



Ann Yrjälä

Public Health and Rockefeller Wealth

Alliance Strategies in the Early Formation
of Finnish Public Health Nursing

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Preface and Acknowledgements

In this book, I offer an analysis of the formation of Finnish public health nursing in the inter-war period and that process' North American influences. It is a multi-layered story, and I aim at understanding the complex processes encountered by many international and national social actors and individual pioneers involved in the professionalization of public health nursing. Finnish public health nursing was shaped as a new paradigm for community-based nursing practice within the context of social reform in the formative stage of the Nordic welfare state.

I have a personal occupational background in public health nursing, and the chosen topic of this study thus reflects my desire to learn more about the history of the occupation I have been practicing myself and to combine it with my academic interest in the Sociology of Professional Groups. The North American influence in the early shaping of public health nursing internationally and in the Finnish context examined here is the activities of the Rockefeller Foundation in the inter-war period. It has been an exciting task to learn about this complex American philanthropic organization and to have an opportunity to collect materials related to this organization's policies and programs concerning public health.

It brings me great satisfaction to thank an extraordinary group of people who have contributed in immeasurable ways to help make this doctoral dissertation project and book a reality. I am particularly grateful for my collaboration with my supervisors, Professor Elianne Riska and Academy Research Fellow Sirpa Wrede. Elianne Riska's support during my studies for the master's degree in sociology and in the initial stage of the dissertation project was vital. As a Research Associate in the spring 2001, within the Academy of Finland research project *Images of Women's Health* (1997–2002, project number 34480, funding decisions 59221 and 74174), led by Elianne Riska, I had an opportunity to collect additional materials for the dissertation project at the Rockefeller Archive Center in North Tarrytown, NY. The first collection of materials had taken place during my studies for the master's degree in sociology at the Rockefeller Archive Center in 1998 and was then financed by a General Grant-in-Aid allowed by the Rockefeller Archive Center. Sirpa Wrede supervised me on my research topic for a long time. Particularly in 2004, I had an

opportunity to intensify my collaboration with Sirpa Wrede as researcher in the Academy of Finland research project, *The New Dynamics of Professionalism within Caring Occupations* (2003–2008, project number 202556) (Swe. *Professionalismens nya dynamik i omsorgsykten*), led by Sirpa Wrede. Particularly the long and stimulating discussions with Sirpa in their temporary home in Helsinki in the spring of 2004 were essential for the advancement of my research project. Elianne and Sirpa—I am grateful for the encouraging discussions, both general and detailed ones, on ideas and interpretations during the research process, the language counseling, and the financial arrangements that your research projects have facilitated. These persons have also contributed with recommendations when I have applied and thankfully received research grants allowed by *Svenska kulturfonden*, *Waldemar von Frenckells stiftelse*, and two research scholarships from Åbo Akademi University (*Stiftelsens för Åbo Akademi forskningsinstitut*).

Furthermore, I am grateful to my external examiners Professor Juha Kinnunen at University of Kuopio and senior lecturer Lars Evertsson at Umeå University. They provided me with useful and constructive comments on the manuscript, which helped me to work with the last part of elucidating different parts of the dissertation text.

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I have been a rather “accidental visitor” at the sociology department, *Åhuset*, at Åbo Akademi University in Turku. Some visits have lasted longer and others have

been very short. Most of my work during the research process has taken place in Helsinki, where I live. My stays in Turku have usually been quite intense; including teaching, research seminars, meetings with my supervisors, colleagues and students etc, and therefore I have lacked the opportunity to discuss things comprehensively with my colleagues at the department. However, the short talks that we have had have been sympathetic, supportive, and important for my social wellbeing as a researcher. I am grateful to Ralf and Elina, Bodil, Hedda and Serge, Jutta and Alf, Pia and Linus, for organizing comfortable accommodation for me in their homes, during my stays in Turku.

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My thoughts also go to my previous colleagues during my career as a public health nurse and my work as a teacher at the Sports and Health Promotion Degree Programme of the Sydväst Polytechnic School. My superiors Hanna Kamppi, Terttu Virta and Mervi Wallin at the Lauttasaari Health Center in Helsinki encouraged me in the early stage of my academic studies. My other colleagues during many years of teamwork at the health center have influenced my occupational identity in a very positive way and inspired my academic research. My fine colleagues at the Sydväst Polytechnic School in Espoo encouraged my academic project. I am very pleased with the flexible working arrangements that made it possible to combine teaching activities at the school with my academic project.

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Helsinki, June 2005

Ann Yrjälä

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List of Used Abbreviations

DME	Division of Medical Education (RF, 1919–1929)
DS	Division of Studies (RF, 1923–1927)
MS	Division of Medical Sciences (RF, 1929–1951)
GEB	General Educational Board (RF, 1902– last appropriation made in 1964)
ICN	International Council of Nurses
IHB	International Health Board (RF, 1923–1927)
IHD	International Health Division (RF, 1927–1951)
NOPHN	National Organization for Public Health Nursing (USA)
PH/ph	public health
PHNing	public health nursing
phn	public health nurse
ph-knowledge	public health knowledge
RF	Rockefeller Foundation (Chartered May 14, 1913)

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The badge is circular with a grey border. Inside, there is a stylized map of Finland in grey. To the left of the map is a sun with rays. The words "PUBLIC HEALTH" are written in a semi-circle at the bottom of the badge, with a small asterisk at the end.

PART I

Aim and Background of the Study

*The badge of the Finnish Public Health Nurses (Finnish Union of Public Health Nurses). For more information see Appendix 4.

