

## To Educate and Protect: Politicians, Nurses and Poor Women in Rio de Janeiro, 1930-1945

*Educar y proteger: políticos, enfermeras y mujeres pobres en Río de Janeiro, 1930-1945*

*Educar e proteger: políticos, enfermeiras e mulheres pobres no Rio de Janeiro, 1930-1945*

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This research examines articles in various public health journals that surrounded the issue of infant and maternal mortality in Brazil from 1930-1945. It uses the increased professionalization and supervision of nurses as a lens in which to fully analyze various policies and programs that were debated within the medical community and Vargas administration. The corporatist state, in conjunction with doctors, consistently looked to nurses as a viable solution to this problem.

Key words:

**First Vargas Era; Nursing Education; Infant and maternal mortality**

Esta investigación examina artículos publicados en diversas revistas dedicadas a la salud que abordaron el problema de la mortalidad materno-infantil en Brasil entre 1930 y 1945. Se utiliza el creciente proceso de profesionalización y supervisión de las enfermeras como una ventana para analizar en profundidad variadas políticas y programas que fueron debatidos dentro de la comunidad médica y en el seno de la administración de Vargas. El estado corporativista, en conjunto con los doctores vieron de forma consistente a las enfermeras como agentes que podían hacer viable la solución de los problemas de la mortalidad materno-infantil.

Palabras clave:

**Primera Era de Vargas; Educación de Enfermeras; Mortalidad Infantil; Mortalidad Materna**

O texto originou-se em base à análise de várias revistas de saúde pública que trataram a questão da mortalidade infantil e das mães no Brasil entre 1930 e 1945. Usa-se a crescente profissionalização e supervisão das enfermeiras a respeito desses aspectos, como uma janela a partir da qual podem ser analisados, de maneira complexa, as várias políticas e programas que foram debatidos pela comunidade médica e a administração de Getúlio Vargas. O estado corporativo, em conjunto com os doutores, viram nas enfermeiras, de maneira consistente, a via de solução para os problemas em discussão.

Palavras-chave:

**Primeira era de Getúlio Vargas; Educação de enfermeiras; Mortalidade infantil; Mortalidade materna**

## Introduction

In Brazil, during the First Vargas Era, 1930-1945, state policy makers, administrators, and the medical community recognized that maternal and infant mortality was one of the biggest obstacles in constructing a cohesive national identity as part of a larger modernization project. If a woman's role in national development was to produce healthy children, the future of the nation, then any medical risk to a mother's health and a child's well-being needed to be conquered. This undertaking had a dual purpose: it would guarantee the next generation of Brazilians would actively participate in the future of the nation and helped foster the ideal of one unified race, *nossa raça*.

This article examines the concrete issue of astonishingly high infant and maternal mortality rates through the lens of public health initiatives, with a focus on the role of nurses. If the state saw children and mothers as an important part of the national identity, how could Brazil build itself into a strong and developed nation with such high numbers of children and mothers dying? It was this dilemma that inspired the state to look to public health programs and policies informed by the increased professionalization of nurses.

## Maternal and Infant Mortality: A Health and Social Problem

Infant and maternal mortality were recognized as a threat to building a cohesive nation very early in the Vargas Era. The medical community and government officials sought to discover the reasons and a cure for the problem that was costing the nation<sup>1</sup>. The poignancy of the problem was explicitly addressed by President Vargas in his Christmas Speech of 1932.

Children are a patriotic task with the power to perfect the race and progress of the nation. The state must assume the direction of children's health and well being when parents are unable<sup>2</sup>.

Vargas's words generated supportive responses from politicians and doctors, who applauded his efforts to resolve the poor quality of life for children and their families.

Statistics of 1932 show that for every 1,000 births in the nation's capital, 180.36 resulted in death at the time of delivery or before one month of age<sup>3</sup>. Without a comparative context these figures did not seem so ominous, but when compared with other urban centers in Table 1, it became obvious that infant mortality was a severe problem in Rio de Janeiro<sup>4</sup>.

**Table 1:** Co-efficient of Infant Mortality in Comparison with other Urban Centers

City	1920	1930
Berlin	157	73
New York	85	57
Paris	97	87
London	75	59
Rio de Janeiro	154	162

Source: Dr. João Vieira, "Higiene prenatal e infantil", *Folha Médica* (September 5, 1934): 293

Two factors, intertwined and not so easily separated, emerged as reasons for the high rates of infant disease and death. First, there were concrete medical threats to newborn and infant children, carefully documented and debated throughout the medical literature. Coincidental to this were the social problems caused by ignorance and poverty that doctors called attention to.

In the editorial section of *Folha Médica*, the journal further explained and quantified causes behind the problem of infant mortality in Rio de Janeiro. It was calculated that of all the deaths of children under the age of two, 45% died from nutrition and digestive disorders including diarrhea, 15% due to prenatal, natal and neonatal problems, which included congenital illness and difficult labor, 15% from respiratory infections, another 15% from transmittable illness, including syphilis, and the final 10% was attributed to other vague factors<sup>5</sup>.

In another article from the *Folha Médica*, Dr. Olinto de Oliveira, Inspector of Infant Hygiene in the Federal District, focused on social dimensions of infant and maternal mortality and the role of nurses. He openly argues that ignorance and extreme poverty were the leading reasons for high rates of infant and children death and disease. Furthermore, he believed that digestive and respiratory diseases, infections and problematic labor and delivery were a result of these issues. In his opinion, visiting nurses, who were professionally trained and morally well prepared, could combat the ongoing problem of ignorance. Their work would be concentrated in poor zones and they would take note of each house and counsel mothers and pregnant women to take their children, sick or not, to the closest health post to get medical advice and attention<sup>6</sup>.

In the health post, doctors would hand out pamphlets containing instructions on food preparation, rules of hygiene and the best way to care for their children. Future mothers needed particular attention by “specialists” on how to avoid the risks of labor. Dr. Olinto de Oliveira also recommended that a school of puericulture would help combat ignorance by preparing young women to be future mothers. They would learn how to bathe, feed and dress their children. He admitted the fight against poverty was more difficult and would need to be taken up by the state through various programs that offered economic assistance to poor women. For example, the Inspector of Infant Hygiene should distribute milk, sugar and flours<sup>7</sup>.

In December 1934, Dr. Pedro de Alcântara published an article that also addressed the problem of infant mortality. He touched on Dr. Oliveira’s ideas of direct and indirect causes for infant death and expanded on social factors that contributed to the problem. For him, poverty forced mothers to work outside of the home, depriving children of her care. In combination, ignorance exposed the women and their children to disease, inadequate diet and accidents. Scientific knowledge was the answer to these problems and he looked to the mother as both culprit and resolution<sup>8</sup>. Implicitly, women were accused of being unable to understand the principles of modern medicine and good hygiene.

Dr. Oliveira’s ideas were echoed one year later, when Dr. Ernesto Gonçalves Carneiro argued that the government needed to be more concerned with support and treatment of poor women, whose lives were at greater risk. Protecting poor women before, during, and after pregnancy would guarantee that the unborn child would not enter the world as diseased and impoverished<sup>9</sup>.

Growing consciousness of the importance of the mother's health prompted Vargas to confront the issue. In December 1939, he again devoted his Christmas Speech to the well being of children, but this time showed more concern for the health of mothers. Despite attempts to implement public health programs that were focused on lowering the incidence of childhood death and disease, Vargas recognized that the desired results had not been achieved. He drew special attention to the high rates of infant and maternal mortality and their cost to the nation, and emphasized that the state needed to turn its attention to women as mothers.

Throughout our vast territory, from urban centers to small nucleuses of population, we have not succeeded in installing an efficient network of maternity and infant welfare services (...) We all know the precarious treatment of pregnant women and the elevated coefficient of newborn mortality above all in the less fortunate classes. [This] problem is directly linked to the progress and the future of the nation<sup>10</sup>.

Later, in 1941, Dr. João Maurício Moniz de Aragão explained that it was indispensable to educate women within strict norms under the rubric of "conscious maternity." It was necessary for future mothers to understand the value and significance of their roles in continuing the species. In his opinion, the goal women should strive for was to have a normal pregnancy, a happy labor, and a healthy child. To achieve this end, education within the modern concepts of mental hygiene would guarantee success<sup>11</sup>.

