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Producing the A-1 Baby: Puericulture Centers and the Birth of the Clinic in the U.S.-Occupied Philippines, 1906–1946

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Producing the A-1 Baby Puericulture Centers and the Birth of the Clinic in the U.S.- Occupied Philippines, 1906–1946

This article offers a history of the policy, practices, and personnel of initiatives focused on maternal and child health, particularly puericulture centers, in the context of interventions into domestic life in other European and American colonial settings. Based on sources ranging from reports submitted by puericulture center nurses to practitioners' journals like the *Welfare Advocate*, the article offers a detailed account of the day-to-day workings of puericulture centers during the interwar period. The article argues that these initiatives became a terrain for the contested extension of state surveillance and power into the intimate politics of family life during the U.S. occupation of the Philippines in the early twentieth century.

KEYWORDS: PUERICULTURE CENTERS · INFANT MORTALITY · PHILIPPINES · MATERNAL AND CHILD HEALTH · GOVERNMENTALITY

One afternoon in 1932, Ms. Isabel Hatamosa, a licensed midwife at the Bacong Puericulture Center in Negros Oriental, was called to a delivery, and responded with her maid and a traditional midwife. The woman, Encieta Fomalon, delivered a baby boy normally, and Ms. Hatamosa and her maid went home, leaving the unlicensed midwife with instructions on how to watch the woman. The unlicensed midwife left an hour later to do some marketing. While she was away, the patient stood up to go to the bathroom, fainted, and fell. Ms. Hatamosa was called to revive her, and found her in a critical condition, with a hard abdomen, convulsive appearance, and hemorrhaging. She suggested that the woman be taken to the Mission Hospital in Dumaguete, but the family refused, arguing that they had no money. Ms. Hatamosa offered her own money, but while waiting for an ambulance the patient's father arrived. Seeing the condition of his daughter, he grabbed a bolo, and chased Ms. Hatamosa, the maid, and the unlicensed midwife, threatening to kill them. An investigation reported what happened next.

The three fled for their lives. It was very dark in the evening, the time being 8:00 o'clock already. In her ignorance of the way through the darkness Miss Hatamosa reached the next barrio of Luzuriag [sic], running. When she could no longer run, she stopped at a small house. There she spot blood, due perhaps to exhaustion. Although the maid was able to avoid the infuriated father, the unlicensed midwife received a wound on her left lower leg. When the ambulance arrived, they found the patient already dead and the midwife and her assistants missing. The incident alarmed the whole town, and town and puericulture officials started to search for the midwife and her assistants and found them. (*Welfare Advocate* 1932a, 11)

The three women went to the municipal president the following day, and the president of the Sanitary Division conducted an investigation, which acquitted all the women of any responsibility in the death, which was attributed to postpartum eclampsia. Although some suggested that Ms. Hatamosa should be given another assignment, the puericulture center officials retained her, promising to help her keep the confidence of the townspeople.

In this article, I draw on archival documents to consider the “birth of the clinic” in the U.S.-occupied Philippines, with the clinic here being understood as puericulture centers (i.e., centers for the care of young children) and their personnel. The story involving Ms. Hatamosa prefigures a number of the themes that I will address in the course of the article: early twentieth-century concerns about the mortal dangers of childbearing and the moral hazards of childrearing, the establishment of local puericulture centers to address these concerns, the extension of biomedicine and the state into the lives and homes of Filipinos through these centers and home visits, certain resistances to those extensions, and the fraught relationship between nurses and traditional midwives.

Foucault's (1994) account of the birth of the clinic focuses on the development of *la clinique*, understood both as clinical medicine and teaching hospital, the shared characteristic of each of which is the examination and discussion of actual cases. He describes the birth of practices, and the birth of new ways of seeing; both lead to constructing something previously invisible as visible. In English, however, clinic has an additional definition, as a facility for diagnosis and treating outpatients. In this article I consider both epistemological and institutional definitions of clinic. I consider the ways that the birth of the outpatient clinic led to a form of “visibility” for Filipino families, as state knowledge and surveillance of family practices increased. But the focus on clinics, and social medicine, could also be seen as a critique, sometimes explicit and sometimes implicit, of the focus of American biomedicine on scientific research and contagious disease, rather than improving care for Filipinos. In addition, I consider the ways that initiatives addressing maternal and child health in local puericulture clinics became a mechanism for the demographic inscription of Filipinos into the colonial and protonational welfare state, by Americans and Filipinos alike, one which was nonetheless a contested extension of state surveillance and power into the intimate politics of family life. The Philippines is compared to and contextualized within a rich, recent literature on interventions into domestic life, especially through maternal and child health, in European and American national and colonial settings (Boddy 1998, 2007; Briggs 2002; Hunt 1999; Hattori 2004; Jones 2002; Jolly 1998b; Manderson 1998; Turritin 2002). This essay thus joins a recent set of essays (Go and Foster 2003) which argue that scholars need to analyze the U.S. colonial state in the Philippines from a global perspective, not to affirm or deny whether the U.S. colonial occupation was more benign

than others (the well-worn “exceptionalist” argument), but rather “to appropriate critically the global perspective that exceptionalist reasoning necessarily entails” (Go 2003, 3).

Maternal and Child Health in an Age of Empire

It is generally argued that concerns about infant mortality in the early twentieth century originated in concerns about European nations and rapidly moved to colonized countries (Davin 1997; Hunt 1988). If this claim remains broadly true, it nonetheless deserves examination in the case of each individual metropole/colony. As we will see below, a historical argument that claims that initiatives began in the U.S. and were then imported by Spaniards or Americans into the Philippines is, and was, a matter for contention.

In Europe moves to address infant mortality arose with changing definitions of childhood and population, and as a response to high maternal and infant mortality rates and falling marital fertility. In some European countries, a focus on infant mortality was given impetus by major conflicts (the Boer War, the First World War) in which modern forms of warfare decimated populations (Fildes et al. 1992; Manderson 1998). Eugenicist fears about “race degeneration” were linked to concerns of national and imperial strength. Women came to be seen more as mothers than as wives as “[c]hild-rearing was becoming a national duty, not just a moral one; if it was done badly, the state could intervene” (Davin 1997, 91). A new language appeared to describe infant mortality, one that not only saw it as a personal tragedy but also saw “population as a national asset, as human capital and as imperial armoury” (Jolly 1998b, 179). The problem of infant mortality was blamed on ignorant and negligent mothers; instruction in mothercraft, depots with safe milk supplies for infants, and well-baby clinics was seen as the solution (Hunt 1999, 240–41) (fig. 1).

There were, nonetheless, some important distinctions in the ways campaigns against infant mortality developed. Klaus (1993) provides a particularly helpful contrast between the maternal and infant child health policies of France and the United States, two countries significant for the development of initiatives in the Philippines. In many western European settings, a declining birthrate, repeated preparations for war, and engagement in colonial campaigns led to public programs to protect maternal and child health and encourage childbearing, which were focused especially, but not only, on working-class women. Pronatalist family policies developed alongside ideas

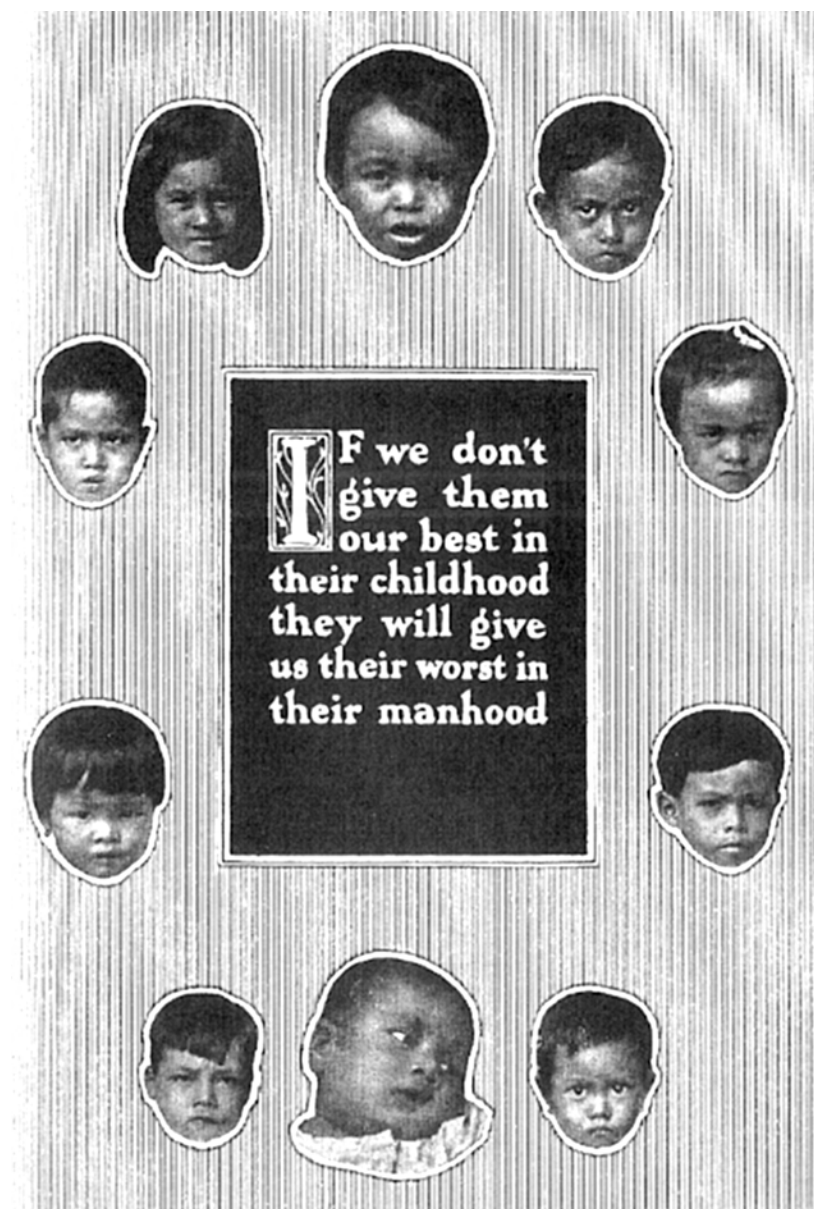


Fig. 1. Image from *Proceedings of the First National Conference on Infant Mortality and Public Welfare*, held in Manila in December 1921