Introduction

Wherever the International Health Division [of the Rockefeller Foundation] co-operates in a public health nursing program, this program will be as varied as the public health program which varies according to the part of the world where it is being carried on. In Panama it will be quite different from what it is in Finland, Hungary, Turkey or the United States. The public health nursing program must always be opportunistic, just as the public health program is. ... Aid to develop a practice field in Greater Helsinki, where both health officers and public health nurses could have good practical experience, would offer an interesting opportunity. (Mary Beard in 1937, associate director of the International Health Division, emphasis added)¹

1.1 Aim of the Study

“Nursing” is a complex phenomenon and different types of nursing have been formed via different processes (Dingwall, Rafferty & Webster 1988 and Davies 1995). This is a sociological study of the social and historical processes during which women’s occupation in public health and public health nursing took shape in Finland. What I consider to constitute the present public health service in Finland, and the part of this which is performed by the occupational group of public health nurses was shaped during a long process which was influenced by several different social actors with different interests who interacted and at times confronted each other in an atmosphere of tension. A study of the early formation of an occupation is a study of a society undergoing temporal social change which shapes the context in which occupations gain a position and will either continue to exist over time or will slowly disappear. The process when a new form of occupational activity gains a position indicates some change in cultural values, social structures and in the patterned actions that reflect the embedded knowledge of the different actors involved in the process.

A sociological analysis which examines the formation of professional jurisdictions needs to be grounded in a historical understanding of the social and cultural processes shaping it (Abbott 1988). This study is a piece of interpretive sociology that aims toward an understanding of the social action/interaction within the process

of professionalization. I regard professionalization as a process which takes place in a system of continuous struggles over jurisdictions which are historically located. By these struggles, professional groups make claims on the right to dominate a particular area of work.

The materials in this study consist of historical documents collected from archives. The interplay between national social actors and an international philanthropic foundation involved in the formation of public health is the focus of the present study. International dissemination of scholarly knowledge, professional practices, and administrative strategies which relate to public health in the inter-war period contributed to the professionalization of public health and social welfare in Finland. These broader social processes, which influenced the specific formation of Finnish public health nursing, are contextualized in this study by the activities of the Rockefeller Foundation, a central actor in international public health activities during the inter-war period and until the post-World War II period.

Nursing, with its tradition of value-oriented action and instrumental or rational action was challenged by the prevailing culture of growing bureaucratic and secular reorganization of welfare and health reform work in the beginning of the twentieth century. The Rockefeller Foundation was one central mediator of this change, by transporting new cognitive constructions and morally governed judgments in public health.

"Rockefeller medicine" emerged at the beginning of the twentieth century and served as a catalyst in promoting public health services in many parts of the world (see, for example, Weindling 1995; Rafferty 1995; Hewa 1997, 1998a, 1998b and 2002 and Äijänseppä 1998). The activities of the Rockefeller Foundation in the fields of medicine and health care laid the groundwork for the development of basic sanitary services and preventive medicine. The Rockefeller Foundation is best known for influencing education and research within American medicine. Less known is the Rockefeller Foundation's interest and role in the formation of central elements in public health nursing with regards to training, work practice and public health service administration. Nursing was never seen as a high priority in the policies and programs of the Rockefeller Foundation, but investments in reform of nursing education became a necessary element in the Foundation's public health programs for rural communities. This study shows that the activities of the Rockefeller Foundation clearly influenced the professionalization of public health nursing and the public health policies in relation to nursing in the U.S. and in other countries. The public health nursing model implemented in Finland in the early 1940s can be traced to the Rockefeller Foundation's programs and policies. The Rockefeller Foundation's policies concerning public health were also adapted to the programs and policies of the World Health Organization (WHO) within the United Nations in the 1950s (John B. Grant, June 6, 1951: 2–3).² This study reflects on the vital role of this large, international health organization in promoting public health reform and professionalization in international, national and local contexts.

The early and formative shaping of welfare states has largely been studied by looking at the developments of state-administered and municipal systems. The variety of voluntary organizations within national and international health work and welfare building in the inter-war period has got less attention in socio-historical research (Weindling 1995). The broad interaction of international expertise in health and welfare between the wars, with their important roles in pioneering innovations, monitoring conditions, setting optimal standards, and organizing assistance of training of personnel, as a result of interchange with public actors, is still a rather neglected research theme.

The multifunctional character of both national administrative and legal frameworks of health and welfare and supporting frameworks constructed by international health organizations need to be acknowledged. Such strategies always include patterns of manipulative actions for the purpose of political usefulness. Larger political issues in the inter-war period are important background elements to recognize but the research focus in this study is more on specific professionalization processes in health and welfare. I relate my study to established research of the link between specific reform cultures visible in welfare policies and professional groups that carry out knowledge-based health and welfare work. I hope to shed light on specific social and cultural roots of welfare policies in order to build an understanding of a new kind of women's agency in professional health and welfare activities that was shaped between the wars.

Previous academic research has covered the specific international influence on the development of Finnish public health nursing in the inter-war and early formative stage of the modern welfare state only to a limited extent. The international impact on Finnish nursing is discussed in several Finnish studies by researchers in education and nursing history. The Rockefeller Foundation's activities (Tallberg 1991; Laiho 1995 (and forthcoming 2005); Sorvettula 1998 and Yrjälä 1999), and the Red Cross supported international course in public health nursing at Bedford College in London (Punto 1991 and Sorvettula 1998), are looked at in relation to undergraduate and postgraduate nursing education and the institutionalization and standardization of Finnish nursing. These studies also include detailed historical descriptions of the role of the International Council of Nurses (ICN) and the Nordic Nursing Association for Cooperation (Swe. *SSN/Sjuksköterskors Samarbete i Norden*) on Finnish nursing (Tallberg 1991; Laiho 1995 (and forthcoming 2005) and Sorvettula 1998). These valuable studies give detailed historical descriptions about the work of the forerunners of the "new" public health nurses (see also Simoila 1994), about the contents of courses in nursing curricula, and about the academization of nursing in Nordic countries. They also provide thorough descriptions about many of the individual pioneers of Finnish nursing. Nonetheless, a more comprehensive understanding of how social and historical international processes in the inter-war period influenced public health and welfare reform, and moreover the new manifestation of 'health nursing,' in a Finnish context, is still lacking.