A system of preconception education would be complimented by prenatal hygiene and assistance at the moment of labor by a specialized technician. In this model of care, the woman would feel comfortable and protected. Following labor and delivery, the child should be raised by an educated and instructed mother and watched over by a competent puericultor. Dr. Aragão concluded, "[t]his child will be a robust adolescent and a strong, vigorous young man. A healthy man constitutes the greatness of a people and the power of a nation"<sup>12</sup>.

In the same year, 1941, Dr. Arnaldo Moraes weighed in again on the problem of infant as well as maternal mortality. He cited numerous statistics that attested to the continuous high rates and argued that the best way to overcome them was to offer comprehensive assistance to poor women. "It is imperative that the men of government show compassion to the impoverished and unsupported woman and child". The high mortality rates were a national problem and thus deserved action and cooperation between central and state governments in establishing health centers and medical training for doctors, nurses and midwives<sup>13</sup>.

In general, doctors offered simplistic solutions to very complicated and entrenched problems. What emerged was a distinct rupture between how the medical community conceptualized poverty and the daily life of the working poor. Upper class educated, male doctors proposed humanitarian solutions, but had no idea of the harsh realities of daily life throughout lower income neighborhoods of the capital city. During this period, many policies and programs only saw the larger objective of a strong healthy unified race working towards the betterment of Brazil through the lens of abstract national pride. Many articles written by the medical establishment elaborated the ideological project of corporatism and nationalism but did not realistically address

daily existence of the people. At the societal level, survival meant fending off disease, starvation and homelessness, a reality that was completely foreign to wealthy doctors and politicians.

Notwithstanding this rupture, the state and medical establishment did make concrete steps toward the improvement of infant and maternal health. This should not be seen as monolithic response, but involved three broad sets of initiatives, which were bound together by the common thread of the professionalization of nursing: creation and centralization of infant and maternal medical services, promotion of milk banks and teaching kitchens, and the eradication of untrained midwives. These policies and programs loosely paralleled changes in the political sphere, gaining and losing priority in accordance with redefinition of the political structure and its ideological context.

These strategies were managed and defined by a complex administrative structure that was also in a state of constant change. With the Revolution of 1930, the new administration created, under the umbrella of the Ministry of Education and Public Health (Ministério da Educação e Saúde Pública, MESP), departments and divisions, whose main goal was to help govern prenatal and natal services. By 1934, the Administration for the Protection of Maternity and Infancy (Diretoria de Proteção à Maternidade e à Infância, DPMI) was established. In 1937, under the auspices of the Estado Novo, DPMI became the Division of Protection of Maternity, Infancy and Adolescence (Divisão de Amparo à Maternidade, à Infância e à Adolescência, DAMIA). And in another set of reforms in 1940, the National Department of the Child was created (Departamento Nacional da Criança, DNC), in conjunction with the National Institute of Puericulture (Instituto Nacional de Puericultura, INP), to oversee all policies, programs and issues related to maternal and infant mortality, child health and well-being<sup>14</sup>. Aside from the various managerial entities created, there were a number of important changes made in the clinic structure of the Federal District.

## **Creation and Centralization of Infant and Maternal Health Services**

Prenatal care in the early years of the Vargas era was characterized by insufficient services and lack of resources. For example, there were not enough beds and clinics to accommodate the number of annual births. It was estimated in 1931 there were 200 beds available to pregnant women in Rio de Janeiro, however, according to Dr. Jorge Santa Anna, the city population required approximately 1,300 beds<sup>15</sup>.

In March of 1933 Dr. Arnaldo Moraes brought attention to the shortage of services in the capital city. He affirmed that prenatal dispensaries were only beginning to be built in sufficient numbers, the money allocated to prenatal and infant hygiene was precarious and the teaching of clinical obstetrics was mediocre. He also pointed out that due to lack of funds, no Chair for Clinical Obstetrics had been hired<sup>16</sup>. His overall assessment was short but harsh and called into question the sincerity of the state's commitment to fight infant mortality.

Dr. Moraes' arguments were substantiated. As the Director of the Vila Isabel Prenatal

Hygiene Dispensary, he saw first-hand the problems associated with lack of services and maternity support. In his annual report for 1932 a number of problems arose that pointed to these lack of services. For example, he noted seven out of ten stillborn deaths were assisted by unlicensed midwives. Labor began at home and only when the mother started to suffer did these women seek medical assistance at the dispensary. He also found most of the patients had not been to the dispensary for pre-natal check-ups and did not return for follow up exams<sup>17</sup>. He believed that if more dispensaries and clinics were available to women they would be more diligent about prenatal exams, doctor assisted delivery and follow up medical appointments for themselves and their children.

In May of 1933, Dr. Olinto de Oliveira conducted a survey of the prenatal and infant hygiene services available in the Federal District. He strongly urged Vargas to allocate more money in order to enlarge prenatal and delivery services. At the time the survey was conducted, there were four active maternity wards: Laranjeiras with 80 beds, Hospital Pro-Matre with 70, Suburbana Maternity had 40 and Pedro Ernesto or Rural Maternity Hospital had 20, for a total of 210 beds. In addition, some beds were allocated to pregnant women at the Catholic hospitals; Santa Casa de Misericórdia, São Francisco de Assis and São João Batista. There were also 20 short term care beds available in a number of small delivery homes scattered throughout the city<sup>18</sup>.

An auxiliary branch of the system was twenty-one small posts primarily outfitted with four beds, staffed by a nurse and an assistant, and equipped with a phone for emergencies. In these posts, patients were treated and moved to a maternity hospital. Their locations included: Guaratiba, Santa Cruz, Ilha do Governador, Ilha de Paquetá, Catumbi, Linha Auxiliar, Realengo, and dispersed throughout the favelas. Another critical component that came to light in the survey was the Home Service. This sector was supposed to organize a census of pregnancies, distribute instructive propaganda and conduct visitations to verify the conditions of the home and living situation. It was created to offer emergency assistance during labor by specialized nurses<sup>19</sup>.

The underlying issues that emerged from the survey and letter of explanation were immediate lack of funding and trained staff, and more importantly a general lack of properly trained nurses. While the infrastructure was comprehensive in theory, what became apparent in later studies was the lack of money to sustain services and the poor condition of many of the clinics, dispensaries and maternity wards.

The issue of economic efficiency was also raised. After these surveys were conducted, it was clear that building larger and more modern maternity wards was time consuming and expensive. The solution to this problem was the creation of prenatal and infant hygiene posts, which in addition to labor and delivery support, would better serve the capital city's poor population. These clinics offered medical exams, dental services, civil record registration, dietary classes and child welfare courses for new mothers. By 1934 their number had doubled from 10 to 20<sup>20</sup>.

In June of 1936, Drs. Olinto de Oliveira and Joaquim Martagão Gesteira appealed to Gustavo Capanema, Minister of the MESP, to create the Getulio Vargas National Institute



of Puericulture (Instituto Nacional de Puericultura Getulio Vargas, INP-GV). Justifying the establishment of a centralized office devoted to child welfare, they argued that “the salvation of our small patriots addressed the larger question of the defense of our race”<sup>21</sup>.

The proposed structure would be composed of numerous and diverse services comprised of: a pregnancy clinic to teach the practice of prenatal hygiene, a clinic for new mothers to disseminate standards of infant hygiene, a nursery, an annex for laboratories and x-rays, a teaching kitchen to demonstrate to new mothers how to prepare infant meals, and a maternal cafeteria. Another section of the Institute would provide a space where poor women could rest before labor. There would be a maternity ward, maternity shelter and a night nursery. The last section of the plan would include a museum and library. Three courses would be offered at the INP-GV: A three-month elementary course instructing school girls to make dolls and other crafts; a mid-level course for normal school graduates and women of society; and a superior course for doctors and persons with a higher degree<sup>22</sup>. No suggestions were made regarding funding the new program, but a sense of urgency was made apparent in order to eradicate the problems of infant mortality and disease.

Oliveira affirmed “the structure would offer moral and material assistance to a large number of destitute mothers and poor children and would facilitate the practices of social and individual hygiene”<sup>23</sup>. Here emerged the conceptualization of hygiene as both an individual and social issue. The very core of corporatism was the reciprocal relationship between the state and society. Initiatives, programs and services were created and implemented with the expressed concern of bettering society. Added to this was how individual identities were subsumed into broader categories, such as profession, gender, familial relations, and age groups. Public health was an integral part of this complicated scenario because it focused on improving the health of the individual for the benefit of the nation. In this context, childbirth was also harnessed as an activity that was encouraged for social benefit.