Source: Peñaflor 1922

of motherhood as a patriotic duty and childrearing as a social service. Many of these policies developed earliest in France, because its birthrate and rate of population growth declined more rapidly in the nineteenth century than in other European nations, including its traditional rivals in Germany and England (ibid., 16–17). France's defeat in the Franco-Prussian war heightened concern about the health and size of the population. It was in part for this reason that France became the site where physicians from around the world, including Filipinos, studied pediatrics and obstetrics. Felipe Zamora, a Manila-based obstetrician who later attended one of José Rizal's sisters, studied in Paris; at one point, Rizal traveled to Paris and visited some of the famous pediatric and obstetric clinics with him (Reyes 2008). Fernando Calderon, a key figure in the fight against infant mortality in the Philippines, also studied in Paris.

French policies were largely influenced by neo-Lamarckianism, i.e., the idea that improving the health and environment of parents could alter the heredity of newborns. This made them compatible with pronatalist and social hygiene movements that worked to improve the general health of the population and to prevent diseases thought to be hereditary, such as alcoholism, tuberculosis, and epilepsy (so-called positive eugenics), rather than segregation of the unfit or preventing conception among the unfit with sterilization or birth control (so-called negative eugenics). The famous demographer, Jacques Bertillon, and Charles Richet were two founders of the French eugenics movement and were leaders of the *Alliance nationale pour l'accroissement de la population française*. They were joined by Adolphe Pinard, professor of obstetrics and gynecology at the *Faculté de Médecine* at the University of Paris. Pinard emphasized educating girls in *puériculture* (the science of child raising) while Pierre Budin developed *consultations de nourrissons* (nutritional consultations), which encouraged breast-feeding, distributed clean or sterilized milk, provided medical supervision to infants, and instructed mothers in scientific hygiene.

The focus on puericulture came to be a unifying force for French eugenicists (Klaus 1993, 22). In order to prevent infant death from diarrhea, the single most important killer of infants, public and private maternal and child welfare agencies in France developed a network of milk stations for artificially fed infants (*gouttes de lait*, or drops of milk) which provided pasteurized milk and medical attention to needy mothers and children and infant health consultations (ibid., 43) in urban and rural settings. Such measures

also extended the surveillance of the state, and of the medical profession, into French families: “[b]y increasing women’s dependence on the medical profession, campaigns to prevent infant mortality contributed to the ongoing process by which professional intervention in the family was established and physicians claimed authority in all aspects of child care” (ibid., 44). Ideas about how to train women to rear children properly spread into other areas as doctors and then the popular press took note of the infant welfare movement in France.

In the United States, by contrast, social scientists noted a decline in birthrate among native-born Whites, but this decline was offset by immigration from southern and eastern Europe, and by the higher birthrate among these immigrants. There was also a deep pessimism about the possibility of transforming African-Americans’ behaviors and practices, as well as those of others taken to be permanently defective (paupers, the feeble-minded, criminals, epileptics, and so on). A moral panic developed about “race suicide,” a concept used to refer to the changing composition of the population. The focus of the U.S. maternal and child health campaigns was thus on quality and composition of the population rather than on population growth, with some organizations at least as interested in “improving the race” as in saving lives. A key example of this was the baby health contests that were popular among women’s organizations, events that rewarded mothers whose children approached certain standards of racial, aesthetic, anthropometric, and psychological perfection. Thus in the U.S. there was a much stronger eugenic element in the infant health movement, and a much more limited public commitment to maternal and child welfare, in part because of racism. Although the U.S. also founded, on the French model, clean milk stations and infant welfare centers, there were fewer bureaucratic administrative resources for federal interventions. American efforts focused on the education of mothers rather than the provision of material assistance, which had become part of the French programs; for this reason, they also more heavily emphasized the importance of visiting nurses and the transformation of home environments according to accepted middle-class standards.

In studies like Jacques Donzelot’s *The Policing of Families*, the establishment of hospitals, convents, and foundling homes in Europe served as a laboratory for the observation of working-class behaviors, a place to launch measures to counteract these, and a means for reorganizing working-class family life for socioeconomic imperatives. Debates about infant mortality

rates were not confined, however, to Western Europe and the United States. By the 1920s, discussions about infant mortality became a matter of colonial policy in a number of areas, including colonial Malaya (Manderson 1998), the Belgian Congo (Hunt 1999), the Sudan (Boddy 1998; 2007), Ceylon (Jones 2002), French West Africa (Turritin 2002), Vanuatu and Fiji (Jolly 1998b), and the Philippines. Infant mortality rates became an index of the general sanitary condition and thus of civilization (Davin 1997, 89).

If, however, discourse about infant mortality in particular and about maternal and child health in general circulated globally, the particular shape that these took in different regions was quite distinctive, influenced in part by local imperial preoccupations or debates among different colonial actors, as well as by local actors and their reactions to different initiatives (see Fildes et al. 1992). Concerns about infant mortality were part of a medical panic, but also a moral one, where the treatment of an issue as a crisis functions as an allegory for multiple social cleavages, conflicts, and antipathies (Briggs 2005, 55). In some places, one can argue that the focus on infant mortality and the increased medical surveillance of women was linked to a recognition of the importance of reproduction (biological, daily, and social) for production. State or corporate medical services were extended to colonized groups to ensure a healthy labor force in colonial Malaya, Sudan, and the Belgian Congo (Boddy 1998; Hunt 1988; Manderson 1998).

Nonetheless, concerns about infant mortality and other reproductive issues did not only arise in connection with labor issues, or the need to secure a colony against potential military invasions, and they did not always arise with metropolitan actors. In particular, I argue that a focus on child health in the Philippines arose first among Filipino physicians and clubswomen who were circulating within cosmopolitan scientific circles. Their key influences were not the U.S. or Spain, neither of which were acknowledged world leaders on these issues, but France and occasionally New Zealand; nonetheless, some American strategies also played a significant role in influencing the shape of Filipino initiatives.

Contested Histories: Initiatives to Address Infant Mortality in the U.S.-Occupied Philippines

Some of the significant historical events and the key actors in the fight against infant mortality in the early twentieth century in the Philippines were contested (McElhinny 2005; 2007a; 2007b). Throughout the first three-and-a-

half decades of the American occupation of the Philippines, until the establishment of the Commonwealth in 1935, the question of who should be responsible for public health in the Philippines was often a fraught issue, and the state of public health work was used to assess the readiness of Filipinos for self-government. In this climate, virtually any political action on public health could be understood, also, as entering into this debate (see Anderson 2006; Dayrit et al. 2002; Iletto 1995; Sullivan 1991). In the roughly chronological account that follows, therefore, I am not trying to offer a comprehensive timeline of all events that shaped the form of maternal and child health initiatives. Instead, I am highlighting a few key debates over what happened as a way of considering “[t]he ways in which what happened and that which is said to have happened are and are not the same may itself be historical” (Trouillot 1995, 4).

In 1907 a society named *Gota de Leche* was organized for the distribution of a safe supply of milk to infants, based on the French *gouttes de lait* model. It was meant to replace the solid food that was frequently used with more wholesome food (cf. Bureau of Health 1909). In other settings, such organizations have generally been described as the initiatives of White women. For instance, Hunt (1988, 403) describes a White colonial woman opening a program called *Gouttes de Lait* in the Belgian Congo in 1912 (Hunt 1988, 403).¹ American colonial records, too, tend to give White women a prominent role when describing the founding of this organization (McElhinny 2007a, b). In its annual report the Bureau of Health (1909, 25) describes the society for the protection and care of infants as run “principally by Filipina ladies, aided by a number of American ladies.” However, the articles of incorporation for this organization, written by Don Felipe Calderon (framer of the first Philippine Constitution), called *La Liga Nacional Filipina Para la Protección de la Primera Infancia* (1907), tell a different story.² The 1907 document, written in Spanish, lists fifteen founders: six Filipino men, all physicians (Dr. Fernando G. Calderon, Dr. Galicano Apacible, Dr. Joaquin Quintos, Dr. Manuel Guerrero, Dr. Gervacio Ocampo, Dr. Ariston Bautista), seven Filipino women (Maria Flores de Villamor, Carmen Manuel de Gerona, Trinidad Rizal, Concepcion Felix de Calderon, Maria Arevalo, Asuncion Soriano, Librada Avelina), one American woman (Helen Wilson), and one American man (the aforementioned Dr. David Doherty).³ This example suggests that Filipinos had an earlier, more central role than other colonized groups in establishing these initiatives.⁴

Fernando Calderon, a Filipino physician who studied in France and Spain during the early years of the American occupation, helped found, as mentioned already, the first Gota de Leche in 1907 (Albert 1921, 83; see also McElhinny 2007a; 2007b).⁵ Calderon earned his degree in medicine from the University of Santo Tomas in Manila, and worked thereafter in two areas of the Philippines (Samar and Leyte) where infant mortality rates were high. His own children died early, probably of beriberi. While in Paris Calderon studied with Dr. Budin, the founder of the consultations de nourrisson, and with Dr. Pinard, the advocate for puériculture. Calderon later became one of the few Filipino physicians invited to join the faculty of the Philippine Medical School (later the University of the Philippines) in 1907, where he served as Director of Obstetrics until 1922.⁶ He was a close friend of Manuel Quezon's.