This study identifies the international and national educational and administrative strategies engaged in by different social actors who have campaigned for public health nursing in different ways and the impact of their activities on national public health nursing policies in Finland. The occupational image for public health nursing which the vanguard of leaders and innovators wanted to create, and protection or extension of nursing's share of the market of well-qualified middle-class women in welfare work of the time, were social aspects aimed at defining the boundaries of this occupational group. I call this leading group of social actors professionalizers of public health nursing (Dingwall et al. 1988: 209). Primarily, I examine how those who worked to professionalize public health nursing used educational and administrative strategies to legitimize and institutionalize public health nursing knowledge and practice. I also study how modes of practice of public health nursing were defined during the 1920s and 1930s. Furthermore, I ask what kind of recognition the professionalizers sought and what audiences they direct their claims to (Abbott 1988). Hence my analytical framework includes the impact of the institutional and interactional context for the dissemination of scholarly and practical knowledge about public health nursing and the organizing of local public health nursing. My argument is that the exchange between Finns and Americans enabled the use of a particular form of making claims, *alliance strategies* (Selander 1989 and 1990; Evertsson 2002), to promote the professional project for the professionalizers of Finnish public health nursing. The focus of my interpretation lies on a critical examination of how such alliance strategies were shaped and of how they influenced the formation of a *professional jurisdiction* for Finnish public health nursing.

I consider the Rockefeller Foundation a social actor among other actors of the process I study. Other actors identified in the study are different voluntary organizations, public agencies, voluntary and public educational institutions, and professional associations – all of which influenced the formation of public health nursing in Finland. I have created two empirically defined abstract categories to describe the social actors that the vanguard of professionalizers of public health nursing interacted with and at times confronted, namely "public health activists" (PH-activists), who promoted education and innovation, and "implementers" of public health programs. My archival materials show that these different social actors have, with their different and often conflicting values and interests, worked together to define the role of public health nursing. The analytical mode of this study of formation of Finnish public health nursing is to approach it as identification of *negotiations* at the intersections of these three kinds of social agency. This interpretive study reflects upon the negotiated and learned meanings (Strauss 1978) of public health nursing that professionalizers, PH-activists and implementers with different roles, with different knowledge backgrounds and power positions, expressed when they interacted and confronted each other in various contexts. The formation of Finnish inter-war public health nursing is thus seen as a social phenomenon, which has been subject to processes such as rearrangement, and reconstruction.

The social scene of these actions/interactions was complex and same key actors could operate as professionalizers, PH-activists, and implementers at different times and social spaces. The task in this actor-oriented and context-sensitive study is thus to examine critically the contents and consequences of the negotiations that these actors have been a part of in relation to the formation of public health nursing. I use the concept *boundary-work*, which was originally developed within the sociology of science (Gieryn 1983: 791–792), as a broader analytic framework. Expansion, monopolization and the protection of autonomy are generic features of professionalization. According to Thomas F. Gieryn (1983), ideologists of a profession or occupation use boundary-work as a stylistic resource in the struggle for professionalization (for interpretations of the concept of boundary-work, see Fisher 1990 and Gieryn 1999). The concept of boundary-work in the context of this dissertation grasps the complex phenomenon of the production and reproduction of cultural hegemony or the authorization of social forces in society in relation to public health. These processes create, maintain or break down boundaries between knowledge units of ‘scientific philanthropy,’ public health, traditional nursing, and public ‘health nursing.’

The more specific theoretical framework of this study, which is discussed in greater detail below, relates to theoretical concepts within the sociology of professional groups, which are theoretical concepts I believe to be useful analytical tools for the interpretation of the professionalization of public health nursing. My interpretive methodological approach, discussed in Chapter Three, is context-sensitive and actor-oriented and aims at tracing critical boundary events in the formation of inter-war public health nursing.

1.2 The Scientification of Welfare Reform

Philanthropy is a broad concept with different cultural backgrounds and applications. This section presents the formation of a secularized and scientific approach to philanthropy in America and Britain.

One major characteristic of the so-called “Progressive Era” in the U.S. (ca. 1890–1918) was the change in mainstream Protestantism (Shalin [1988] 1997). At the end of the nineteenth century, the predominantly individualistic Evangelicalism of the pre-Civil War era shifted to socially conscious and reform-oriented forms of Christianity. The political Left in the U.S. saw Progressivism as the first step towards social market forces. A notable feature, in relation to the theme of this dissertation, is that the Progressive Era stimulated municipal reforms, the survey of immigrants, and the formation of settlements (cf. Muncy 1991).

A shift of emphasis from an older Christian and individualistic style of charity toward a newer bureaucratic form of so-called scientific charity took place at the end of the nineteenth century and during the beginning of the twentieth century. The British social historian David Owen introduces the term “scientific charity” in his

broad work, *English Philanthropy 1660–1960*, published in 1964. Scientific charity is viewed as the type of charitable activity which took place between the 1860s and 1914, which could be anything from purely Christian charity to the social reform work found in the early welfare state after 1914. This new form of philanthropy focused on rationality and on achieving lasting results. The aim was to create a sense of responsibility for the recipients of aid by supporting self-help; this would make people self-sufficient. By this individual-centered philanthropic approach to support of the recipient, it was thought that he or she would become a model for others in the community. Scientific charity applied orderly investigations of social and health problems and the gathering of facts and statistics. It relied on experts to reach a lasting impact on and change in social welfare and public health.

Philanthropy refers to a wide range of activities which have their ideological roots in a number of different moral, social and political ideas. A common conception of philanthropy is associated with the idea of being charitable to those less fortunate which both Catholicism and Protestantism have traditionally viewed as a Christian obligation (see, for example, Prochaska 1988). During the nineteenth century, a more secular version of humanitarian work among the poor and sick emerged as a moral obligation of the middle classes (see, for example, Kunitz 1974 Checkland 1980; Payton 1988 and Martin 1994). This version of philanthropy as a class-based project is associated with the emergence of industrialized modern society, in which the lower classes were a source of concern for the upper classes (see, for example, Lasch 1977 and Donzelot 1979).

The Rockefeller Foundation (chartered in 1913) was one of the central foundations in the United States. At the end of the Progressive Era it engaged in extensive scientific giving, whereby it hoped to bring about social change, rather than in traditional, distributive charity projects (Sealand 2003). Soma Hewa, a Canadian researcher of philanthropy and social development, identifies two fundamental terms which came into play as guiding principles of the Rockefeller Foundation, ‘wholesale giving’ and ‘scientific philanthropy’ (Hewa 1998a, 1998b and 2002). Frederick T. Gates, a Baptist minister and the key organizer of early Rockefeller philanthropy, stated that wholesale giving was the method of philanthropy and that scientific philanthropy was the objective (Hewa 1998b and 2002).