While many of the proposals of Oliveira and Gesteira were vague, the driving principles of the Institute were in accordance with state thinking. A National Institute of Puericulture was a centralized approach to the increasingly obvious problem of the ineffective labyrinth of services dedicated to women and children’s health. Just as the political arena was becoming standardized and centralized under the auspices of the corporatist ideology, so was health care.

Following the suggestions of Oliveira and Gesteira, a National Institute of Puericulture (Instituto Nacional de Puericultura, INP) was created by law 378 on January 13, 1937, under article 54, of the new organizational format of MESP. Dr. Joaquim Martagão Gesteira was appointed its Director and later that year in December the INP was incorporated into the newly formed federal university under law 98<sup>24</sup>. Within the umbrella of service and programs there was also a specific department dedicated to the federal capital, the Puericulture Service of the Federal District (Serviço de Puericultura do Distrito Federal, SPDF).

The main goal of the INP was to study and investigate health and hygiene problems of children. Moreover, it was responsible for the organization of puericulture courses at the medical

school, as well as the educational preparation of Brazilian mothers. The Institute was composed of three sections: 1) research and investigation, 2) assistance services – eugenics and prenatal puericulture, post natal puericulture and pediatrics and pathology, and 3) educational - superior course for doctors, mid-level course for nurses and women of society and an elementary course for girls. This course had speakers and films and was free of charge<sup>25</sup>. The INP hoped that material and observations collected would lead to research and publication in the annual journal, *Revista do Instituto*<sup>26</sup>.

Nevertheless, the structure of the Institute was more complex than just a few medical offices and exam rooms. There was a belief at many administrative levels that the state should offer a number of services guaranteeing the health of the child from pre-conception to school age. In the drafted “Project of Regulation,” Capanema took into consideration Oliveira and Gesteira’s early suggestions to establish a comprehensive set of services and health centers that not only sought to battle against infant and maternal disease and death, but was also reflective of the Vargas Administration’s dual objective, to centralize and standardize federal authority in every aspect of daily life and improve the Brazilian population, for the greater good of the nation.

Above all, the INP was established as a model and dictated policy, which remained true to the Vargas model of central bureaucratic management from the top down. Even though the INP was established in Rio de Janeiro and initially sought to incorporate the clinic at Gamboa, the Puericulture Service of the Federal District (SPDF) was established shortly after and became the governing body of services and clinics open to the public in the capital city.

The SPDF was inaugurated in May of 1937 and headquartered at the Arthur Bernardes Children’s Hospital, in Flamengo, near downtown, with Dr. Mario Olinto de Oliveira as its Director. Its staff included, among others, prominent doctors with a long history of work in the field of infant mortality and disease in the capital city, Dr. Clovis Corrêa da Costa, Inspector of Maternal Hygiene and Medicine, and Dr. Arnaldo de Moraes<sup>27</sup>. The SPDF was made up of puericulture centers, health posts, outpatient clinics, food assistant posts, a section of maternity hygiene and medicine, and maternity clinics. The puericulture centers were the most comprehensive and well staffed with 20 pediatricians, 10 ear nose and throats specialists, 10 dentists, a 20 person maintenance staff, 20 guards and 20 servants. The health posts constituted the next level of care and were staffed by 10 pediatricians, 10 maintenance personnel, guards and servants.

The outpatient clinics, focused on less complicated medical procedures, were staffed with eight clinical supervisors, students and groundskeepers, guards and servants. The food services sector provided nutritional support to poor women and their children. and consisted of a supervisor, two assistants, eight maintenance personnel and 16 servants. The Division of Maternity Hygiene and Medicine represented a new direction in the battle against infant death and diseases. The focus of this division was on pre-conception health and delivery. There was one technical inspector, a supervisor of prenatal exams, 20 labor and delivery specialists and a total support staff of 20 maintenance personnel, guards and servants. The last line of services offered included maternity wards, which were staffed with four chiefs and eight assistants<sup>28</sup>.



SPDF was illustrative of the micro-management approach of the Vargas Era. It was designed to fit into the centralized model as were many of the other changes implemented throughout the period. MESP would supervise the INP which in turn would manage the SPDF. Within the SPDF, the Director and his board would supervise the eight divisions. While the eight divisions would interact with the public and make medical decisions based on these interactions, the guiding policy and management decisions would come from the top with each level referring to the one above them for approval. The thinking was that with centralization efficiency would follow, resulting in lower rates of infant disease and death. This idea was not new or unique to Brazil but took on new meaning in the corporatist regime. As evidenced in the writing of Brazilian and international public health administrators, economic efficiency was the answer to fiscal issues and health concerns<sup>29</sup>.

However, the SPDF suffered from a number of problems early on. In September 1938, Dr. Oliveira wrote to Gustavo Capanema to complain about some of the problems he was encountering in trying to set up the SPDF. Most importantly, Arthur Bernardes Children's Hospital, which was shut for renovations three and a half years before, had still not reopened and the 20 health centers and posts had been reduced to 18 because of lack of money and trained personnel. Food service centers had not even been constructed and the one existing center in Gamboa was near collapse. The maternity centers were non-existent and lacked any type of funding for home delivery assistance. The hospital maternity ward in São Cristóvão had encountered numerous difficulties in daily operations and the only other maternity ward, part of the Arthur Bernardes Children's Hospital was closed due to lengthy renovations. Additionally, Dr. Oliveira's other proposed services, such as social assistance to poor mothers and home obstetric service, had not been taken into serious consideration<sup>30</sup>. He was outspoken about these concerns and even suggested at one point that the INP and all lower sectors should be privatized and not fall under the supervision of the MESP<sup>31</sup>.

In July of 1939, Dr. Clovis Corrêa da Costa drafted a formal report to Minister Capanema bringing to light a number of problems with the puericulture centers. The state was confronted with the general lack of services and poorly defined policies that needed to be more concretely defined. First, it was clearly articulated that many doctors who worked in the health centers did not understand poverty that women who frequented the centers lived under. Also a major obstacle was lack of space throughout maternity wards in the city<sup>32</sup>. Although some women were coming to the health centers to seek treatment, many were being turned away because their medical needs could not be met.

Corrêa da Costa cited the poor condition of health centers as another reason for a lack of professional service. The fourteen health posts that he visited were in various states of decay and some presented dangers to pregnant women. For example, the center at Tiradentes was located on the 2<sup>nd</sup> floor of an old condemned building whose only access was a long and dark staircase, which had already provoked accidents among pregnant women. The Teodoro da Silva Center had termites and urgently needed general repairs and the one on Rua Visconde de Jequitinhonha proved to be too hot in the summer and had a particularly steep and dangerous staircase which was a danger pregnant women and children<sup>33</sup>.

Clinic bureaucracy, or lack thereof, also raised issues of competency. While some doctors were very detailed in their record keeping others were not, leaving many of the records incomplete. Examination of the patients was not professional and lack of equipment proved to be another obstacle. Absence of competent records, poorly made exams and faulty and missing equipment made it difficult to keep track of women who were utilizing these services. It was impossible for the centers to maintain an ongoing relationship because the course of treatment for pregnant women was inconsistent. Postpartum exams were not even considered feasible because there was no way of knowing how the pregnancy had ended. According to Dr. Corrêa da Costa, the clinics needed to be more closely supervised<sup>34</sup>. He made a number of important observations and suggestions, most importantly, was the lack of financial resources and trained medical staff. In his opinion nurses were the answer to this problem.

Many in the medical community were in agreement with him. Irene Drummond, a non-practicing medical doctor, wrote an article in *Brasil Médico* that offered her support to this problem and called on the state to develop a visiting nurse program. She cited poor distribution of beds for obstetric patients and felt that home birth, with the presence and supervision of a visiting nurse, was a good alternative. It was her experience that women in labor went to the health centers only to be sent home again. While large central maternity wards were the best answer, they were expensive and took a long time to build. In the meantime, "ignorant" pregnant women not seeking out services in the smaller clinics throughout the city due to lack of space and were giving birth at home solely with the help of an untrained midwife.