In 1913 the Liga established the first puericulture center in Manila. In 1916 the Third Philippine Legislature appropriated P1 million for work for the protection of early infancy, to be used as matching funds for money raised by local groups eager to have a puericulture center in their town (Elicaño 1931, 19). Puericulture centers were often the first sustained and biomedical presence in Filipino communities and, although their mandate was to deal primarily with high infant mortality rates, their practices often extended to a wider range of ailments, particularly in the absence of other medical practitioners. The philosophy behind them was that "if we wish to educate the masses, we have to come in contact with them more or less continuously in order that the efforts put in will bring the desired results" (*ibid.*).

Indeed, as American physicians and scientists began to interest themselves in the problem of infant mortality, many wondered why they had not noticed the problem earlier. In 1910 two American physicians noted that five years earlier native physicians had begun to attribute infant deaths to beriberi: "For some reason the subject has never been taken up by the American physicians in the Islands, owing, possibly, to the fact that they do not come in contact with the poorer Filipinos, and hence are never called upon to treat them. In the various hospital dispensaries the children are looked after by the native doctors" (McLaughlin and Andrews 1910, 64). However, the lack of interest was less puzzling in light of early comments by key American public health officials on infant health. The 1908–1909 annual report of the Bureau of Health (1909, 47) goes so far as to say that: "So far as the effects upon the census statistics is concerned, a high death rate among infants,

unless brought about by epidemic diseases or other special causes, does not alarm the health officer, as he knows that it will be offset by a higher birth rate. . . ." Indeed, the American colonialists were sometimes critiqued for their focus on those infectious diseases most likely to impact their own ability to stay in the tropics, for focusing on medical and scientific research for its own sake rather than investing in the measures (like the production of more tikitiki extract) that could help large numbers of infants, as well as for their inattentiveness to infant health.

Issues of public health, alongside such questions as the financial extravagances of the insular government, the need for more Filipino autonomy in various executive roles, and who had the authority to originate measures dealing with revenue and appropriations, were a regular terrain for conflict between Filipinos and Americans. From 1907 to 1916, there was a bicameral form of government, with an elected Philippine Assembly and an American-dominated U.S. Philippine Commission that included the American governor-general, and had both a legislative and executive role. This structure was supposed to offer Filipinos experience with self-government, as they were tutored in democratic rule as the junior partners (Golay 1997, 157). After a Democratic victory in the U.S. presidential election in 1912, and the subsequent appointment of a governor-general supportive of rapid Filipinization and Filipino self-rule, the Speaker of the Assembly, Sergio Osmeña, introduced measures meant to accelerate the Filipinization of key executive roles and of the insular service.

The administration of public health services by the Bureau of Education, and thus under the American vice-governor-general, became a focus of Filipino criticism as "Filipino leaders were aware that in the eyes of many Americans their claims to greater government autonomy were flawed by their lack of experience in dealing with public health problems"; in 1915 the legislature had authorized the transformation of the Bureau of Health into a commissioned service called the Philippine Health Service, and transferred it to the Department of the Interior headed by (ardent nationalist) Rafael Palma (Golay 1997, 191). In 1916 the Philippine General Hospital was separated from the Public Health Service and placed directly under Secretary Palma after student nurses at the hospital, filing charges against the American director and chief nurse, went out on strike. An investigation exonerated the Americans, but when they chose to resign they were replaced by Filipinos (see Anderson this issue).

Also in 1916, and of significant import for the battle against high infant mortality rates, was the passage of Act 2633, or the Osmeña Bill, which called for the establishment of puericulture centers nationwide. This act appropriated P1 million for work for the protection of early infancy, with plans that had to be approved by the organization which had founded the Gota da Leche, the Liga Nacional Filipina Para la Protección de la Primera Infancia (Kalaw 1921, 15).⁷ By 1918 the eruption of a smallpox epidemic, alongside the even more devastating flu epidemic of 1918 (see Gealogo this issue), led to shrill American critiques of the deterioration of public health services under Filipino administrators (Golay 1997, 224).⁸ In 1920 the election of a Republican U.S. president, Warren Harding, led to the appointment of a fact-finding mission on the current state of the Philippines, headed by Gen. Leonard Wood

and former Governor-General Forbes. The report emphasized the deterioration in government efficiency under the policy of Filipinization, singling out public health services and the administration of justice for particular critique, and concluded that, although many Filipinos desired independence, their tutelage should continue under American rule. Wood was subsequently appointed governor-general, and struggles erupted between Wood and Filipino legislators. In the 1922–1923 legislative session, the legislators responded to the criticisms of the Wood-Forbes report by twice submitting a bill calling for the creation of a department of public health, which would remove public health services from the supervision of the American vice-governor (Golay 1997, 244). Woods vetoed each of these bills.

By 1921 infant mortality was seen as one of the Islands' most pressing problems, and was used to gauge readiness for independence by Filipinos and Americans alike.⁹ A succinct statement of the concerns is found in the *Welfare Advocate* (1934, 9): "The progress of a nation depends in a way on its population. Our economic progress is rather slow because we do not have enough man power necessary for the opening of undeveloped areas. . . . Aside from efforts to reduce infant mortality, our population, in preparation for our independence, must be augmented by increasing our birth rates."

One sign of the concern was the convening of the First National Conference on Infant Mortality and Public Welfare in December 1921. This extraordinary conference attracted thousands of participants from around the Islands (fig. 2). In ways described elsewhere (McElhinny 2007a; 2007b), Filipino politicians and physicians challenged accounts of American scientific and medical superiority by emphasizing that Filipino physicians were the first to notice the problem of infant mortality, that Filipino scientists conducted the most extensive research leading to insights into beriberi as a vitamin deficiency disease and its treatment, and that Filipino voluntary organizations had done the key work in distributing safe milk and tikitiki to reduce infant mortality rates (Albert 1922; Balmori 1922; Quintos 1922). For example, Quintos (1921) argues that it was a Filipino physician, Dr. Manuel Guerrero, who first informed colleagues that the disease called *taon* by Filipinos was not infantile eclampsia or a digestive order, as earlier physicians had suggested, or even primarily due to the use of unsanitary milk, as earlier American public health reports had suggested, but instead was the beriberi of breast-fed infants, which had been also discovered by Hirota in Japan. He says Guerrero made these comments in a memorandum read in October



GOVERNOR-GENERAL WOOD AND PARTY

Front row, from left to right: Archbishop MICHAEL J. O'DOHERTY, Governor-General LEONARD WOOD, Speaker SERGIO OSMEÑA, House of Representatives; Senator RAFAEL PALMA, Dr. JOSÉ FARELLA, Public Welfare Commissioner.

Fig. 2. Participants representing key groups and factions at the First National Conference on Infant Mortality and Public Welfare, Manila, December 1921

Source: Frontispiece, *Proceedings of the First National Conference on Infant Mortality and Public Welfare* 1922

of 1904 to colleagues at the *Colegio Médico Farmacéutico of the Philippines*, a moment well before Americans had turned their attention to infant mortality. The *Colegio* was an older professional association that Filipinos had been encouraged to abandon in favor of the Manila Medical Society, established by Americans in 1902. The Society, however, remained an organization that attracted less than 10 percent of the physicians in Manila to its meetings, most of them American. Its first Filipino president (Fernando Calderon) was not elected until 1919. Another more open and larger group, the Philippine Islands Medical Association, was set up in 1903. Although the first president of this association was an American, its first two vice presidents were Filipinos (one of them was José Albert, a participant in the 1921 conference) (see Anderson 1992, 322). The emphasis on the *Colegio*, then, is a clear comment on the significance and level of Filipino medical expertise.

Quintos argued that in 1916 the same Doctor Guerrero made a speech at the opening ceremonies of the University of Santo Tomas, and proved in that address that the excessive mortality in the Philippines was due to *taon*, which explained why more deaths occurred among breast-fed infants than among the artificially fed. The mention of this institution, too, is significant. The medical school at the University of Santo Tomas had produced Filipino physicians since 1871 (Anderson 1992, 323).¹⁰ Americans argued that the curriculum offered there needed to be revised, expanded, and modernized, and so in 1907 they set up a competing institution in the Philippine Medical College.

Finally Quintos (1921, 88) argued that the experiments by Doctors Albert, L. Guerrero, J. Gavieres, Andrews, Calderon, and Gabriel

and above all, the wise experiments accomplished by the *Liga Nacional Filipina Para la Protección de la Primera Infancia*, had come to confirm the assertions of the aforesaid Dr. Manuel S. Guerrero and to establish, beyond all doubt, that the “*taon*” was the infantile *beri-beri*, that said disease comes from the milk of a woman suffering from *beri-beri*, and that it is cured and prevented with the *tiqui-tiqui-extract*.

Note that the use of the Tagalog name (*taon*) also acknowledges a kind of Filipino folk expertise in recognizing the disease. The list of physicians here includes some of the most prominent physicians practicing, without the support of American education or research, when the American occupation began.