Two key tactics which were also applied to the Rockefeller business activities—centralization and rationalization—were used within Rockefeller philanthropy to create an institutionalized philanthropy which was governed by a set of rules (Hewa 1998b). The rules dictated that donations were to be given to larger umbrella organizations rather than to individual charitable organizations. The use of the donations was to be carefully planned and build on a focused study of social conditions before contribution of aid. It was characteristic for the wholesale model of Rockefeller philanthropy that guarantees were sought for how the donations would be continuously useful. In Gates’s liberal capitalist thinking, which was influenced by social Darwinism, small-scale local charitable activities were seen as “worthless” receivers

of funding (quoted in Hewa 1998b: 108). As a result of personal and religious experiences, Gates became critical of certain aspects of Christianity and church sponsored charities. In his view, these charities had not gone to the center of any problem. He was convinced that the only way to gain prosperity was “discipline, determination and hard work” (quoted in Hewa 1998b: 129). For the maximum benefit of society, the “driving force of the civilization” had to be the individual’s high degree of self-sacrifice and commitment (quoted in Hewa 1998b: 102). By Gates’s time, society had “failed to sort out the difference between charity and philanthropy” (quoted in Hewa 1998b: 110).

I have chosen to use the term scientific philanthropy to refer to the activities of the Rockefeller Foundation to promote science and rationality in public health. I do this to contextualize the formation of Finnish public health nursing in relation to this scientific approach to philanthropic activities carried out by the Rockefeller Foundation in the field of public health during the first half of the twentieth century.

Whereas earlier eras of medicine saw the decay of morality as the cause of disease, the sanitary era focused on the pollution of the environment and on preventative measures such as clean water and sanitation. The new ideas of public health reflected the developments of scholarship within preventive medicine (Karisto 1981a and 1981b; Armstrong 1983 and 2002; Berliner 1985). The early social medicine movement of the mid-nineteenth century looked at disease as primarily stemming from social exploitation and poor living conditions. For the pioneering members of this movement, the role of the physician was that of a defender of the poor and a political actor. In the 1870s and 1880s, new developments in technology made the visualization of bacteria possible. Microscopic findings led to a decreased interest in socially and environmentally mediated effects of pathogenic microorganisms. The sanitary reform movement, together with the implementation of bacteriological discoveries, was the basis of community action which led to a marked decline in the high death rate in the first decade of the twentieth century in the United States (Rosen [1958] 1993).

Industrialization, immigration and the associated expansion of urban communities lead to new types of social and health problems. Social reformers turned their attention to new tasks when they surveyed emerging communities. Poverty and unemployment, especially in growing metropolises, resulted in greater difficulties in the field of community health. Social reformers of the era, who were middle-class progressive representatives of their professions, concluded that steps needed to be taken to get to the bottom of the environmental problems of urban areas. In the poor areas of the cities, maternal and child mortality was high and tuberculosis and other communicable diseases spread. Malnutrition was rife. The condition of preschool children and children attending school was found to be extremely poor. Social reformers followed the rapid transformation of a primarily agrarian society with a scattered population into an industrial one. Stephen J. Kunitz, researcher in the sociology of medical knowledge and the history of medicine, states that in the

view of social reformers, the new health related social problems were caused by the disintegration of traditional family and community life, and this led to the disintegration of the traditional means of socialization and social control (Kunitz 1974).

Medical research, medical education and public health gradually became the corner-stones of Rockefeller scientific philanthropy (Fosdick [1952] 1989; Brown 1979; Hewa 1998a and 2002). Gates's own negative personal experiences of the curing powers of medicine had made him very skeptical towards medicine and the quality of the medical schools in the U.S. at the end of the nineteenth century. He altered his viewpoint on medicine after studying new medical textbooks in 1897, especially William Osler's book, *Principles and Practice of Medicine*, which had a reductionist and mechanistic perspective, and was influenced by the germ theory of the time. The germ theory implied that every disease was caused by a specific agent, such as by specific bacteria, and the cure was to destroy this infecting agent. It does not consider social and environmental contexts to be important mediating elements in health and illness, and rather oversimplifies the complex phenomenon of health and illness in society (Berliner 1985).

Gates believed that existing medical schools' teachings did not affect the health of people in any real way. In 1898, he stated that "if there existed a science of medicine, that science was not being taught or practiced in the United States" (quoted in Hewa 2002: 16). Gates gave a corresponding meaning to the support of new medical research and the advancement of humanity and the progress of civilization. The social sciences were not promoted by Rockefeller philanthropy in this early stage (Fisher 1993 and Hewa 1998a). However, in the charter of the Rockefeller Foundation, no specific field of knowledge is emphasized. The objectives of the Rockefeller Foundation are broadly defined in the charter's first version: "to promote the well-being and to advance the civilization of the United States and its territories and possessions and of foreign lands in the acquisition and dissemination of knowledge, in the prevention and relief of suffering, and in the promotion of any and all of the elements of human progress" (Fosdick [1952] 1989:15).

Unlike the majority of its counterparts, the Rockefeller Foundation engaged in social reform with a global agenda. Public health became a major field of work for the foundation. Other foundations established at the same time, such as the Milbank Memorial and the Commonwealth Funds, advocated more specific purposes in promoting new ideas about public health.

1.3 Scientific Philanthropy and Professionalization

Characteristic themes of the Progressive Era in the U.S. were professionalization and social control (Kunitz 1974). For large philanthropic foundations, such as the Rockefeller Foundation, the central goal in the Progressive Era was the transformation of major social institutions. Many of the ideas of early twentieth century

American philanthropists were therefore quite grandiose. Large-scale philanthropists held the conviction that society could be improved through the systematic discovery and application of knowledge.

Science and learning were key elements in the emergence of the new occupations of the Progressive Era and in the development of traditional professions. The professions were to enable the control of a variety of health-related social problems. The transformation of the social institutions that kept social and health problems in check was to be achieved through the reform of professionals. Upgrading and standardizing the training for many professions became an important goal of scientific philanthropy in the beginning of the twentieth century.