To guarantee the success of the program, it was indispensable to have a specialized team of visiting nurses, which included an obstetric nurse, a trained midwife and social assistant. It was not possible to separate one from the other. Since someone should educate the pregnant women and new mother and assist in the necessities, it was preferable all the attributes be conferred in the same person. A visiting nurse had a double role to educate and investigate<sup>35</sup>. The role of the nurse in prenatal care and assistance during labor would become a state focus later on, but in the meantime the state turned its attention to better understanding lack of services in the federal capital.

Capanema and other members of the state medical community continued to sing the praises of puericulture and services offered in the Federal District. Instead of addressing Oliveira's criticisms, the state re-focused its attention on resolutions to problems that were less expensive and already established. It was a move to ignore obvious faults of the system and only focus on what was being done right. There was continued theorizing on the best system to meet the needs of the public through more economical means.

By 1941 the medical community agreed that the state's measures to implement and establish medical services were not working. The city of Rio de Janeiro was still plagued by high rates of infant mortality. According to Dr. Carlos Abreu, in 1938 23.3% of all children died before the age of one and 42.5% died before reaching the age of nine. Of those who died before the age of one, 20% were victims of gastro-intestinal disease while the countless others who escaped death still suffered from malnutrition<sup>36</sup>.

The state did not immediately shift its focus away from building a medical service structure to accommodate poor pregnant women. Instead, a number of bureaucratic changes followed. In January 1940, all 20 puericulture posts were transferred to the Rio de Janeiro's Mayor's office in accordance with decree-law 1040 of January 11, 1939. They were eventually subordinated to the Department of Puericulture, which was created by decree-law 6641 March 14, 1940. The posts were: Botafogo, Central, Catumbi, Copacabana, Engenho Novo, Estrela, Gamboa, Gávea, Ipanema, Laranjeiras, Morro do Pinto, Missão de Cruz, Madureira, Piedade, São Cristavão, Santa Teresa, São Francisco Xavier, Triagem, Vila Isabel, São Vicente de Paula.

A few years later, another survey was conducted in order to best assess what services were available and what needed to be done<sup>37</sup>. The 1943 Survey illustrated lack of medical services available to poor pregnant women, despite the state's diverse attempts to lower infant mortality through increased medical services available. Health posts and clinics were in constant need of repairs, money and trained staff. The administration grappled with what model was best suited for the capital city, large central maternity wards or smaller neighborhood clinics. What transpired was a confusing web of services caught in a constant state of renovation that was never able to meet the needs of poor mothers. In addition, the survey illustrated a change in direction from an emphasis on medical services to food programs and nursing.

According to the survey, written by Dr. Carlos Abreu, official measures undertaken by the state were envisioned to elevate the economic and cultural level of people through the improved dietary and nutritional standards of children under one year old. He pointed out that ignorance and poverty were prevalent in the city and the most adequate method to combat these problems was the distribution of milk, flour, juice, vegetable stews and soups. He also recognized that the current public health system while targeting the "unprotected" portions of the city's population still only managed to serve 50% of the needy<sup>38</sup>. Focusing on the poor and ignorant was one way the medical establishment, in concert with the state agenda, could close the societal divide and promote the idea of a cohesive national identity while at the same time opening a larger space for nurses to work.

The Mayor's office had immediate plans to build more teaching kitchens in order to disseminate food preparation lessons. There was a continued movement to register women in the puericulture posts in order to keep tabs on them throughout their pregnancy, but the move was away from providing medical services instead focused on teaching them practical skills of motherhood based on scientific and modern principles of child welfare<sup>39</sup>.

The city government turned its attention to the construction of new puericulture posts in suburban areas. According to Abreu, the new posts were more economical and did not require costly medical equipment. He believed puericulture posts could be modestly installed with simple construction of wood and would be staffed by visiting nurses, not doctors<sup>40</sup>. The use of nurses also represented a new direction in the state's thinking. Nurses were less expensive to educate and, as women, they may have gained more acceptance in the field of obstetrics and gynecology. They could also function as social workers enlarging the field of state influence into homes and private lives of poor women.

The National Institute of Puericulture and the Puericulture Service of the Federal District looked good on paper and in theory should have been able to confront many, if not all of the problems that were impacting children in the capital city. Yet Capanema and his fellow politicians and doctors found reality to be much more complicated. An enduring lack of resources, staff and an inefficient public health system directly affected the quality and outcome of medical services.

Early in the Vargas Era, the state relied on already existing public health posts and dispensaries to make up the medical service infrastructure. These health posts and clinics were inadequate, and prior to the founding of INP and SPDF there was no infusion of monetary resources to bring them into line with demands for a new centralized governing body. Also, with the state focused on establishment of the INP, many other aspects of public health services were ignored.

Detailed surveys that came later in the period recognized the weaknesses of the public health system and began to focus primarily on nutrition and feeding of women and children and the role of visiting nurses. Although neither of these fields were new to the administration, renewed emphasis on them changed the course of action to combat infant mortality and subsequently construct a new national identity centered on a healthy and prosperous Brazilian. Also, within this new direction, puericulture in Brazil became intimately and narrowly associated with diet, nutrition and the increasing importance of nurses.

## **Milk Banks & Teaching Kitchens: A Nurses Proper Place**

Doctors and politicians were aware of sub-standard dietary habits of poor populations and knew malnutrition was one of the reasons that young children, under the age of two, were dying in such high numbers. A milk bank was a centrally located kitchen that prepared healthy meals for poor women and also pasteurized milk for newborn consumption. In addition, women were educated about the preparation of healthy meals and practical notions of hygiene. The essential role of milk banks was recognized within the medical community and the state as an answer to infant disease.

Similar to public health centers, the federal capital had a large number of milk banks and was an optimum place to experiment with the implementation of the teaching kitchens. The milk bank program was developed in June 1931 and was managed by the National Department of Public Health. It was funded by state money but also received a large portion of its financial support from the Association of Society Women for the Protection of Infancy, who campaigned for private donations. It was initially a rural program with its headquarters in Jacarepaguá<sup>41</sup>.

Dr. Olinto de Oliveira was an ardent supporter of food service programs and advocated very early on in the Vargas Era to expand such initiatives. He argued that “the basic principle in combating infant mortality was to protect the women and the home in order to ensure a happy child”. In his opinion, the best way to promote a robust and happy child was to provide poor

families with good quality milk, flour, fruits, and vegetables. While his call for material support did not outline any concrete plans, his line of thinking can be seen in support of the milk bank program. As with the medical service infrastructure, many of his suggestions were later incorporated into state policy<sup>42</sup>.

In early 1933, the role of milk banks in the fight against infant mortality began to reach a larger audience. In *Folha Médica*, Dr. José Savarese, Director of Rural Sanitation in the Federal District, argued that, in rural zones in particular, children were born into ignorance and were the victims of insufficient maternal feeding. In his view, it was the responsibility of the public health system to organize the largest number of milk banks possible. According to his calculations 30% of children died from gastro-intestinal illness within the first two years of life. The number of deaths for children enrolled in the milk bank dropped to 1%<sup>43</sup>.

In September of the same year, Dr. Savarese presented his work at the National Conference for the Protection of Infancy, in Rio de Janeiro. While his speech reiterated the role of ignorance and poverty in the lack of nutrition and proper diet, he took his plan further and made many concrete suggestions to expand and enhance the milk bank service. Based on the work of milk banks in Penha, Campo Grande, Anchieta, Bangu and Ilha do Governador with poor families; he outlined a plan of action. First, the state should construct milk bank centers throughout the Federal District, mostly in the favelas, factory centers and rural zones. Within these centers, diverse services should be offered, such as prenuptial and eugenic counseling, prenatal and infant hygiene clinics as well as nurseries. In addition, infant hospitals, a central maternity ward and small centers in conjunction with health centers for pregnant women should also be erected. A shelter for homeless mothers, a maternal school and laws protecting domestic and factory workers should also be part of the state's plan to protect women and children<sup>44</sup>.