Throughout his account Quintos emphasizes the work of Filipino voluntary associations. He says he lacks “adequate words with which to make prominent the gigantic work undertaken in behalf of our people by the *Liga Nacional Filipina para la Protección de la Primera Infancia*, which unselfishly and perseveringly, has investigated the beneficial results produced by the *tiqui-tiqui* extract in the prevention and treatment of infantile *beriberi*” (ibid., 91). His only mention of the work of American contributions to the investigation of *beriberi* comes six pages into his nine-page account, when he briefly mentions that the American doctors Chamberlain and Wadder discovered *tikitiki* extract in 1914, but he quickly returns to the work of the *Liga*, emphasizing its four years of research done after this discovery, and the fact that it led to a 1918 report to the Philippine legislature. Similarly, when asked for information for a world encyclopedia on the world’s children in 1921, José Fabella (1926), Public Welfare Commissioner, underlined that this work had started even before the coming of Americans to the Islands.

As mentioned above, it is not the task of this article to determine the “truth” of these various claims—if, indeed, such is possible to ascertain. Instead, what is noteworthy are the remarkably different histories of Filipino public health initiatives offered by different actors; these scientific and historic articles become the grounds for the elaboration of a nationalist history. There is nonetheless a certain amount of shared ground. All parties seem to accept that performance in public health issues has a wider import for assessing civic virtue, and readiness to rule.

This major conference coincided with, and perhaps marked, the founding of the Office of the Commissioner on Public Welfare under Fabella’s direction, with its single most important mandate being to address high rates of infant mortality and to deal with the welfare of other children. If health services and education remained significant domains of American influence, this office, which was distinct from each of these, demonstrated that the development of welfare initiatives for Filipino families was firmly under Filipino control from the beginning. Infant mortality was styled not as a medical but a sociomedical problem.¹¹ The key strategy developed to address infant mortality was the establishment of a *puericulture* center in each town; this was deemed the most central task of the new government commission on public welfare. These centers can be seen as the crucial founding act of the Filipino welfare state, as well as the birth of the clinic in the Philippines; I focus on these centers in the remainder of this article.¹²

The Birth of the Clinic: Puericulture Centers and Demographic Inscription in the Philippines

The establishment of the Office of the Public Welfare Commissioner in 1921 led to a rapid growth in the number of puericulture centers, with 357 organizations established by 1930, 180 of which received government aid (ibid.). Puericulture centers were a public-private initiative. Money for the establishment of puericulture centers came in part from local communities, with women’s organizations typically composed of women from the local elite responsible for their organization, and another portion coming from the insular government. The central government cast its lack of financial support as a benefit to Filipinos: “this system of cooperation between the Government and an organization of private citizens . . . [will] arouse and promote public spirit and consciousness in the importance of infant mortality so that the people of the community will learn to solve this and other local problems with less and less dependence on the Central Government” (Office of the Public Welfare Commissioner 1930, 13). The language here echoes the language of many American colonial enterprises, which aimed at socializing Filipinos into the civic and hygienic skills they were perceived as needing for independence (see Anderson 2006; Rafael 2000). Nonetheless, the degree of responsibility thus evinced could also be used to suggest the superfluosness of these attempts at tutelage. Tranquilino Elicaño (1931, 8), chief of the Maternity and Child Hygiene Division of the Office of the Public Welfare Commissioner, argued that the government needed to invest more money, especially in places where the infant mortality rate was high, in part because of a degree of poverty that meant that local communities could not afford to establish puericulture centers.

Although the government’s aim was a puericulture center in every town, the centers were not evenly distributed. The areas which were best served in the early days of puericulture centers were the two largest cities, Manila and Cebu, and the province of Negros Occidental, which had remarkable transportation and communication possibilities because of the sugar producing and processing industry. Manila became the key site for training puericulture center workers. By 1930 there were six centers and five subcenters, all located in poor districts of the capital, that were used as training centers for puericulture centers, as they extended their activities to families in these districts. As elsewhere, the actions of the urban poor, or of those working in the total institutions of labor plantations, were those most actively and

comprehensively surveyed by the state, or by corporations. Nurses who were training to be puericulture center nurses spent a month learning about the organization and administration of the centers, and gaining practice in giving lectures, cutting layettes, and reviewing information in pamphlets on maternity and child hygiene.

For the first few years, until 1926, the success of puericulture clinics was assessed by the amount of the work done by a puericulture center, gauged by attendance at the clinic, the number of home visits done by nurses, the number of lectures given, the number of unlicensed midwives given instruction, and so on. This measure, however, did not assess whether fewer babies were dying; it also focused only on those in direct contact with the clinics, and thus the state. After 1926 success was gauged by comparing the mortality rates of infants under the care of the center to those of other infants. As a result, puericulture nurses were asked to record every birth in a community. The table below shows the infant mortality rate (IMR) in towns with puericulture centers that submitted complete reports in the late 1920s.

YEAR	TOWN’S IMR	IMR FOR BABIES CARED FOR BY PUERICULTURE CENTERS
1926	148.9	68.8
1927	86.5	55.5
1928	126.9	60.7
1929	92.2	62.0
1930	111.0	59.4

Source: Office of the Public Welfare Commissioner 1930, 12

Welfare officials concluded that the death rate among infants given some care by the puericulture center was about 50 percent lower than infant mortality rates in the whole municipality, and at rates comparable to the countries with the lowest infant mortality rates of which, it is important to note, the U.S. was not one. In 1930 one writer argued that, “[I]f we take the average of the death rate among infants cared for, we find that it is 61.75 per 1,000, which rate can be compared favorably with those of countries having low infant mortality, like New Zealand, Holland, Norway, etc.” (*Welfare Advocate* 1930, 2).¹³ It is important to be cautious in the assessment of these and other statistics, since not all commentators felt that they were thorough, accurate, or trustworthy. Strikingly, the U.S. was not on this list. If this

change in measuring success in 1926 shifted the focus from the amount of work done by a center to the effectiveness of the work done, it also reflected a more ambitious attempt at protonational inscription of Filipino subjects, since the focus was not only on those who attended the puericulture centers, but also on those who did not. Those who did not also merited assessment and judgment; all families, whether or not they sought the services of the clinics, were being assessed by its standards.

Cultivating Infants: The Practices and Personnel of the Puericulture Centers

Although some puericulture centers could afford both a physician and a nurse, in general the fortunate centers had nurses; those with less money hired midwives. One of the key legacies of American colonial occupation of the Philippines was the Americanization of medical education, including the establishment of nursing training programs (Choy 2003). Such programs continue to shape the migration of Filipino women throughout the world as nurses, midwives, and live-in caregivers. Nursing programs recruited initially reluctant upper class girls for programs in which they learned modern (and medical) tactics for home management and hospital housekeeping, which they then were asked to use to transform the home management skills, including childrearing, used by Filipinos. One distinctive aspect of Filipino nursing, however, was that the earliest, and some of the most significant, nursing tasks were in the realm of public health nursing, and the key task of such nursing was seen as dealing with infant mortality. (American counterparts worked in settlement houses, child welfare associations, and factory dispensaries.) One of the key tasks of the Filipino Nurses Association, founded in 1922, was “to cooperate with other organizations in the reduction of infant mortality and in the repression of preventable diseases in the Philippine Islands” (cited in Choy 2003, 53).

The mandate of nurses in puericulture centers was educational and preventative. In theory they were to take care of well babies, while sick babies, older children, and adults were to be referred to physicians. However, in many areas nurses and midwives were the only trained medical personnel in the area, and so they handled sick children, as well as other medical cases. In the puericulture clinic, nurses held consultations for sick and well mothers and children. They measured, weighed, and examined children to see if they were healthy and if their development was normal. They also gave weekly

lectures and demonstrations, trained unlicensed midwives, organized public conferences, organized mothers’ clubs for lectures, and established little mothers’ leagues to train girls in proper infant care techniques.

The lectures covered such topics as how to care for babies, how to bathe them, how to give the breast properly, the preparation of bottles, the sewing of a baby’s layette, and so forth. The lectures were often resisted. In 1927, for instance, one article reported that the mothers often refused to stay and hear the talks, and if they stayed they would not stay quiet: “There were cases that when asked to stay for a while, used to turn their backs and remark further that there was no use to make them stay, for they are old enough and know what to do; that they were busy at home and it was only wasting their time to make them stay, etc. etc.” (Javier 1927, 6). The strategies suggested for building an audience marked some of the challenges puericulture center workers faced in early years, and some of the resistance, or indifference, offered to the increased surveillance and paternalism of the welfare state:

In many instances the lecturer is aroused to the verge of losing his temper because of being ignored by the people. In this particular work the nurse therefore should always be in good humor and have the ability to smile even if she is angry, should be open, indeed and simple. The “don’t” and “not” must be omitted because they hurt the feeling of the mothers. Giving incidents that are pleasant and at the same time instructive breaks the monotony of the lecture. (ibid.)

The construal of the fight against infant mortality as central for building the nation meant that in certain accounts the puericulture nurse figured as national heroine. One correspondent wrote from Malaybalay, Bukidnon, in February of 1941:

We admit that as a name, Sinforosa Pangontao is nothing to sigh about. We even admit that as a young woman, Miss Pangontao is not a raving beauty. But we will not admit that, as a public health nurse, she is not our favorite local heroine. Ilocano immigrants brought to town the story of Miss Pangontao, who, called out in flood and storm on a difficult delivery case, climbed aboard a steady old carabao and, small sodden figure of a girl in a nurse’s uniform, clung to the carabao’s horns to swim the treacherous Manupalay river. On both sides of

the river, in the storm, the homeseekers watched the black dot of the carabao's head and the small white figure, rooting for her, praying for her. When asked why she took such risks, she said, "I'm a government nurse and there's a citizens' baby having a hard time getting itself born." The baby was a boy. The mother lived to nurse him. (Crispin 1941, 67)

However, not all nurses were so kindly received, especially if something went wrong and especially in the early days of establishing puericulture centers, as the story with which this article opened indicates.