The Rockefeller Institute for Medical Research was established in 1901 (Hewa 2002: 36–37). The Rockefellers' first grant-giving foundation, the General Education Board (GEB), which was established in the following year, aided public school programs in the South of the U.S. These included farm demonstration programs and, later on, the first public health program to be conducted by the Rockefeller Foundation. By the end of 1909, the Rockefellers had contributed \$53 million to the GEB for educational reform and for the creation of a system of scientific education. The first of the Rockefeller Foundation's international program expanded the so-called hookworm disease (a parasitic disease) campaign and other public health campaigns against ailments such as tuberculosis, malaria and yellow fever in rural areas into world-wide programs (Fosdick [1952] 1989).

Through the hookworm campaign and similar programs, the Rockefeller Foundation had a stake not only in the development of public health and the medical profession, but also in the training of other allied professionals, such as public health nurses in the United States. Through inter-war campaigns abroad which were devoted to fighting different infectious diseases like tuberculosis and malaria in different countries, the Rockefeller Foundation broadened its influence on training public health professionals at an international level.

A higher standard for medical training was the priority, but as this dissertation shows, a more standardized training for professionals like nurses and social workers was also on the agenda for scientific philanthropy. Middle-class female reformers were important initiators of this particular type of reform work.

General or sick nursing was still regarded as a low-status career for women in the early twentieth century, and almost anyone could become a nurse by volunteering to work in hospitals. Women with educational backgrounds did not aspire to the career of a sick-nurse. When philanthropic foundations began to expand public health programs, they required skilled public health personnel such as nurses for community work. Alongside with its major projects dealing with the medical profession and scientific medicine, the Rockefeller Foundation also carried out programs which aimed at reforming nursing, training midwives and, especially, public health nursing training. These activities took place during the inter-war period and were

linked to the ideas of social reform of the Progressive Era. At an early stage of the development of the Rockefeller Foundation's policies regarding local public health, public health nurses were seen as important mediating professionals between new scientific knowledge of preventive medicine and public health and the population. The Rockefeller Foundation sponsored a number of studies to examine the conditions of nursing education in North and South America, Europe and Asia. Following a detailed study on nursing in North America by Josephine Goldmark in 1923, the Rockefeller Foundation endowed an experimental nursing education program at Yale, Vanderbilt and Toronto universities, which later formed the basis for the development of a nursing curriculum and training which the Foundation sponsored in other parts of the world.³

The Rockefeller Foundation aimed at a reformation of medical education and emphasized in an early stage the development of scientific medicine. The Rockefeller Foundation had had an interest in this issue for about ten years when it welcomed the so-called Flexner Report and the activities that followed (Flexner 1910). This influential report on medical education in the United States and Canada, for the Carnegie Foundation for the Advancement of Teaching, included a review of all medical schools in the U.S. and Canada. The Flexner report became a landmark of medical education reform (Stevens 1971; Berliner 1975 and 1985; Brown 1979; Starr 1982 and Hewa 2002). Abraham Flexner lacked medical training but was a professional educator and reformer who had graduated from Johns Hopkins University. The choice of Abraham Flexner for this position was explained by Henry S. Pritchett, the president of the Carnegie Foundation, who stated that "these medical schools should be studied not from the point of view of the practitioner but from the standpoint of the educator ... this is a layman's job, not a job for a medical man" (Flexner 1960: 45 and 70–71). Abraham Flexner's brother, Simon Flexner, was director of the Rockefeller Institute for Medical Research (Hewa 2002: 36).

Abraham Flexner defined the term "profession" in a new, practical way which fit the reformist thinking of the Progressive Era. This was contrary to established ideas about the knowledge-producing role of learned or scholarly professions in society:

Professions involve essentially intellectual operations with large individual responsibility; they derive their raw material from science and learning; this material they work up to a practical communicable technique; they tend to self-organization; they are becoming increasingly altruistic in motivation (Flexner 1915: 581).

Johns Hopkins School of Medicine had been established in 1893 at Johns Hopkins University, which had been established in 1876. In 1911, the General Education Board of the Rockefeller Foundation adopted the recommendations of the Flexner Report as its official policy toward medical education reforms, which it financed during the first half of the twentieth century. The Johns Hopkins School of Medicine became "the living model" for Flexner, thus "translating the Hopkins medical school

into a standard against which to judge all other medical education in the U.S.” (Brown 1979: 145). In 1916, the Rockefeller Foundation established the first public health school in the U.S. at Johns Hopkins: the School of Hygiene and Public Health. According to Hewa (2002: 31) the Rockefeller Foundation had given \$7.1 million by 1924 to the Johns Hopkins School of Hygiene and Public Health at Johns Hopkins University.

By the 1910s and 1920s, professionalization projects among physicians working within public health reflected a competition between generalists and sector-oriented specialists. Social medicine and reform-oriented general practitioners and scientifically oriented elite practitioners such as obstetricians, gynecologists and pediatricians thus negotiated the division of new labor relating to public health (Dingwall et al. 1988).

1.4 The Organization of Local Health Centers

During the 1920s and 1930s the Foundation promoted an idea of local health centers which provided a broadly defined public health service for the local community. Sociological research has paid little attention to the Rockefeller Foundation’s impact on the organization of local community-based welfare and health work and on the Foundation’s educational strategies concerning the role of welfare and health professionals, such as nurses. The Rockefeller Foundation is often criticized for its narrow belief in biological causes to health problems, technical and biomedical cures (e.g. vaccinations), and male-dominated medical authority over disease and social problems during the inter-war period (see, for example, Brown 1979). This criticism refers to those early programs which aimed at decreasing infectious diseases in poor areas of the U.S. and other countries. These activities have been interpreted by some social scientists as an expression of the Rockefellers’ cultural imperialism. This critic considered the perceptions of the social reality that the Foundation represented to be favorable to the dominant class and its advocacy of corporate capitalism, which these social scientists believe limits humanitarianism (see, for example, Brown 1979; Arnove 1980; Ettling 1981; Birn & Solorzano 1997 and 1999 and Kavadi 2002). The mentioned hookworm campaign of the 1910s in the U.S. and abroad is a well-known example of this narrow and rather limited concept of public health work, which has since gotten a lot of attention in both histories and annual reports of the Foundation and in the work of critical social scientists.

