case for future midwifery training. It also lends support to the idea that some New Mexican women pursued midwifery based on family tradition and that these skills were passed intergenerationally.

Despite Lucero's interest in furthering her knowledge and skill, Earp denied her petition for formal midwifery training based on her age. Earp explained: "Unfortunately, the only school of midwifery in America requires that its students be between 25 and 35 years of age and therefore I do not see how it would be possible for us to help you to obtain training in this country."[22] In this instance, the age requirement established by Bellevue Hospital was an impediment to Lucero obtaining formal midwifery training. While the lack of further documentation prevents our knowing the specific biographical details in this instance, in the case of other New Mexican midwives, many had their own children first before pursuing midwifery. Women drew upon their own experiences of birth and used this knowledge to assist other women. This pattern of delaying midwifery practice until after a woman established her own family has also been noted among other racial, ethnic, and immigrant communities in the United States. The maximum age requirements set by the Bellevue Hospital excluded women, such as Lucero, who saw age and experience as an asset to rather than an impediment from becoming a midwife.

In the hopes of finding more potential midwifery students who met the Bellevue Hospital requirements, Earp produced a radio broadcast. In January of 1933 Earp went on the air to give a series of talks about motherhood and midwives in New Mexico. He issued an appeal for midwife pupils or young women who were qualified and wanted to spend nine-months studying

midwifery at the Bellevue School of Midwifery in New York. He mentioned that there was no funding source for this training at the moment, but that he hoped to generate a list of qualified candidates and then search for the funding. To be qualified the young women had to be between 23 and 35 years of age, a high school graduate, live in a community where medical aid is unobtainable, and be willing to return and remain in that community. Importantly, the candidates should speak the language of the communities where they plan to practice. Earp further explained that "this means that in most cases suitable candidates will be Spanish American." Earp's appeal was then repeated on-air in Spanish.[23]

Following this radio address, Crisanta Duran from Cubero, New Mexico wrote to Earp expressing her interest in midwifery training. Duran heard about the training course in midwifery from Miss Levy, county nurse of Valencia County and Dr. Frisbie. Duran was a high school graduate from Teacher's State College in Silver City and additionally she had 70 college term hours. She taught for thirteen years in Valencia and McKinley counties. At the time of writing, Duran was 35 years old, or at the upper age limit for training.[24] In all respects, Duran appeared to be an "ideal" candidate for this training. Earp wrote to the CF requesting funding for Duran to study midwifery. He explained that the total expense for a year of training would be $75 plus a round trip train ticket between NM and NY for $157.28.[25] The CF denied this additional funding request explaining that the current economic condition in the country is causing "jitters" and that certainly there were no immediate funds to help pay for Miss Duran's training in midwifery.[26] The records do not indicate that Earp was able to secure any other funding for Duran's or any other aspiring New Mexican midwives' training.

Following these initial rejections for funding expenses related to formal midwifery training, Earp wrote again to the CF to further clarify the role of midwifery in New Mexico.

Earp reiterated his requested for funding explaining that there was "serious need" for trained midwives in New Mexico. He further made the claim that this state could serve as a model for other states where obstetrics could not be entirely handled by physicians.[27] In response, the CF stated that funding midwifery in New Mexico looked "exceedingly difficult" considering the numerous conflicts between the medical profession and those attempting to raise midwifery standards. The fact the Earp wanted to use "native girls" without much educational background was cited as adding even more of a difficulty. In concluding, the CF advised Earp not to be discouraged and to write again when the economy picks up.[28] This exchange illustrates how women in New Mexico aspiring to be formally trained midwives were thwarted based on negative perceptions about their gender, racial identity, and economic status.