An important part of the work of puericulture center nurses, as illustrated by this story, was training unlicensed midwives, also called *hilot* or sometimes *herbolario*. Practitioners of "modern" medicine argued that the great majority of cord infections and untimely deaths of the mother and child could be traced to unlicensed midwives, and that many of the gynecological defects evident in Filipino mothers were due to the improper practices of unlicensed midwives (*Welfare Advocate* 1932b, 24). Note that, in the story with which this article opens, the puericulture center officials structured the story so as to attribute any blame to the unlicensed midwife, who failed to stay to monitor her patient. Many of the practices critiqued in the Philippines tried to disrupt relations with traditional healers, midwives, and other neighbors and family members who might be involved in child-bearing or childrearing. Critiques of traditional healers were widespread in colonial settings (see Boddy 1998; Manderson 1998), although the World Health Organization has reversed this practice recently (Jolly 1998a). This episode has its parallel in the attempts of physicians in the same period in the U.S. and Europe to establish their domain of professional expertise by seizing it from midwives (Boddy 2007; Ehrenreich and English 1979; Hattori 2004). In many settings, however, people continued, and continue, to seek the services of a range of possible healers, focusing less on perceived incompatibilities in epistemology or approach than on the efficacy of the practice. Although unlicensed practitioners were decried, there was also a reluctant recognition that *hilot* and others were necessary, given the paucity of trained technical personnel. Less often acknowledged, but probably equally important, was the fact that the use of *hilot* and others probably served as a way to win the loyalty and compliance of rural communities skeptical of biomedicine; such an acknowledgement would have opened space

for a critique of "modern" biomedical practices that is generally not found in documents of this period.¹⁴ In one report, it was noted that "unlicensed midwives constitute one of our health problems in regard to maternal and infant mortality and to render them less dangerous to the community, efforts are being exerted to gather them for instruction on the principles of hygiene and to train them on the management of normal deliveries" (Office of the Public Welfare Commissioner 1930, 13). Rather than antagonizing them, nurses were urged to attract midwives to the puericulture center in order to give them instructions in the "scientific way of handling labor" (Office of the Public Welfare Commissioner 1928, 31). Nonetheless, such training could sometimes backfire. Some unlicensed midwives were invited to attend a series of lectures, and were rewarded for attending with a card, but "[t]he unlicensed midwives made it appear that the card was a license for them to practice, thus enhancing their popularity in the community. The issuing of the card was immediately suspended" (Buenafe 1932, 27).

By 1932 unlicensed midwives were becoming increasingly unwelcome in some areas. In some parts of Negros Occidental their work was legally banned; they were no longer given lectures in communities where there were maternity houses, and where trained midwives, nurses, and doctors were in private practice. Still, however, nurses and licensed midwives reported difficulties in getting people to patronize their services. The assistant superintendent of the Nurses Service of the Office of the Public Welfare Commissioner told this story:

A woman of comfortable means was about to deliver so an unlicensed midwife was called to attend her. After the baby was born, the uterus came out with the placenta probably from manipulation and the woman bled that she died from exhaustion. The husband immediately filed a complaint against the center nurse accusing her of not giving the proper instructions to the unlicensed midwife. In the town where this particular case happened there are two Maternity Houses, several doctors and nurses and graduate midwives in private practice. Now I ask you, who is to blame? (ibid.)

Often nurses and midwives found themselves called in after the *hilot*, when the life of the patient was hanging in the balance, and were blamed for not training unlicensed midwives properly, or even for themselves being improperly trained.

Because of the shortage of nurses for the large number of puericulture centers opening around the archipelago, and perhaps also because of dissatisfaction with training hilot, many centers chose to employ graduate midwives. Midwifery schools were established in Manila and in Cebu in 1922 and in Bacolod in 1923 (Philippine Health Service 1927, 182–83). These staged a training course (nine to twelve months) in obstetrical nursing, anatomy and physiology, dietetics and housekeeping, infant hygiene and feed-

ing, bacteriology, and hygiene and sanitation. Apparently these schools were enthusiastically received. In Manila virtually all of the students were supported by their parents. In Bacolod and Cebu the students were *pensionados* of charitable organizations like the puericulture center or local women's club or of municipal governments; the new midwife in turn pledged to serve a puericulture center in the place where she came from for at least one year (Office of the Public Welfare Commissioner 1928, 38).

A decade after they were established these midwifery schools had graduated 517 midwives. Some, it was reported, were doing well. But the majority "are encountering difficulties due to the seeming indifference of the people and the apparent popularity still of the unlicensed midwives" (Buenafe 1932, 20). In Occidental Negros, many graduate midwives were employed by well-to-do families to take care of infants and even older children. Indeed, by 1932 puericulture center executives were arguing that *pensionados* should serve centers pensioning them for three years instead of one, so as to meet the increasing demand for their services (Salud 1933, 6). The most significant transformation of practices affecting children might be seen as affecting wealthy, rather than poor, families.

Home visiting was considered the most important part of the work done by puericulture center nurses, since "the health commodity [is] not yet well accepted by the public, [and] much time for propaganda must necessarily be given in order to attract and keep up the clientele" (Office of the Public Welfare Commissioner 1928, 30–31). Nurses were told that only one-fourth to one-third of their time should be spent in the center; as much as possible time should be spent in home visiting and propaganda work (*ibid.*, 22).

Health visitors in other locales were often represented as European. The standard representation of the goodness of Belgian colonial rule was a European male doctor tending to the health of an African woman with child, sometimes with a European woman (wife or nurse) at the doctor's side (Hunt 1999, 269). Similarly, in the Federated Malay States in the 1920s a key figure of surveillance was the Health Visitor who was ideally (from the colonial government's point of view) supposed to be a European nurse (Manderson 1998). However, in the Philippines the increasing invasiveness of public health measures, with their surveillance of the intimacies of everyday life, had a Filipino face (fig. 3).

That the nurses were Filipinos did not necessarily mean people were more receptive, or that their questions were seen as less intrusive. Practices



Fig. 3. Poster produced by Office of the Public Welfare Commissioner

still established class- and race-based hierarchies. As Fanon (1965, 131–32) notes, in writing about Algeria,

There is a manifest ambivalence of the colonized group with respect to any member who acquires a technique or the manners of the conqueror. . . . there is . . . the awareness of a sudden divergence between the homogeneous group, enclosed within itself, and this native technician. . . . The native doctor is a Europeanized, Westernized doctor, and in certain circumstances he is considered as no longer being a part of the dominated society.

New puericulture nurses were warned that they would experience difficulties in dealing with new dialects and customs. They were also told to expect families that would ask many questions about the center that were “immaterial and unnecessary,” but which they nonetheless must be prepared to answer, otherwise people would develop a negative opinion of them. They were warned that they should not be stopped by inclement weather or by very embarrassing social situations, “as for example, when she goes out to visit during siesta hours and be met at the door by an angry woman or man, or be ignored altogether by them. So visiting tends to cultivate patience and forbearance.”

Making their way to the homes could be strenuous:

My barrio visits have to be done almost always by walking along the trails and also by sea trips. I am afraid to pass the sea this time as the Pacific Ocean is roaring and very rough. My first visit to the barrio was indeed successful but my second visit last week was very discouraging. I ate my luncheon at 3:00 o'clock in the afternoon and had a bad headache, but still I continued my work just the same. Visiting barrios here is getting hard on account of the mud, of the rain, and of the dense forest I have to pass through. The second barrio I went to took me 3 hours walking and I slipped on the mud several times. I guess nobody has ever suffered similar hardships, as there are no mountainous places to be compared with Oras. Here we have no trucks or autobuses, and the barrios are very far from the town and it requires courage to go to some of them. . . . When I reached home from my barrio visits all I could do was to lie down and sleep like a log, although all parts of my body were tired and aching. (Espino 1931, 5–6)

Nurses were also warned that according to the experiences of others they might be misled, that when a nurse asked for the name of the family whom she was going to visit it was not unusual that “the people gathered in big groups and many foolish questions were asked and little cooperation extended to her or attempts to deceive her were made.”

In home visits nurses were supposed to become acquainted with the actual home conditions and economic status of the families she worked with, and adapt her recommendations accordingly. Nurses were asked to visit each home six to twelve times during the course of a year to ascertain what adjustments needed to be made in the financial, social, moral, and other living conditions of the patient so that the puericulture center could be effective (Office of the Public Welfare Commissioner 1928, 31). Her advice was not therefore confined to childcare, the care of the sick or of pregnant women, but extended to anything that indirectly affected the welfare of the mother and child. Her recommendations could have been hygienic, or health-related, as when she investigated the family's food. But her comments could extend even further to the management of household finances. The chief of the Maternity and Child Hygiene Division of the Office of the Public Welfare Commissioner argued that “[I]t has been observed in many cases that family incomes do not cover the family expenditures but with a wisely made budget, deficit can be avoided” (Elicaño 1931, 9). Puericulture nurses were thus seen, in part, as helping to establish families in ways that were more respectable and independent than before, and aligned with modern notions of appropriate consumption.

Asking intimate questions and keeping records of responses was thus an important, and time-consuming, part of the job. Some forms were said to take as long as an hour to fill out. The amount of paperwork associated with individual records and monthly reports led to criticism by one private physician, who argued that too many of the puericulture center workers worked mechanically and performed their duties perfunctorily, more concerned with paperwork than real help (Filoteo 1927, 1–2). The kinds of questions asked led to resistance from patients. Puericulture center officials lamented that “if the mother or caretaker of the patient is stupid, it takes more than 30 minutes to take the data” and warned others that sometimes record keeping led to “disappointments which go even as far as insults. This is specially true when we take the data in the houses when the husband is present” (Romasantes 1927, 7). Advice about how to deal with resistance and con-

cerns shows, albeit indirectly, people's reactions to the intense and intimate surveillance linked with the monitoring of the birth, health, and death of infants (Escobar 1927).