This leaves an important gap concerning the impact of the Rockefeller Foundation on the initiation and development of local community-based public health and social welfare work in the research. Especially the promotion of the training of different professionals for these purposes in the United States and internationally as a feature of the early formative stage of the modern welfare state has been ignored. The Rockefeller Foundation’s co-operation with the Finns had a vital impact on the professionalization of Finnish public health nursing. The fellowship program and

the demonstration project involving a local health center setting represent critical events that influenced the shaping of boundaries for the occupational jurisdiction. This process needs to be analyzed.

1.5 Philanthropic Organizations and Settlements as Institutional Contexts for New Women's Occupations

Early developments of Rockefeller philanthropy were paralleled by early professionalization of welfare work. This occurred in the setting of institutions dedicated to social reform in early twentieth century, such as settlement houses. The kind of local social engineering and scientific management in focus here is the activities at a nurses' settlement, the Henry Street Settlement, in New York City. These activities extended the boundaries of female philanthropy and influenced the professionalization of public health nursing and are therefore seen as early boundary-work in this dissertation.

American social historian Robyn Muncy (1991) has investigated the creation of what she calls a female dominion in American reform 1890–1935, and has found that it was based on the continuing reform activity of white, middle-class women. These female reformers, who represented settlement houses, schools of social and health services and administration, and governmental organizations such as the Children's Bureau, professionalized and institutionalized their reform culture while also lobbying for a federal legislation of social and health reform. According to Muncy this process was enabled by a well-integrated network of people, small-scale voluntary organizations, and bureaus devoted to various reform causes. Muncy's research highlights the relationships among governmental organizations, educational institutions, and voluntary agencies, and thus describes the complex connections and relations between public and private authority during the Progressive Era in the U.S. The Children's Bureau was a policymaking body dominated by women that opened new professional opportunities for women in the 1920s. Associated professionalization strengthened the women's commitment to reform. This is contrary to traditionally male-dominated welfare policy-making, where members of traditional professions and reform-orientated workers have had opposite views about the way to reach health and social services for the communities better. Traditionally strong professional organizations such as medical associations were opposed to what they perceived as "governmental interference" in independent professional activities. Muncy points out that gender-specific experience within philanthropy and social reform has influenced the early professionalization of health and social services. Although men and women appear to have been engaged in the same struggles, the tactics, motives, understanding of the mission, and results of their work have varied according to gender. Female or "democratic" professionalism, to use Muncy's (1991: 158–165) empirically defined concept, emerged from different circumstances and contexts than did the traditional, male-dominated professional projects. According

to Muncy, this early female professionalism stressed non-hierarchical relationships and participatory democracy, even though authoritarian elements seeking power were also involved, as in all social processes.

The settlement houses were usually located in the heart of urban slums of big cities such as London, New York City or Chicago. A wide variety of programs that sought to help the poor were usually run by middle-class female activists. The purpose of the middle-class female “social engineers,” such as Jane Addams who led the Hull House in Chicago and Lillian Wald who made a long career at the Henry Street Settlement in New York City, perceived their task as the bridging the gap between the educated and laboring classes by providing education, cultural activities, and health care services to working people. For educated American women the settlement work in a working-class neighborhood offered wholly new opportunities in public life that could be justified as an extension of accepted female activities (Muncy 1991). Settlement women had the unique possibility for employment and independence from their families which challenged earlier gender relationships.

Nordic social reformers often used the concept or metaphor of social engineering, first used in the U.S. in the 1920s, to connote the relation between expert knowledge and social regulation (Halvorsen 1996). Social engineering has been defined as governmentally planned social change and social development in order to manage society through investigations of different social indicators and social trends (Marshall T.H. 1939 and 1957; Marshall G. 1998: 611). In the Nordic context, social engineering was powerfully expressed in the ideas of Alva Myrdal and Gunnar Myrdal (1934 and 1941; Myrdal, A. 1941 and Myrdal, G. 1943). Alva and Gunnar Myrdal were influenced by the U.S. social reform ideas, during their visits in the country. Scientific management was to be a leading strategy in the reforms they drafted. Scientific management refers in this context to appropriate technical training and proper socialization of professionals by using scientific principles in order to serve the broader aims of society (Berliner 1985).

In Swedish society, social engineering became a central approach in the regulation of the quotidian level of family life. The “little life” was at the core of early Swedish welfare state building (Swe. *folkhemmet*) (Hirdman 1990: 30). National governmental policies concerning welfare, employment and education were aimed at shaping different measurable features of society. For example, official statistics such as health and mortality data have been used to indicate to what extent a society is “progressing.” In the pioneering phase of the welfare state, governmental policy programs were framed as “objective” and “scientific.” Popular enlightenment regarding health (Fin. *kansanvalistus*, Swe. *folkupplysning*) was often at the core of such policies.

Ideas from social engineering about the role of public health for the shaping of the nation were also influential in Finland, but there there existed an independent tradition of social hygiene (Wrede 2001). Social hygiene was a broad mindset aimed at a hygienic transformation of all aspects of everyday life, including hous-

ing (Saarikangas 2002). In the beginning of the twentieth century there existed a fertile basis for female organization around health education issues. Women took part in both broader popular enlightenment efforts and in specific allied women's organizations which worked at the promotion of local welfare (Karisto 1981b: 103). Teaching help and self-help to families and individuals with regards to everyday health habits as a mechanism of social control on a local level also promoted welfare on a more collective level. Social engineering and social hygiene were related and overlapping approaches to social reform in Finland in the inter-war era, with important implications for the development of professions (see, for example, Helén and Jauho 2003; Wrede 2003).

According to Karisto (1981a), research of social medicine and health care practice became more disparate fields in the 1920s and the 1930s than they had been previously. One reason for this was that scientific medicine strengthened in Finland during this time. Observed health behavior and social circumstances in different population groups and investments in popular health education had traditionally been important sources for the research of social medicine.