Dr. Savarese continued to campaign for the expansion of milk banks. He argued, "in part the ignorance of mothers in the feeding of newborns is the known cause as determining infant mortality in the first 2 years of life". But he took the role of the state and food distribution programs even further. In his opinion, "poverty was incompatible with order, discipline, morality and education". In establishing the relationship between poverty and morality, Savarese also drew attention to larger issues such as the "powerful factors like bad heredity conditions of the parents whose union in general is made without attending to the rules of eugenics and as such resulted in precarious births". According to him, "milk banks could resolve poor and inadequate diets, a major cause of infant mortality", but could also cure Brazilian society of many of the social ills that impacted the lives and health of children<sup>45</sup>.

Dr. Savarese's comments hinted at the other side of the medical establishment's concerns. In spite of the many state initiatives supporting the betterment of the Brazilian race, they did not explicitly engage in a discourse about the racial and biological factors that determined health and well being. Savarese ultimately couched his concerns in the language of eugenics which had the ability to overcome these issues. In this sense, while he came close to engaging the debates over scientific racism that the Vargas administration had been so careful to avoid, there was still a way to resolve the problem, through medical and social programs like the milk banks.

There was renewed focus on the care and feeding of children, through which the state could meet numerous demands with little output, hopefully attain better results and open up a larger sphere of influence for nurses. Early years of the Vargas administration focused on medical services and even though other social programs were not ignored they were not given priority. In the later years, instead of trying to rebuild and start from scratch in the construction of large central maternity wards and prenatal and infant hygiene clinics, the medical community and state picked up the banner of poor diet and nutrition as the leading cause of infant death and disease and showed renewed interest in trying to eradicate this problem.

In January of 1937 under law no. 378, chapter 9, article 116 the federal government took over policy implementation and management of milk banks. This shift was part of the larger centralization of authority in the sphere of public health<sup>46</sup>. Moreover, it was representative of the general move to centralize services in order to make programs more efficient. Just as medical services for women and children were being brought together under the umbrella of the INP and SPDF, milk banks and other food distribution programs were being brought together under federal control.

In late 1937 Dr. Savarese wrote to President Vargas urging him to recognize the important contributions of a large scale milk bank system. In his letter, he made reference to his presentation at the conference from four years earlier and reiterated many of the same points. Savarese was also critical of the government for not taking his proposals seriously. He argued that there was no such thing as infant hygiene in Brazil because so many children were still dying of avoidable causes. In the capital city, infant mortality rates were 200 for every 1,000 births. In his point of view an infant milk bank system was still the best option to lower these figures<sup>47</sup>.

Vargas directed his response in a memo to Capanema a few days later on October 23, 1937. He asked that the Minister take a closer look at the value of milk banks as a weapon in the fight against infant mortality. Capanema's reply to the President accounted for 252 milk banks that served 835 Brazilian municipalities and were organized by the National Department of Health. He affirmed that he would undertake a careful study of the infant feeding problem, to better understand the role of milk banks<sup>48</sup>.

The writings of Savarese, and correspondence between Vargas and Capanema, point to an important juncture in public health policy and local programs. While the national government was moving to centralize programs and services in order to guarantee efficiency, such moves did not always promise success. Dr. Savarese, like Dr. Olinto de Oliveira, was critical of the state's actions, but such debates were not open to the general public and made by individuals not a collective majority. The state evaluated new programs and if they were deemed beneficial to the nation they were incorporated into the larger public health structure. Programs and policies that combated infant death and disease were linked to the larger project of societal improvement and national development.

In 1940, the federal government began to transfer many maternal and infant services to municipal governments. While no mention of milk banks was specifically made, other food



distribution programs emerged and were under the direction of the capital city's Mayors office and included small milk distribution sections as part of their larger structure. In particular, teaching kitchens became an important focal point within the field of maternal and infant support services.

The March 29, 1941 issue of *Brasil Médico* was dedicated to covering the ceremony commemorating Children's Day. Mayor Henrique Dodsworth, Dr. Carlos Abreu, Director of the Department of Puericulture, Dr. Mario Ramos, Chief of the 4<sup>th</sup> District of Puericulture in Botafogo and a number of other medical doctors were present and made speeches that shed light on many of the new directions of public health programs. Dr. Jesuino de Albuquerque, Secretary of Health and Assistance of the Federal District, in his opening remarks, praised Puericulture Service of the Federal District for supporting expansion of the teaching kitchen program and added that such accomplishments were integral to the "formation of the future potential of the Brazilian Man"<sup>49</sup>.

Teaching kitchens emerged as an economical tool in helping teach women how to be good and competent mothers. As infant malnutrition became viewed as a serious health problem the state redirected its energies toward teaching women how to cook healthy and nutritious meals. But the state's objective was much broader and not viable. Drawing women into food programs helped reinforce the ideal role of mother that the state had constructed. Yet, at the same time the implementation of food programs illustrated how unrealistic state thinking was. Politicians and doctors assumed that handing out milk and other essentials and teaching women how to prepare it was the answer. No consideration was given to the absence of running or clean water, electricity or deficiencies in living conditions.

The new kitchens, relatively simple with a small area to prepare meals and staffed by nursing students, were opened in Botafogo on Rua General Severiano, in Copacabana on Rua Rainha Elizabeth, and in Vila Isabel, on Rua Teodoro da Silva. These facilities would also include milk banks that would furnish 3,000 bottles of milk a day and adhere to the latest scientific methods of feeding. The objective of the teaching kitchen and milk banks was to assist in regular feeding of children by keeping their food intake under strict control. The medical community believed that the establishment of a standard diet in accordance with the child's age was an indispensable tool in the fight against infant mortality.

A speech by Dr. Salvio Mendonça, Chief of the 8<sup>th</sup> District of Puericulture, claimed that teaching kitchens represented a contribution of great medico-social significance, representing "a truly new path to reduce infant mortality that above all weighed heavily on death rates of the general population". He continued that "the severity of our demographic statistics is really disquieting in the capital because not only is it a threat to progress but all methods to lower infant and mortality have been ineffective". For Dr. Mendonça, the primary function of the public health system was to guarantee proper feeding of Brazilian children in order to lower infant death and disease and amplify the vitality of the nation. Teaching women to cook and providing them and their children with proper nutrition was the most successful avenue to pursue<sup>50</sup>.

Dr. Carlos Abreu also participated in the commemoration, and said that the role of the kitchen was very important in the fight against infant mortality with the objective of reducing

death of children enrolled in these services. Each of these centers was to be guided by scientific principles and it was the “noble task of puericulture to assist the poor mother in raising her child”. He recognized that the web of services was sometimes confusing due to lack of funds and staff, a duplication of services at the federal and municipal level and lack of centralization for diverse services<sup>51</sup>.

Within the maternal and infancy support system the kitchen was proving to be the most effective way to draw poor women in to the system and was also cost effective. The three new kitchens that were being inaugurated were to be followed by five more, in Gamboa, Penha, Bangu, Rua da Relação, and Praça da Bandeira. In the opinion of Dr. Abreu the role of the kitchen would not only “combat infant mortality but also better the race”<sup>52</sup>.

Aside from the role of the teaching kitchens, Dr. Abreu superficially alluded to other weapons in the fight against infant mortality. First, he called on the state to make a census of all pregnant women in the Federal District. Second, he appealed for stricter management of unlicensed midwives, concentrating on prenatal and obstetric education and services. In his opinion, more obstetric beds needed to be made available as well as expanded prenatal hygiene and obstetric education. Abreu vaguely conceded that more could be done to improve the health of newborn children but offered very little in the way of concrete plans. This show of concern with little action was typical of the later Vargas Administration<sup>53</sup>.

## **The Midwife Problem and the Professionalization of Nurses**

In the later years of the Vargas Era, the administration, at many levels, took a closer look at the persistence of the midwife problem and its relationship to nursing. Initially, the state took official steps to supervise any person who wanted to practice medicine. In doing so, midwives, who had only gained the attention of a few doctors, became a larger target of many reforms to remove them from power. Moreover, with the creation of a public health and hygiene certification course and curriculum, coursework of the nursing school was revamped to include gynecology, labor and delivery courses. The medical community and politicians felt these changes would help them overcome a losing battle in the fight against infant mortality, with the midwife centered squarely in the middle of the problem.

There was a sharp distinction made between a nurse, a trained midwife and an untrained midwife. The first two had some degree of education and more importantly were under the supervision of the medical establishment and the state. In order to better a child’s chances of survival, the state wanted to control and manage a woman’s labor. However, the reality was women in the Federal District were having their babies at home assisted by an untrained and uneducated midwife. Further professionalization of the nurse and more education seemed to be a logical answer to this problem.