Puericulture centers also enlisted schoolchildren, especially girls, to support these centers, thus constructing all young Filipinas as community health care workers. This support partly took the form of training in hygiene and housekeeping in schools.¹⁵ A key textbook on housekeeping for Filipino girls included chapters on infant care (fig. 4). In the 1911 edition American teacher and domestic scientist Alice Fuller (1911, 218) blamed infant mortality on the "fact that those who have the care of little babies do not understand their needs." She adds, "When the women come to understand that babies do not die because God wants them, but because they do not have proper care, and when women set about to find the proper way to care for babies, they will do more for their country than they could possibly do in any other way" (ibid., 216). In the 1919 edition by American Susie Butts (1919, 117), infant care was "intended to teach schoolgirls to take a more active part in the bettering of the condition of babies in the Philippines. After studying this chapter, each girl should try to give intelligent help in the care of her little brothers and her little sisters, not forgetting to help as many other babies as she can." In both editions instructions on baby's clothes, things for the baby, preparation of modified milk, feeding the baby, taking care of the baby's teeth, weaning, and the like are laid out in painstaking, and even insulting, detail, in the Fordist management style of the time (McElhinny 2005).

In 1922 the Director of Education issued a circular suggesting that all pupils, but especially girls in grades 4–7, should be given instruction on the aims, activities, and organization of puericulture centers (fig. 5). Girls were to act as extensions of the government surveillance of households:

Girls are asked to report the names and addresses of their neighbors who are mothers of young babies to the authorities in charge of puericulture centers either directly or through their teacher. School girls and teachers are also encouraged to use their influence in inducing mothers with their babies to attend the puericulture center for the purpose of receiving instructions. . . . School girls are further encouraged to visit homes where there are babies for the purpose of assisting mothers in carrying out instructions given by puericulture centers. Girls in the intermediate grades are made to feel that their work in

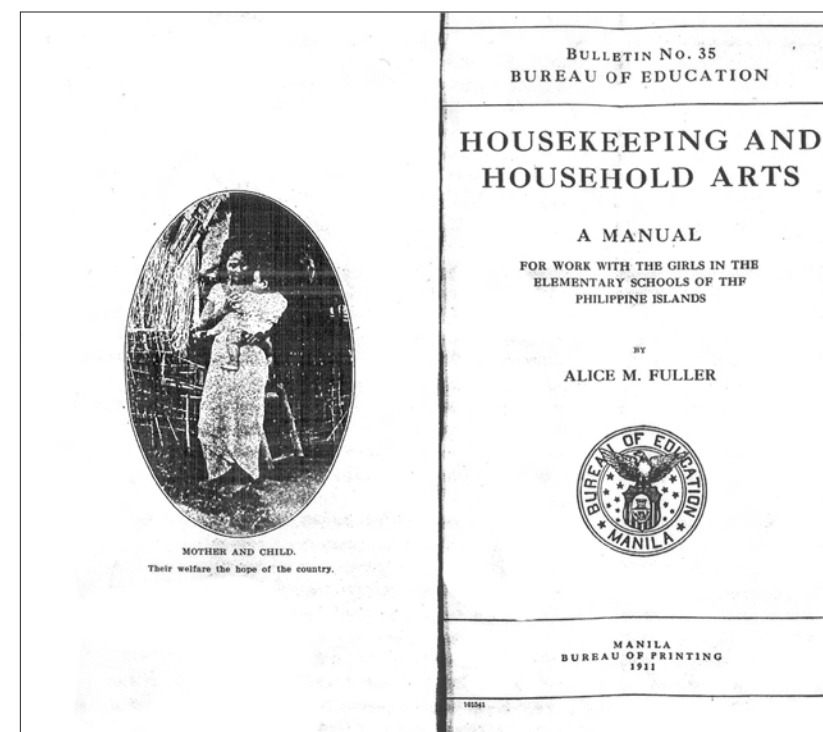


Fig. 4. Frontispiece of Alice Fuller's 1911 manual *Housekeeping and Household Arts*

assisting nurses in charge of puericulture centers is a part of their work in the domestic sciences. (Office of the Public Welfare Commissioner 1922, 19)

As in colonial Malaya (Manderson 1998, 42), the focus on the recruitment of schoolchildren to the project of domestic science could have shown some pessimism about ultimately recruiting adults. Schoolchildren were the hope of the future; they were the ones who were educable and reachable, while adults were seen as more recalcitrant to change (cf. McElhinny 2005). It was also, perhaps, another attempt to disrupt traditional social relations, an attempt that gave authority to children over adults.

If the notion of puericulture centers drew clearly on French institutions, some of the practices used to attract clientele drew from American practices of the time. Giving prizes in baby and mother contests was seen as

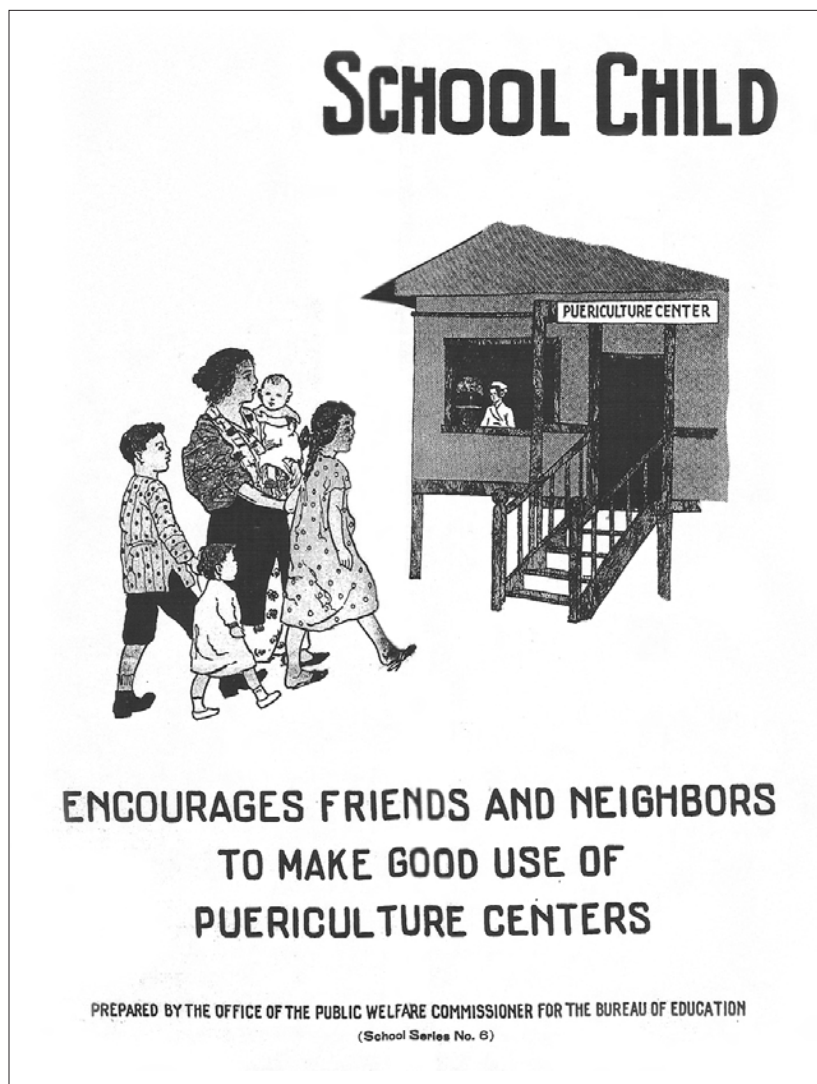


Fig. 5. Poster produced by Office of the Public Welfare Commissioner

a way to make “instructions as attractive as possible, not only for the purpose of stimulating their absorption but above all their practice” (Office of the Public Welfare Commissioner 1928, 36). Contests were supposed to coincide with a holiday—town fiestas, Christmas, Rizal Day, or mother’s day. All participants were given a token prize, although only 5 percent were to

be given awards. An A-1 child was a child deemed free from all correctable defects, who increased regularly in weight and practiced the health rules of cleanliness and regular activity, had sufficient rest, and was nourished with appropriate foods.¹⁶ In order to participate, mothers had to be willing to answer all questions on the baby contest standard scorecard issued by the Office of the Public Welfare Commissioner (1921).

The scorecards were adapted from livestock rating systems used in U.S. agricultural fairs, which also assessed for A-1 characteristics (Klaus 1993). They grew out of marked concerns with eugenics in the U.S. context. Questions included whether a physician or midwife had attended the birth, whether the baby was bottle- or breast-fed, the number of feedings in twenty-four hours, whether the birth was registered and if not why not, if the baby slept alone, if the baby slept in open air, how many windows are open in the house at night. The scorecard also listed activities that children of different ages should be able to accomplish (e.g., a 4-year-old child knows its own sex). The scorecard included the weight targets for different age groups, but also a number of checkpoints for head, posture, and gait; moral deportment, such as a child lacking self-control; and general condition (looks very fat, is bow-legged, irritable, or nervous).