A central argument in the literature which focuses on women's social history in relation to philanthropic work at the end of the nineteenth century and beginning of the twentieth century is that the sphere of philanthropy was relatively open to women, if compared with other public arenas such as politics and economics (see, for example, Prochaska 1980 and 1988; Satka 1995; Jordansson & Vammen 1998; Markkola 2000a, 2000b and 2002). Although women's activities aiming at social reform were often limited by patriarchal laws and rules, modern forms of philanthropy emphasizing a social instead of purely Christian orientation were seen as fitting for women. Social change during this period redefined gender relations by giving new interpretations to the established notions of "women's vocation" (for studies of Britain and the U.S. see Prochaska 1980 and Skocpol 1992; for studies of Finland see Sulkunen 1987, 1989 and 1990; Satka 1994 and 1995 and Markkola 2000). Local welfare workers were supposed to act like "doctors," diagnosing social problems with support from scientific knowledge and methods and by coordinating and planning traditional relief in a new and more efficient way.

Considering the suggested impact of philanthropy on the emergence of social policy, there is an interesting connection between North American scientific philanthropy and the early formation of public health nursing. In the inter-war period, the Rockefeller Foundation played a central role in the reform of American nursing education and public health nursing in particular. Many of the staff members within American reform-minded philanthropies had settlement-work backgrounds or were engaged in active collaboration with the settlements (Sealand 2003). As an organization with an international agenda in scientific philanthropy, the Rockefeller Foundation was a major player with resources to initiate projects, conduct reports and lobby for policy changes. Its activities were not only related to scientific medi-

cine. The Foundation influenced the building of a knowledge base and new modes of practice within general and public health nursing.

This dissertation shows that female nursing reformers played key roles in the formation of health policy, similar to those roles which female welfare activists and doctors played in public health and social welfare in the United States during the 1920s, when the so-called Sheppard-Towner Act was introduced and implemented. Previous research has shown that this innovative program for child and maternal welfare resulted from a coalition of women's interest groups and that the program promoted the position of women professionals (Lemons 1973; Meckel 1990; Muncy 1991 and Skocpol 1992). When the Act was dismantled in 1929, nursing activists were able to continue their activities through such organizations as the Rockefeller Foundation. They focused on educational strategies, many of which became internationally disseminated.

1.6 The Professionalization of Finnish Public Health

The Rockefeller Foundation was a significant catalyst for Finnish public health. It began to interact with Finnish public health agencies in the mid-1920s when it initiated its activities for the development of public health in Finland (Sorvettula 1998). In the 1930s, this collaboration increased. The Rockefeller Foundation issued fellowships in North America for Finnish nurses and physicians, enabling them to study nursing and preventive medicine relating to public health in settlements, private and public health organizations and at universities. Many of those fellows became educators and administrators within public health institutions in Finland. The fellowships enabled an exchange of public health ideas and practices. Finnish public health reformers, officials and educators received financial support from the Rockefeller Foundation to visit other European countries to study things such as different educational projects within nursing. Furthermore, the Rockefeller Foundation and Finnish public health authorities carried out a major experiment in Finland in the beginning of the 1940s: a generalized training field for public health nursing at a health center in the Municipal of Helsinki near the capital of Helsinki was established.

The programs and policies which the Rockefeller Foundation carried out in Finland during the inter-war period were influenced by the social reform approaches of the American Progressive Era and by the kind of female dominion created in American reform 1890–1935 (see, for example, Muncy 1991.)

The inter-war political situation in the world, with its tensions and conflicts, was reflected in these international public health programs. At the time, the focus of the Rockefeller Foundation was on the threat that the Soviet Union and its allies posed to the interests of capitalist democratic societies. Also, ideas of eugenics were embedded in the social reform thinking and scholarly knowledge of the time (Steinmetz

1993: 200–202) and recognized and promoted by the Rockefeller Foundation (Brown 1979). The Rockefeller Foundation did not approve of the developments in Nazi Germany, but it considered the Soviet Union a bigger threat to the United States than Germany. However, whatever possible international politics which were the motivating background context for the strategies of the Rockefeller Foundation lies beyond the main focus of this dissertation. This study of the early formation of public health nursing in Finland highlights the Rockefeller Foundation's innovative approaches to public health and its role as an initiator in the shaping of new local public health praxis and the education of public health personnel.

These approaches and experiments had a major impact on the considered necessity of improving the training of professionals. This makes the Rockefeller Foundation's activities a central influence in the development of public health nursing in Finland. These innovations supported the claim for a jurisdiction for public health nursing in the Finnish health care system in the 1930s. This is particularly important when we consider that hospital medicine was the dominant strategy for Finnish health policy at that time (see von Bonsdorff 1978 and Wrede 2000). In the 1920s, the Finnish medical profession had only a minor interest in taking part in public health activities. Previous research on the formation of public health in Finland suggests that the reason for this lack of interest resulted from other professionalization projects that the medical profession was engaged in at that time (Vuolio 1991). This notable project aimed at establishing municipal physicians as autonomous practitioners. Physicians endorsed municipal involvement in their employment, but the group only accepted a narrow, strictly defined role in public health (Vuolio 1991). Finnish sociologist Sirpa Wrede (2000 and 2001) has argued that the medical profession's attitude left a vacant jurisdiction in public health, which women's professional groups such as public health nurses and midwives were then able to claim (Wrede 2001). Furthermore, both international and Finnish social scientists have stated that there was a gendered division of labor in public health which made room for women's professional groups that could occupy the woman's place in public health (Davies 1988 and Wrede 2003).