In January of 1937, the federal government created the National Service of the Supervision

of Medicine (Serviço Nacional de Fiscalização da Medicina, SNFM) under law 378, article 33, with the explicit purpose to centralize and professionalize the practice of medicine<sup>54</sup>. It called for immediate supervision of all persons practicing medicine, pharmacy, dentistry, veterinary medicine, nursing, and many other medical professions. Article 9 sec. 1 of the new law required that people in all of the professional categories had to register their diplomas with state authorities<sup>55</sup>.

The new resolution had an immense impact on the Ana Nery School of Nursing (*Escola de Enfermagem Ana Nery*, EEAN) and the role of nurses working with prenatal and infant hygiene. While Bertha Pullen, from the United States, the schools director, had campaigned for stricter control over who was considered a nurse, her pleas were never directly addressed. The centralizing move of the state incorporated many of the concerns that had been expressed before. Closer state supervision provoked dramatic changes in the administrative structure of the school. The first major change to come about after the creation of the SNFM was renovation of the nursing school curriculum.

In 1937, two new courses were available for nursing students. First, there was the "Fundamental Principles of Public Health Nursing". This was a basic course that did not focus on women and children. The second course was geared to visiting nurses who worked in puericulture, with the explicit goal of protecting the infant and the mother. Protection of the infant was usually at the exclusion of the mother as nurses were seen as scientifically trained and knowledgeable. Protection of the pregnant woman focused on prenatal visits made to the home and offered courses for future mothers on breastfeeding, care and nutrition. There was also a series of lectures devoted to the special vigilance of mothers who worked as they posed a danger to the health and well being of their child<sup>56</sup>. Course descriptions were relatively superficial and did not offer students any hands on training or practical experience. As the debate heated up about lack of services and staff, and the problem of untrained midwives, many male doctors agitated for new courses to better prepare nursing students for specialized care.

Also at this time, the nursing school underwent a number of administrative changes that weakened its autonomy. In January 1937 the school was moved to the Director of Port Health of the Federal District and then in March of the same year it was relocated to the Director of the Health of the Federal District. And finally in July 1937 under law 452, the EEAN was transferred to the University of Brazil, which was administered by the Department of Education, MESP<sup>57</sup>. The nursing school administration felt that each change "reflected considerably in the efficient management of the school". However, the enrollment of new students continued to be low<sup>58</sup>.

In November 1937, Ms. Mary Elizabeth Tennant, from the Rockefeller Foundation's Division of Nursing, arrived in Rio to study the nursing situation. One of her major concerns was the poor training many of the nurses received. She also complained that public health nursing skills were superficial. By the end of 1937, there were 258 graduates and 11 certified practical nurses<sup>59</sup>. In addition to poor performance, Bertha Pullen, who was considered a knowledgeable leader and expert from the United States, and who had the support of the Rockefeller Foundation resigned as of August 31, 1938 and no permanent replacement was appointed<sup>60</sup>. These changes coincided with increased participation of medical school professors and students from the public health course in the EEAN.

In May of the same year, J. P. Fontenelle, Professor of Sanitary Organization and Hygiene and Public Health Administration, published an extensive report on prenatal services in the Federal District. Part of the report presented statistics of the services yet rendered with no in-depth analysis. The other half was focused on problems related to untrained midwives. According to Fontenelle, hundreds of unlicensed, uneducated and illiterate midwives assisted in a high number of deliveries in Rio de Janeiro and posed a threat to expecting mothers<sup>61</sup>. Even though sanitary regulations prohibited these untrained women from practicing, they assisted 95% of all deliveries throughout the city. Fontenelle's studies show among 3,798 pregnant women who completed the services of the health centers in 1935 and 1936, 2,429 (86.20%) were assisted by untrained midwives, 248 (8.8%) by doctors at home and 141 (5%) gave birth in hospitals and maternity wards. He recognized that it was impossible to eliminate untrained midwives and felt surveillance by public health nurses and supervision by the medical establishment was the best way to resolve this problem<sup>62</sup>.

His plan was vague and unstructured yet outlined how visiting nurses would collect names and addresses of women enrolled in health centers and prenatal dispensaries. They would then make home visits to verify the mother's health and disseminate educational material including lessons about prenatal and pregnancy hygiene. The overall objective was to ensure that the woman returned to the dispensary for labor and later infant medical exams<sup>63</sup>. While Fontenelle's report did not offer a detailed solution, it did illuminate the seriousness of the untrained midwife problem. Future state inquires investigated this issue further and had more concrete solutions.

In July 1939, Dr. Clovis Corrêa de Costa once again advocated for the development of a home delivery service. He wrote a report on the condition of maternal and infant hygiene in the federal city. As he had done before, he emphasized the "precarious nature of labor and delivery service in the capital city". This time, however, he verified that there were only 350 beds to accommodate the 33,674 deliveries. The current number of beds attended to 9,100 deliveries per year. The remaining 27,674 deliveries occurred outside of the hospital. He went on to say that only 10,000 of these women could have afforded adequate medical attention. The rest lacked proper housing, hygiene and lived in abject poverty, and would have benefitted from medical attention in maternity wards had there been space<sup>64</sup>.

Costa reoriented his proposal to include an examination of midwives and their involvement in pregnancies of poor women. He noted that untrained midwives were the only option for women not served by the maternity ward system. He estimated for every 200 deliveries untrained midwives assisted in 132 times. He believed the solution was to build more maternity wards and create a Home Obstetric Service (*Assistência Obstétrica Domiliciar, AOD*), with the latter receiving more attention as the entire program of support for maternity could not be executed simultaneously due to financial reasons. Internment was reserved for those with toxemia, complicated labor and substandard living conditions. Home assistance was ideal for a healthy patient who had no complications and satisfactory living conditions. According to his plan, patients under the care of the AOD did not require food, clothing, light, medications, nursing services, and there would be no disruption to the home life of other family members. Taking away the care of the mother and wife, who attended to the domestic economy, was disruptive to the moral order of the household<sup>65</sup>.

People in charge of deliveries were the fundamental cornerstone of AOD and were supervised by the medical infrastructure. Criteria for selecting the midwives was problematic. Dr. Corrêa de Costa proposed an open certification program for midwives. They would be obliged to complete an internship in one of the city's maternity wards and remain under constant supervision of a medical doctor. Because of the lack of trained midwives and a certification program, he suggested the service utilize nurses who specialized in obstetrics<sup>66</sup>.

The AOD would provide visiting nurses with necessary materials for a natural birth - alcohol, mercury, silver nitrate solution, cotton, gauze, coconut soap, thermometer, scissors, stethoscope, and string to tie the umbilical cord. He estimated that 1,000 bags containing these vital items would be needed for the inauguration of this service. Transport of the midwife to the residence during the night would necessitate a few automobiles and removal, in case of complications, would require ambulances. Dr. Corrêa de Costa stipulated that only women previously enrolled in puericulture clinics were eligible for AOD services. In summary, Dr. Corrêa de Costa proposed that lack of services and staff in the maternity services could be resolved in two ways. First, as discussed earlier, was the costly construction of new clinics and maternity wards. Second, recognizing the financial constraints, the creation of a home labor service comprised of visiting public health nurses trained in obstetrics and certified midwives<sup>67</sup>.

Like others before, Dr. Corrêa de Costa's plan looked good on paper but did not realistically assess financial and physical restrictions of the maternal and infant hygiene infrastructure. The state, despite valiant attempts to accurately quantify its poor population, never had a complete picture of the problem. While estimates were made in good faith, their final tabulations were probably much lower. In addition to a lack of numerical understanding, the state and medical community never fully understood how impoverished many of the city's residents were. To assume only 17,000 plus women out of an estimated 27,000 had the material conditions to give birth at home was a gross miscalculation. While there was no hard data, lack of success of previous programs pointed to the overwhelming number of people who needed assistance.

The creation of the AOD called on the state to provide more staff and resources, at a time when lack of such funds was recognized as a serious threat to the development of a comprehensive plan to reduce the high infant mortality rates. In light of this, state and medical attention turned to nurses to shore up the lack of available maternal and infant health services. In line with this focus, the plan for the AOD was not immediately accepted, but it was followed by a renovation of the coursework at the nursing school.