Such contests were said to be extraordinarily popular in the Philippines, according to both journalists and public welfare and health workers. Whatever their effectiveness at convincing people of the rightness of the proposed activities, they were fairly effective at not only conveying what the government thought was appropriate childcare but also perhaps in convincing participants to produce the verbal responses that would receive a positive response. The goal of making A-1 children was largely influenced not only by changing the biological understanding of childbirth, but it was also determined by the discursive production of new ways of life and the alteration of traditional social life and norms.¹⁷

The aims of puericulture centers were to effect wholesale change in domestic practices. Dr. Cesar Filoteo, a private physician who had been asked to speak about how puericulture centers helped private physicians at a Regional Conference for Puericulture Center Works in Cebu in 1927, ended up offering a critique of many of their practices. Some he saw as useless, superfluous, or silly. For instance, Filoteo (1927, 1) asked sardonically how people could be expected to feed babies with artificial milk and orange juice when they could not afford to buy these. He asked how babies could be fed

by the clock where nipa shacks had no timepieces, and how babies could be properly clothed in a full layette when they had only a few rags to cover their nakedness. He asked how people could be expected to understand lectures in English, let alone technical English.

In a measured response to Filoteo, addressed “To Puericulture Center Nurses, Midwives and the Public in General,” it was noted that not all of these critiques were merited, and none was insurmountable in any individual with common sense. The response noted that home visiting would allow nurses to make recommendations based on the family’s income and the availability of resources (if bottled orange juice was too expensive, substitute fresh; if this was unavailable, use tomato juice); that baby clothes did not need to be expensive cloth but merely clean rags; that in the absence of watches people still knew when to prepare breakfast, when to send children to school, when to prepare food for laborers coming home at midday to eat (*Welfare Advocate* 1927, 3–4). The respondent did not note Filoteo’s motivations for his

critique, though private physicians saw the free services of puericulture centers as competing with them for paying patients (fig. 6).

Filoteo saw other measures as not being realized, however noble. He saw them as being hijacked by the wealthy members of the community, away from the most needy ones. He argued that the centers had become public dispensaries where old and young, rich and poor, including male adults, went to be diagnosed and given free medicine. He noted the dilemma: that often those rich enough to contribute several pesos to get the puericulture center started expected treatment in return. But he also voiced his concerns that the rich and well-to-do were getting most of the care, while the “deserving poor” were neglected. Filoteo (1927, 1)

argued, perhaps only partly facetiously, that perhaps the mandate of the centers would be understood more clearly if they weren’t called “puericulture” — “a tongue-twisting, classical word. Why not the simple Mother and Baby’s clinic and add the word ‘poor’ in big letters”?

The response noted that, indeed, centers did sometimes find themselves with many rich and well-to-do patients who had paid a two-peso annual membership and then expected nursing care of sick children and regular attendance at deliveries, though this was an attitude centers were working to change. It also clarified that puericulture centers were meant to educate everyone on puericulture, and thus everyone was welcome to physical examinations and advice without charge, since ignorance about baby and mother care was found among the rich and the poor. However, if the patient required treatment, rich patients were referred to private practitioners and asked to pay according to a posted schedule of charges. Finally, it argued that, for the “poor and ignorant” who used puericulture centers, the name was not tongue twisting—to these clients they were simply the “Center” or “Centro” (*Welfare Advocate* 1927, 3–4).

Into the Remainder of the Twentieth Century

Puericulture centers only ever reached a fraction of the population. In 1934 the annual report for the Bureau of Health argued that 27,434 mothers and children were registered at and attended to by puericulture centers. The total population of the Philippines at the time was estimated at 19,929,526 (Public Health Service 1934).¹⁸ Work on reducing infant mortality rates was slowed by the worldwide depression, and then largely interrupted during the Japanese occupation of the Philippines from 1941 to 1945. Health services were limited during this period, and at the time of liberation there was widespread incidence of malaria, tuberculosis, venereal disease, malnutrition, and beriberi.

There were a number of joint U.S.-Philippine public health projects after the Second World War. In 1951 the Philippine-American Public Health Project coined a new term, “Rural Health Units” (RHU) for medical units that were to carry out seven basic health services (maternal and child health, environmental health, communicable disease control, vital statistics, medical care, health education, and public health nursing). By 1958 RHUs were made an integral part of the public health care delivery system. However, Filipino medical historians report that the RHUs had constant problems, including lack of medicines and supplies, inadequate supervision and funds,

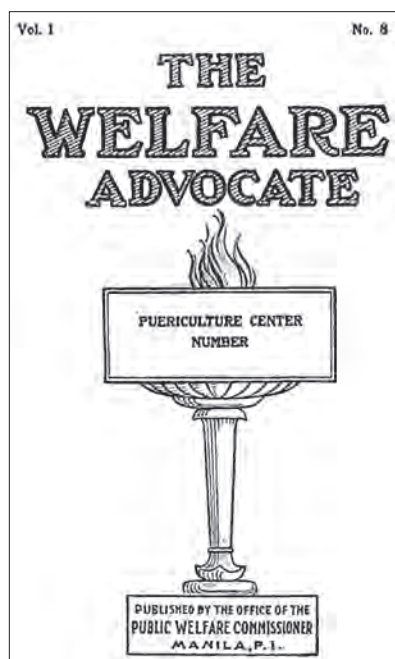


Fig. 6. August 1927 issue of *The Welfare Advocate*, a regular newsletter for public welfare workers

problems in training and staffing, as well as unspecified problems that arose with puericulture centers (Dayrit et al. 2002, 68).

Puericulture centers continued to face fund-raising challenges, as was evidenced by the establishment of a National League of Puericulture Centers (NLPC) in 1961 to help volunteers who were overburdened with unending fund-raising for their centers.¹⁹ As an umbrella organization it lobbied for legislation for funding of puericulture centers, and conducted fund-raising campaigns of its own for puericulture centers with beauty contests, raffles, and benefit dinners and luncheons in order to raise money for needy centers.²⁰ Puericulture centers continued to be maintained by women's groups into the 1980s (Ankara 1984). However, many puericulture centers have disappeared in recent years, or been taken over by other municipal functions. Progress in reducing infant mortality in the Philippines stalled; infant mortality may even have increased in recent years. Through 1990 there remained large differences in life expectancy and infant mortality among different regions and provinces (Department of Health 1993, 13).

Colonial State Inscription Through the Clinic

Rafael (2000, 23) has noted the connection between benevolence and discipline in the Philippines, and many medical historians have also flagged the interrelationship between public health programs and increased state and medical surveillance. The establishment of puericulture centers seems to have led to a decline in infant mortality rates. But another important effect was the elaboration of a form of state inscription.

The ways that families interacted, and in particular the way that mothers interacted with children; the ways that they handled pregnancies, labor, birth, breast-feeding, other forms of feeding; whether they rocked their babies when they cried or took them out in the evening air to a fiesta all started to fall under the state purview with the establishment of the network of puericulture centers around the Islands. In the Belgian Congo, attempts to medicalize childbirth could be seen as a

"diluted form of indirect rule." . . . The medicalization of childbirth was tied to the increasing bureaucratization of colonial life, and high attendance statistics in maternity wards were a by-product of a pronatalist colonial welfare state. . . . medicalizing birth was not only about giving birth in the Congo, but about counting—privileging and enumerating—

birth. The bureaucratic imperatives of *colonial inscription*, the demographic arm of the sanitary modality of colonial rule, effected this intense pressure on getting numbers. (Hunt 1999, 263)

Similarly, in talking about early attempts at census taking by the American regime in the Philippines, Rafael (2000, 23) argues that "through continuous and discrete observations, the targets of benevolent assimilation could be identified, apprehended, and delivered for democratic tutelage." He points out further that "whether it was in the areas of public order or public health, education or elections, incarceration or commerce, such supervision sustained the articulation of colonial rule at both the ideological and practical level. By rendering visible the subjects of colonization in particular ways, colonial supervision amounted to a powerful form of surveillance" (ibid.). Numerous forms of technology contributed toward this increased surveillance, from mapping and ethnography to censuses and photography. Puericulture centers, as the first regular clinic in many towns, combined a range of these technologies. Nonetheless, although in many of the areas that Rafael describes, and indeed in many other areas of public health in the Philippines (campaigns against leprosy, malaria, and smallpox), the forms of surveillance were colonial, the forms of surveillance linked to infant mortality could be understood as (proto)national.

In arguing about what is distinctive about colonial medicine scholars have tended to take one of two positions. The first (cf. Jones 2002) argues that there was virtually no difference between imperial and national interventions, and both should be understood as advancing the welfare of the less advantaged. Such an argument dovetails neatly with proimperialist arguments that would argue that it is to the benefit of the colonized to be colonized, in ways which set aside critiques of imperialism as unaccountable power (Connelly 2006, 19).²¹ Indeed, journalist Max Boot (2002) has recently argued that public health improvements justified U.S. occupations of Cuba, Haiti, and the Philippines. A second (cf. Arnold 1993) would argue that there are indeed marked similarities between imperial and metropolitan initiatives, but that this is not necessarily a sign of benevolent intervention; in both cases people who are less advantaged are, in effect, being colonized by modern medicine, with emerging systems of knowledge and power, of ideology and administrative mechanisms being characteristic of bourgeois societies and modern states throughout the world. Those targeted might

be characterized by race, class, or both. This argument tends to minimize the significance of national autonomy, and perhaps also some of the forms resistance to colonialism can take; nonetheless, it also suggests the ways in which both colonial and elite national actors and institutions, as well as state actors on the ground (like puericulture physicians, nurses, and midwives) are agents of governmentality.