In conclusion, the records from the IHB and the CF provide an important window into the history of public health in New Mexico. These documents proved further insight into the significant economic constraints to establishing and maintaining a public health department in this large, rural, and economically impoverished state. Additionally, these archives reveal the ways racialized and gendered perceptions about the inhabitants of New Mexico had literal effects on the health, bodies and wellbeing of New Mexicans. In turn, the nascent institution of public health became a site for maintaining, and at times challenging, norms of race, gender, and class. Perhaps nowhere is this more evident than in the conflicted relationships between New Mexican midwives and the public health department. While New Mexican women had practiced midwifery for generations, as medicine modernized in the early twentieth century, these same women were excluded from formal medical training. This ongoing exclusion of New Mexicans had a direct impact on reproductive health for years to come.

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] Recommendation to the General Director of the International Health Board in Reference to New Mexico, 5 May 1920, Folder 93, Box 16, Series 2.234, Rockefeller Foundation International Health Board, Rockefeller Archive Center, Sleepy Hollow, New York; hereafter IHB.
[2] Clinton P. Anderson to George E. Vincent, 24 February 1920, Folder 1274, Box 91, Series 5.1.2, IHB.
[3] Ibid.
[4] Recommendation, 5 May 1920, IHB.
[5] G. S. Luckett to John A. Ferrell, 15 Aug 1922, Folder 1746, Box 130, Series 5.1.2, IHB.
[6] Report Union County, First Quarter, 1922; Report San Miguel County, Second Quarter 1922; Report Torrance County, Second Quarter, 1922, Folder 701, Box 59, Series 3.234J, IHB.
[7] New Mexico Report of Vital Statistics Activities for Fiscal Year July 1, 1928 through June 30, 1929, Folder 709, Box 59, Series 5.2.234K, IHB.
[8] G. S. Luckett to William J. Ferrell, 19 April 1930, Folder 2253, Box 237, Series 18.1, Commonwealth Foundation; hereafter CF.
[9] Ibid.
[10] Ibid.
[11] Barry C. Smith to G. S. Luckett, 20 February 1930, Folder 2253, Box 237, Series 18.1, CF.
[12] New Aid For County Health Work, 14 April 1930, Folder 2253, Box 237, Series 18.1, CF.
[13] Barry C. Smith to G. S. Luckett, 20 February 1930, CF.
[14] G. S. Luckett to Barry C. Smith, 27 February 1930, Folder 2253, Box 237, Series 18.1, CF.
[15] Rupert Asplund to Billy Tober, 25 April 1931, Folder 2254, Box 237, Series 18.1, CF
[16] J. Rosslyn Earp to Miss Kraker, 2 May 1931, Folder 2254, Box 237, Series 18.1, CF.
[17] New Mexico – Public Health Nursing Program, 5 April 1932, Folder 2255, Box 237, Series 18.1, CF.
[18] J. Rosslyn Earp to Clarence L. Scamman, 27 April 1932, Folder 2255, Box 237, Series 18.1, CF.
[19] Ibid
[20] Clarence L. Scamman to J. Rosslyn Earp, 9 May 1932, Folder 2255, Box 237, Series 18.1, CF.
[21] J. Rosslyn Earp to Leonides G. Lucero, 8 September 1932, Folder 2256, Box 237, Series 18.1, CF.
[22] Ibid.
[23] Broadcast for January 2, 1933, Folder 2256, Box 237, Series 18.1, CF.
[24] Crisanta Duran to J. Rosslyn Earp, 9 March 1933, Folder 2256, Box 237, Series 18.1, CF.
[25] J. Rosslyn Earp to Clarence L. Scamman, 13 March 1933, Folder 2256, Box 237, Series 18.1, CF.
[26] Clarence L. Scamman to J. Rosslyn Earp, 18 March 1933, Folder 2256, Box 237, Series 18.1, CF.
[27] J. Rosslyn Earp to Barbara Quin, 22 August 1933, Folder 2257, Box 238, Series 18.1, CF.
[28] Barbara Quin to J. Rosslyn Earp, 25 August 1933, Folder 2257, Box 238, series 18.1, CF.