It was unlikely that the EEAN administration would welcome a contingent of untrained midwives into what they thought of as nursing territory. Earlier management changes and emerging concerns of the medical community provoked a number of important changes in the nursing school. By early 1940, Dr. Sylvio L. Sertã, arguing that the nursing students needed more hands on experience, suggested development of a new course in obstetrics and gynecology. The new course would have a theoretical foundation in order to expand knowledge and function of the obstetric nurse.

The obstetrics portion of this class would cover issues such as understanding anatomy and physiology of the female genitals, development of the egg and fetus, conducting a pregnancy exam, hygiene of pregnancy and mechanics of normal delivery. Nursing students would also learn the procedures to follow in the event of an abnormal delivery. These would include: premature births, use of anesthesia, mothers with syphilis, tuberculosis, and those who presented obstetric hemorrhaging, infection or required surgical intervention. As affirmed by Dr. Sertã, “the objective was to prepare ‘true midwives’ with the capacity to attend to pregnant women and women in labor in their homes”. He believed that home birth was more economical and rational but should always be in connection with a central maternity ward<sup>68</sup>.

Total hours for this section was 30, including exams. The gynecology portion of the new course was 10 hours plus one hour for exams and should follow or be taken at the same time as obstetrics. Topics covered were disorders and infections of the female genitals such as fistulas, deformities, benign cystic tumors, and cancer. It also addressed problems with ectopic pregnancy, gynecological accidents, operations and general care<sup>69</sup>.

In addition to the new obstetrics/gynecology course, the required class in puericulture was expanded and became the specialized focus the nursing school and medical school aimed for. The ob/gyn class centered more on women, labor and delivery. The newborn was the focus of the third course and covered subjects such as the history of the protection of infancy, the importance of preconception and prenatal hygiene and eugenics. A large emphasis was also placed on care and feeding of the newborn, and working with the mother to meet her older child’s needs. The idea of protection against disease and mortality was a central theme throughout the class<sup>70</sup>.

Once the state began to acknowledge the weighty threat of untrained midwives, substantial changes were made in coursework reflecting a new direction of learning for nursing students. These changes also illustrated the emerging involvement of the medical school in the education of nurses. In the earlier years, doctors had no direct interest in the school’s curriculum or the breadth of knowledge, or lack thereof, in the courses offered. However, as nurses became an essential part of the fight against infant death and disease, the medical establishment and the state took a more diverse and active role in this field.

Aside from developing new courses offered at the EEAN, the state and medical community pushed for more policy changes to protect pregnant women and newborns from midwives. In his speech commemorating Children’s Day, Dr. Carlos Abreu called for expansion of midwife certification. He qualified himself and argued that only those who had attained a certain “cultural level” would be enrolled in such a course. Through such education the untrained midwife, who was illiterate, had no concept of hygiene, and was unable to learn, would be eradicated. Certified midwives would take the place of untrained and uneducated women who assisted in 80 – 90% of births in the capital<sup>71</sup>.

Other members of the medical establishment also took an interest in training nurses and midwives. In mid 1941, J. P. Fontenelle, published two extensive articles in *Folha Médica*



reviewing the history of nursing throughout Brazil. The first article, published on July 5<sup>th</sup>, traced the trajectory of nursing education and legislation that created the EEAN and the supervisory role of the DNS in this field<sup>72</sup>. This article outlined basic responsibilities of the visiting nurses and opened the door for future works that would analyze and expand on specific functions of visiting public health nurses in latter years of the administration.

In the article published in the July 25<sup>th</sup> issue of the journal, he acknowledged that visiting nurses were an integral part of the public health infrastructure in Rio de Janeiro<sup>73</sup>. These two articles highlight the work of visiting nurses in part because the profession needed more financial resources and nurses. They were an important part of the fight against infant mortality but the demand far outstripped the supply.

By early 1943, the medical establishment was firmly entrenched in resolving the midwife problem. According to a report, despite that fact that all health clinics had prenatal services, they had not produced desired results. The culprit was the untrained midwife. Dr. Bichet de Almeida Rodrigues declared that prenatal hygiene was of utmost importance to ensure a healthy child. It was imperative that medical services teach pregnant women how to care for themselves and their newborns. Ignorance and lack of hygiene posed one obstacle and untrained midwives another. Ideally the system could inter poor women who lacked education and hygiene, however, educating and monitoring midwives was a more immediate and less expensive solution<sup>74</sup>.

Dr. Jorge de Rezende, Chief of Service of the Obstetric and Prenatal Hygiene Services of the Medical and Surgical Assistance to the Municipal Employee Clinic (Assistência Médico-Cirúrgica dos Empregados Municipais – Prefeitura do Distrito Federal, AMCEM), wrote about services offered by the clinic in 1942. His scathing report shed further light on the untrained midwife problem. He stated, “the large majority of patients hospitalized had never been seen by a doctor. It was common for the mother and newborn to be under the care of a “dishonest” midwife. The mother’s health was normally in a precarious state and the fetus was close to death or dead”. Moreover, the obstetric division cared for a number of women who had attempted abortion through voluntarily ingestion of some type of tonic, portrayed as clearly a criminal work, most likely provided by the untrained midwives, were increasing<sup>75</sup>.

Some women were naïve enough to confess to intentional abortion, and others showed sure signs of the work of an abortionist. Such measures were, as the author argued, a complex social problem, and a popular resource of the single mother and adulterer. Abortion was a lucrative industry practiced by untrained midwives, certified midwives, and even doctors<sup>76</sup>. But it was the untrained midwife who became the target for the problem of abortions and poor prenatal care. In this article, the midwife was criminalized by her relation to abortion.

The administration responded to the report reassuring the medical community it was undertaking a number of programs and changes to address the issue. It recognized the problem and persistence of untrained midwives in the federal capital acknowledging 94% of pregnant women were assisted by them. The state proposed the expansion of maternity wards throughout the city. Thirteen of the established health posts would be given more space for labor and

delivery and furthermore, a number of newer, smaller maternity clinics would be considered for construction<sup>77</sup>. This report marked the final concrete debate about maternal and infant policies and programs. After 1943 the Vargas Administration fell silent and while it did not argue against the harsh realities of infant and maternal mortality it did not prioritize the problem as it had done in earlier years.

Throughout the fifteen years of the Vargas Administration, various sectors of the medical establishment, sometimes in conjunction with politicians, tried various ways to combat the high rates of infant mortality and disease. Despite concerted efforts in building a comprehensive and efficient system of prenatal, maternal and infant hygiene services, expanding milk and food distribution programs, more closely supervising the education and participation of nurses, and attempts to eradicate untrained midwives, infant death and disease continued to hamper state efforts to build a healthier, stronger Brazilian society.

In late 1943, the Society of Pediatricians argued to expand the visiting nurse program. The Society, which had been absent from earlier debates, argued that rates of infant mortality in the first year were rising, the majority of deaths occurred in the first and second weeks of life followed by deaths within the first month of life. Meeting minutes focused primarily on high rates of newborn death due to tetanus, in districts served by untrained midwives<sup>78</sup>. The Society's concerns emerged late in the Vargas Era and took a back seat to political changes and the end of corporatist policies. In 1945 Vargas was removed from power by the military and his administration was dismantled. Infant and maternal mortality would continue to impact the nation but would not garner state attention and policy focus as it had done earlier.

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## Notes

<sup>1</sup> Infant mortality was defined as children who died during delivery or before their first birthday. This broad definition also included stillborn deaths and death before one month of age. At times, the Vargas administration arbitrarily extended the age range to two years old.

<sup>2</sup> Arquivo Nacional: Gabinete Civil da Presidência de República 1930-1945: Ministério da Educação e Saúde Pública, box 33: folder 05 doc. Hereafter referred to AN/GCPR/MESP. In this quote "syphilitic" was not a reference to having syphilis but was a way to signify general illness.

<sup>3</sup> Figures are cited from João Vieira, "Higiene prenatal e infantil", *Folha Médica*, September 5, 1934, pp. 293-295.

<sup>4</sup> Rio de Janeiro was the administrative center of the nation. As the nation's capital it was home to the executive, legislative and judicial branches of the federal government, but was also administered by a municipal political infrastructure.