In the Filipino case, however, it would seem a mistake to blur the distinctions between colonial and national health initiatives too quickly, either to praise or critique them. Strikingly, although some participants in the puericulture movement were trained in the U.S., infant mortality rates in the U.S., and strategies for reducing them, were not generally seen as the model toward which Filipinos should aim. Instead, they focused on countries with even lower infant mortality rates (like France and New Zealand), and more than once favorably compared their efforts to American ones. To argue for all Western, biomedical initiatives as colonial would be to cede to American colonial discourse precisely what Filipino physicians, nurses, and midwives regularly contested: they often argued, instead, that their knowledge of different tactics for dealing with infant mortality denoted their international and cosmopolitan participation in a community of science, an argument which at least implicitly and sometimes explicitly noted their readiness for self-rule, underlined the gaps and holes in the health and welfare issues American colonial institutions attended to, wrote and rewrote histories in ways which centered Filipino initiatives and success in saving the lives of Filipino mothers and children. Nonetheless, such protonational efforts were also contested attempts to make Filipino bodies ever more visible to the colonial, commonwealth, and national state, in ways which made them available for political and economic disciplining. Some of the resistance to these attempts is also documented here.

Notes

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- 1 Hunt (1988, 403 n. 12) notes that one of the first infant consultations was founded in France in 1892. Strikingly, concerns about fertility decline emerged a half century sooner in France than in some other European countries, and thus its *Gouttes de Lait* and infant consultations became the model for infant welfare efforts in other countries such as England and Belgium.
- 2 The purpose of the organization is described in a note written in English and attached to these articles of incorporation, as "purely benevolent in caring for children, and protecting them through such medico-hygienic measures as science may suggest."
- 3 Further research needs to be done on these participants. Apacible was a distant cousin of José Rizal's, living with him in boarding houses while they were both students. He studied medicine in Barcelona and Madrid, and was the president of Solidaridad. He also treated Rizal's sister, Soledad, after her sister Olimpia died in the course of a labor. Trinidad Rizal was one of Rizal's unmarried sisters. Reyes's recent (2008, 230–43) analysis of Rizal's correspondence with his nine sisters on female sexual and reproductive health shows both his sisters' pressing desire for information and advice on painless parturition and breast-feeding, concerns which suggested that they saw childbearing as dangerous as epidemic disease, as well as Rizal's reticence on this same point. He did not specialize in obstetrics, as they requested, nor did he offer them the practical advice they requested. Rizal corresponded with his sisters about lectures in obstetrics at San Carlos, about a visit to the Laennec Hospital in Paris with the obstetrician Felipe Zamora (who later treated his sister Saturnina for a disorder of the uterus), and trips with Felix Pardo de Tavera to examine how women's illnesses were treated at the Lariboisiere Hospital. Reyes's analysis points us to the centrality of motherhood and childrearing to the *ilustrado's* developing sense of Filipino nationality. The ways that obstetrical and pediatric education shaped this, and the political and social networks Gota de Leche drew on, deserves further investigation.
- 4 In each of the annual reports produced by the Department of Public Welfare, established in 1920 with its primary task being reduction of infant mortality, the work of Gota de Leche was always prominently displayed and discussed. Indeed, given the small numbers of infants regularly assisted by Gota de Leche, the prominence of discussions of its work might be seen as linked more to its early initiatives than to its continuing work. However, its importance is also linked to its role in showing what the American colonial government was not doing at the time.
- 5 Gota de Leche still exists, and still distributes free milk to families from 859 S. H. Loyola Street in Sampoloc, Manila. The building, designed in 1915, was renovated as a heritage building in 2003.
- 6 See the May 1948 issue of the *Journal of the Philippine Medical Association*, a memorial issue devoted to reviewing Dr. Fernando Calderon's work; cf. Fuentes 1996. His brother, Felipe, was famous for drafting the Malolos constitution (a constitution that undergirded the First Republic of the Philippines inaugurated by Filipinos during the Philippine-American War) and in some circles later infamous for serving as advisor to the American colonial government. Felipe Calderon's wife, Concepcion Felix de Calderon, was one of the other founders of Gota de Leche.

- 7 The reasons why this private organization was given such power in a government initiative remain to be elucidated, through further research in legislative records. Fernando Calderon was a close friend of Manuel Quezon (Fuentes 1996); however, this does not fully explain why Osmeña, Quezon's sometime rival, would support this bill. My thanks to Filomeno Aguilar for raising questions about this connection.
- 8 Although the eruption of this smallpox epidemic was seen as evidence of Filipino weaknesses in guarding public health, contemporary and recent commentators like José Fabella and Warwick Anderson note that in fact the eruptions of these epidemics could be understood as the failure of the American program of immunization. The smallpox vaccine used was only effective for seven to eight years; without regularly renewing the immunization campaign, which the Americans launched earlier, an epidemic was predictable.
- 9 Maternal mortality did not receive the same extended attention. See *Welfare Advocate* (1930a, 1) for one review. Maternal mortality statistics were seen as an indication of the quality of birth attendants, but not as an indication of the overall health of the population. Interestingly, the maternal mortality rate in the Philippines was claimed to rival that of the U.S. (six maternal deaths for every 1,000 babies born alive). The U.S. was seen as having a scandalous maternal mortality rate in comparison to other countries like Scotland (5.8); Germany (5.3); England/Wales (3.8); Denmark, Norway, and Sweden (2.6); and Holland (2.3) (*Welfare Advocate* 1929a, 3).
- 10 Anderson (1992, 332) in an otherwise rich, enlightening, and critical account of the Filipinization of tropical medicine seems to accept that in the 1920s most of the Filipino physicians had been trained under Americans or in the U.S. This claim deserves further empirical investigation. As he notes, Filipinos were admitted to American training hospitals in only modest numbers until the Filipinization campaigns begun in 1914.
- 11 For this phrase, see *Welfare Advocate* 1930b, 11.
- 12 In colonial Malaya, when attempts to recruit women to infant welfare clinics failed, reformers turned to offering courses in domestic science (Manderson 1998, 42). However, the instruction of hygiene and domestic science in Filipino schools was part of the American-shaped curriculum from the beginning, and has been extensively described and critiqued elsewhere. For colonial documents, see Fuller 1911; Butts 1919; for scholarly analyses, see Eviota 1992; May 1980; Sobritchea 1989.
- 13 Strikingly, the U.S. was seen as markedly behind other countries in gathering statistics on registered births. As late as 1916 and 1917, those writing to the U.S. Children's Bureau for this information were told birth registration was far from complete, lagging far behind most European countries. Writers complained that China and Turkey would have satisfactory data before the U.S. (Klaus 1993, 18). In the Philippines, Filipino physician Fernando Calderon (1909, 44) criticized the Bureau of Health's efforts to gather statistics on infant health: "Instead of bringing before you foreign statistics as to the relative mortality of breast-fed and bottle-fed infants, I would have greatly preferred to present such data taken from the records of the Insular Bureau of Health. Unfortunately, that Bureau was unable to furnish me with them because no such data exist." The annual report of the Bureau of Health (1909) includes a defensive commentary, which suggests that, although long recognizing the significance of this issue, it believes that reliable figures cannot be obtained. Statistics do appear two years later, in 1911, and in every annual report thereafter.
- 14 My thanks to a thoughtful reviewer for drawing my attention to this point.
- 15 See the pioneering work of Sobritchea (1989) on the role of gender in American colonial education in which she traces the ways that many aspects of the curriculum were sharply gender differentiated, with boys trained in gardening, woodwork, and basket and mat weaving while girls were taught lace making, sewing, and housekeeping.
- 16 In 1934 the Director of Health reported 4,892 A-1 children in the elementary grades (Philippine Health Service 1934). The A-1 baby program was marked as a significant success in this report, with keen interest from children, teachers, and parents leading to the number increasing each month.
- 17 The Office of the Public Welfare Commissioner (1927, 13) noted that "the regular visit of the nurse to the house serves to remove 'although gradually' the tendency of some mothers to neglect in carrying out medical advice, until the use of proper procedure in taking care of themselves and of their babies comes to them naturally as a habit." Registering births was seen as important because it established date of birth and parentage; the age of a child for attending school or working in places where child labor is restricted; helped determine in courts of justice whether a girl has reached the age of consent, or the age that they can marry without parental permission; established the age for voting; and helped the state keep track of additions made to the population and which elements of population were contributing to this increase.
- 18 Numbers may have jumped up markedly by the following year. In 1936 it is reported that there were 233 puericulture centers, with an attendance of 493,733 and eight community-health centers serving 350,717 (see Philippine Health Service 1936, 9). Dr. Tranquilino Elicaño, Director of the Office of Public Welfare, Maternity and Child Hygiene Division, was quoted as saying that, in municipalities with active puericulture centers, the infant mortality rate dropped from a national average of 165/1,000 to 111/1,000, while the infant mortality rate among those attending the centers dropped even further to 59.04/1,000. *Philippines Free Press* 1931.
- 19 See histories of puericulture centers summarized in the program of The National League of Puericulture and Family Planning Centers, Inc. 1982 Convention and Diamond (69th) Jubilee Commemoration of the Puericulture Center Movement, 14–16 Apr. 1982, Quezon City Sports Club, available in the library at the headquarters of the National Federation of Women's Clubs (NFWC Building, Corner J. LL. Escoda and San Marcelino Streets, Ermita, Manila).
- 20 International organizations like the WHO-UNICEF developed training sessions in maternal and child health for center nurses and midwives. In 1976 the USAID launched a nationwide family planning program, and nineteen puericulture centers in the provinces of Pampanga, Laguna, Tarlac, and Sorsogon were chosen as pilot family planning clinics. This pilot program was later extended to other centers, which became known as puericulture and family planning centers. The ways in which these new efforts affected initiatives to improve maternal and child health remain to be documented. Pres. Ferdinand Marcos declared 1973 the year of the puericulture center movement in recognition of the value of puericulture centers in his New Society's development programs.
- 21 Arguably, Jones (2002) is able to make her argument at all because of the relatively early indigenization of medicine in Ceylon (see also Birn 2005 on Uruguay). It is worth exploring further whether the indigenization of medicine, which is evident in all three sites, was linked to the rapid advance of efforts on child health.

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