<sup>5</sup> *Folha Médica*, October 15, 1931, p. 348.

<sup>6</sup> *Folha Médica*, March 5, 1933, p. 126-127.

<sup>7</sup> *Idem*. Also the milk banks (lactários) should supply poor women with milk for their children and offer cooking classes and classes on the basics of caring for children.

<sup>8</sup> Pedro de Alcântara, "Causas de mortalidade infantil", *Pediatria Prática*, December, 1934, pp. 465-484.

<sup>9</sup> Ernesto Gonçalves Carneiro, "Aspectos Hospitalares no Rio de Janeiro"m *Brasil Médico*, December 14, 1935, pp. 118-119.

<sup>10</sup> Getulio Vargas, *A nova política do Brasil*, Vol. 7: "No limiar de uma nova era", José Olympio, Rio de Janeiro, 1938, p. 157.

<sup>11</sup> João Maurício Moniz de Aragão, "Mulher e Raça", *Brasil Médico*, May 10, 1941, pp. 341-342.

<sup>12</sup> *Idem*.

<sup>13</sup> Arnaldo Moraes, "Trabalhos Originais", *Folha Médica*, January 5, 1941, pp. 3-5.

<sup>14</sup> Marismary Horsth de Seta, "Instituto Fernandes Figueira: Delineamento de 50 anos de história institucional" (M.S. Thesis, Universidade Estadual de Rio de Janeiro, 1997), p. 56.

<sup>15</sup> *Revista Gynecologia e Obstetrícia*, March 1931, pp. 99-100.

<sup>16</sup> Arnaldo de Moraes, "Dispensário de higiene prenatal", *Folha Médica*, March 15, 1933, p. 129.

<sup>17</sup> *Ibid.*, pp. 130-131.

<sup>18</sup> Arquivo Nacional: Gabinete Civil da Presidência da República 1930-1945: Ministério da Educação e Saúde Pública., box 33. Correspondence between Olinto de Oliveira and Getúlio Vargas dated May 4, 1933. Hereafter referred to AN/GCPR/MESP.

<sup>19</sup> *Idem.*

<sup>20</sup> Centro de Pesquisa e Documentação de História Contemporânea do Brasil, Gustavo Capanema Collection, roll 62, pp. 294-300. Hereafter referred to CPDOC/GC.

<sup>21</sup> CPDOC/GC, roll 60, pp. 417-418.

<sup>22</sup> *Idem.*

<sup>23</sup> *Idem.*

<sup>24</sup> CPDOC/GC, roll 60, p. 457.

<sup>25</sup> CPDOC/GC, roll 60, p. 687.

<sup>26</sup> CPDOC/GC, roll 60, p. 442.

<sup>27</sup> CPDOC/GC, roll 60, p. 460.

<sup>28</sup> CPDOC/GC, roll 60, pp. 462-464.

<sup>29</sup> João de Barros Barreto, "Normas Para Uma Organização Estadual de Saúde Pública", *Arquivos de Higiene*. Vol. 7, No 2, November 1937, p. 349.

<sup>30</sup> CPDOC/GC, roll 60, pp. 539-540.

<sup>31</sup> CPDOC/GC, roll 60, pp. 541-542.

<sup>32</sup> CPDOC/GC, roll 60, pp. 433-441.

<sup>33</sup> *Idem.*

<sup>34</sup> *Idem.*

<sup>35</sup> Irene Drummond, "Algumas sugestões em torno do problema da maternidade", *Brasil Médico*, September 20, 1941, pp. 649-650.

<sup>36</sup> *Brasil Médico*, March 29, 1941, p. 248.

<sup>37</sup> CPDOC/GC, roll 62, pp. 294-300.

<sup>38</sup> *Idem.*

<sup>39</sup> *Idem.*

<sup>40</sup> *Idem.*

<sup>41</sup> José Savarese, "Lactários infantis", *Folha Médica*, March 5, 1933, pp. 125-126.

<sup>42</sup> *Folha Médica*, September 5, 1931, p. xiv.

<sup>43</sup> José Savarese, "Serviço de Lactários no Distrito Federal", *Folha Médica*, March 5, 1933, pp. 125-126.

<sup>44</sup> AN/GCPR/MESP box 121 package 2, doc. 33637.

<sup>45</sup> José Savarese, "Trabalhos Originais – O lactário na campanha contra a mortalidade infantil", *Folha Médica* November 25, 1933, p. 575.

<sup>46</sup> *Diário Oficial da União* (Rio de Janeiro) January 15, 1937, p. 1210.

<sup>47</sup> AN/GCPR/MESP, box 121, package 2, document 33637.

<sup>48</sup> *Idem.*

<sup>49</sup> *Brasil Médico*, March 29, 1941, p. 245.

<sup>50</sup> *Ibid.*, p. 246.

<sup>51</sup> *Ibid.*, p. 248.

<sup>52</sup> *Ibid.*, pp. 249-250. In this article race only referred to the idea of a singular unified Brazilian race. It was not a recognition of racial difference.

<sup>53</sup> *Ibid.*, p. xxiii

<sup>54</sup> CPDOC/GC, roll 58, p. 142.

<sup>55</sup> CPDOC/GC, roll 58, p. 147.

<sup>56</sup> Arquivo de Escola de Enfermagem Ana Néri, box 63, folder 54, year 1937. Hereafter referred to as EEAN.

<sup>57</sup> EEAN, box 61, folder 02, document, Annual Report 1937, p. 1.

<sup>58</sup> *Ibid.*, p. 7.

<sup>59</sup> *Ibid.*, p. 8.

<sup>60</sup> EEAN, box 68, folder 30.

<sup>61</sup> Many of the medical journals at this time, both official and unofficial, provided a venue to publish official reports. In this case, Fontenelle was the editor for *Folha Médica* and his 1935-1936 report was published in the following issues: No. 33 11/25/1937, No. 34 12/5/1937, No. 36 12/25/1937, No. 1 1/5/1938, No. 2 2/5/1938, No. 3 2/15/1938, No. 4 2/25/1938, No. 5 3/5/1938, No. 6 3/15/1938, and No. 7 3/35/1938.

<sup>62</sup> J. P. Fontenelle, "Trabalhos Originais – Serviço prenatal nos centros de saúde, 1935-1936", *Folha Médica*, May 5, 1938, p. 154.

<sup>63</sup> *Idem.*

<sup>64</sup> CPDOC/GC roll 60, pp. 433-441. "Relatório apresentado pelo Inspetor Técnico de Higiene e Medicina da Maternidade do Serviço de Puericultura do Distrito Federal."

<sup>65</sup> *Idem.*

<sup>66</sup> *Idem.*

<sup>67</sup> *Idem.*

<sup>68</sup> EEAN, box 71, folder 95. Memo from Dr. Sylvio L. Sertã to D. Lais Netto dos Reyes (Interim Director of EEAN) regarding the Development of a New Ob/Gyn Course dated February 15, 1940.

<sup>69</sup> *Ibid.*

<sup>70</sup> EEAN, box 71, folder 96.

<sup>71</sup> *Brasil Médico*, March 29, 1941, p. 248.

<sup>72</sup> J. P. Fontenelle, "Visitadoras na saúde pública", *Folha Médica*, July 5, 1941, pp. 150-156

<sup>73</sup> J. P. Fontenelle, "Visitadoras na saúde pública", *Folha Médica*, July 25, 1941, pp. 160-168.

<sup>74</sup> Bichet de Almeida Rodrigues, "Trabalhos Originais – Luta contra mortalidade maternal e mortinatalidade", *Folha Médica*, January 5, 1943, p. 5. This was a report presented to Professor J. P. Fontenelle in the Public Health Course at the Oswaldo Cruz Institute in Rio de Janeiro.

<sup>75</sup> Jorge de Rezende, "A propósito da Estatística Anual do Serviço de Ambulatório de Obstetrícia e Higiene Prenatal da Assistência Médico-Cirúrgica dos Empregados Municipais", *Revista de Ginecologia e d' Obstetrícia*, February 1943, p. 95.

<sup>76</sup> *Ibid.*, pp. 96-97.

<sup>77</sup> CPDOC/GC, roll 62, pp. 294-300.

<sup>78</sup> *Jornal de Pediatria*, No 9, October-November 1943, p. 498.