1.7 Negotiations of a Professional Occupation for Women in Inter-War Public Health

This study on boundary-work of the formation of public health nursing emphasizes the processive nature of the social construction and institutionalization of expertise. I position the professionalization of early Finnish public health nursing in the construction of a market of professional services (Larson 1977). Further, I identify a system of competitive occupational relations (Abbott 1988). The work of American sociologist Andrew Abbott (1988) on negotiated boundary events in the social history of different professional groups is a central theoretical and methodological tool in my study. Both Larson (1977) and Abbott (1988) focus on three central mecha-

nisms in the process of professionalization: prior training, socialization, and publicly recognizable professionals. Larson emphasizes not only market-based professional autonomy but also the role of state intervention as a 'shelter' which secures professional autonomy. Professionalization is thus a matter of reproducing trained subjects in society which is influenced by both market forces and governmental policies. Recent Nordic social studies on welfare service professions and occupations (see, for example, Erichsen 1996; Karvinen 1996; Evertsson 2002 and Aili 2002) have used the broad historical and social mapping of occupational groups present in Abbott's interpretation of the system of professions.

A second theoretical model that guides this analysis highlights the gendered patterns of professional projects. British social scientists Ann Witz (1992) and Celia Davies (1988 and 1995) have examined the shaping of nursing and midwifery in the U.K. from a gender perspective. Their theoretical models on gendered professionalization have been partly applied to and further developed in research on women's occupations in a Nordic context (see, for example, Emanuelsson 1990; Silius 1992; Henriksson 1998 and Wrede 2001).

A third theoretical reference I incorporate in my study is interpretations of so-called alliance strategies (Selander 1989a, 1989b and 1990; Evertsson 2002). Occupations in the middle layers of the hierarchy of professions (e.g. nurses, teachers and social workers), with specific knowledge and an exclusive competence oriented on practice, have used such alliance strategies when they have struggled for a position in the "world of work," a notion introduced by the American sociologist Everett C. Hughes (1958 and 1963).

My study of the professional project (Larson 1977 and Macdonald 1995) of Finnish public health nursing examines one particular type of professional strategy used for collective social mobility in the making of jurisdictional claims (Abbott 1988), namely educational strategies. I define educational strategies as cultural work in which an occupational group engages, either independently or through interacting with other actors who have a stake in developing the occupation (alliance) in the hopes of applying abstract knowledge into practice. Through this work, cultural structure (knowledge, values and norms in the world of work) is transformed into practical claims (Abbott 1988: 79). These practical claims are intended for various types of social control in various types of settings. Educational strategies are particularly central for knowledge-based occupations. Explanations of the power of professions have traditionally underlined the importance of a profession's "esoteric knowledge" (Freidson 1970b). Abbott (1988: 55–57), thereby giving abstract, academic knowledge as the basis for an occupation's jurisdiction a central role. It accomplishes legitimating, research and instruction, and it has an impact on how vulnerable the occupation's jurisdiction is to outside interference.

In the case of professional esoteric knowledge, Abbott (1988: 70–73) identifies the notions of full and subordinate jurisdictions. Every profession aims for a domain

of work which it defends and tries to expand. The legally established control of the domain should also be legitimated within the culture by the authority of the profession's knowledge and it should shape the public's idea of the tasks which the profession does. One typical example of a full jurisdictional settlement is the jurisdiction of medicine over sickness. Occupational groups with limited mobility within a circumscribed environment represent alternatives to full jurisdiction. Nursing is a typical subordinate settlement of jurisdiction. It is a public and legal settlement, but it is subordinate in the sense that nursing has become necessary for the successful practice of medicine dominated by the superordinates of physicians (Witz 1990). From time to time the subordination of nursing in relation to medicine has been more or less contested, and there have been, for example, different types of attempts to subdivide the area of tasks within the full jurisdiction of medicine. My empirical inquiry about jurisdictional claims of public health nursing in relation to knowledge base and modes of practice illuminate how the subordination of the nursing jurisdiction has been challenged when nurses entered the field of community welfare and public health care in the inter-war period.

Abbott's theory does not include a consideration for gender differences in the means of organizing knowledge socially. Therefore, it is important to consider such differences and the importance of gendered power in shaping the room for professional strategies (Witz 1992; Wrede 2001 and 2003) in a study of the formation of a jurisdiction for a women's occupational group like public health nurses in the inter-war period. From this perspective, it is important to pay attention to how occupations are gendered. British sociologist Celia Davies (1988) has in her analysis of "health visiting" [an early established form of public health nursing in Britain] examined its formation as the emergence of "a woman's place in public health." This kind of sociological analysis draws attention to the formation of a division of labor in public health activities and the kind of knowledge and modes of practice which the occupation is associated with. My empirical evidence challenges the idea of simplistic hierarchies between full and subordinate jurisdictions which research emphasizing medical dominance (Freidson 1970a) and patriarchal control of women's professional groups (Witz 1992) emphasizes. This is in line with recent research concerning the Nordic countries (see, for example, Benoit and Heitlinger 1998; Karvinen 1996; Karvinen, Pösö and Satka 1999; Johansson 2001; Wrede 2001; Aili 2002 and Evertsson 2002), which suggests that in addition to the control of abstract knowledge the modes of an occupation's practice are important for its professional autonomy. I examine how core components of both abstract knowledge and modes of practice are redefined in the division of labor and the reform of public health nursing education, or, in other words, how cognitive and social legitimation strategies were carried out and demonstrated in the division of labor.

1.8 Presentation of the Study

The focus of my study is on the vacant jurisdictions in public health for women's professional groups and especially one such professional group, public health nurses in Finland. When I refer to the representatives of the new specialty in nursing in this dissertation, I have decided to use the American English professional title *public health nurse*, because this title has been used both in North America and Finland through the historical period which is the focus of this study.⁴ There have been many professional titles within health nursing in Finland: from the Finnish titles *terveyssisar* and *terveydenhoitajatar* to the present *terveydenhoitaja*, paralleled by the Swedish terms such as the older title *hälsosyster* and the contemporary title *hälsovårdare* (for a detailed outline of the professional titles see Siivola 1984 and Simoila 1994).

Philanthropy is a broad term; in this dissertation, I focus on *organized* and *scientific philanthropy* as an arena for innovative, institutional experiments and practices within welfare building. The emergence of a notion of women's professions was a central opportunity for middle-class women in the early twentieth century; it allowed women to open previously closed doors to occupational practice in society. At the time, women had only a limited access to public arenas in both Finland and the United States. It is important to study the connection between organized and scientific philanthropy and the early formation of public health nursing, because the philanthropic field was one of the first arenas outside the domestic in which middle-class women could work.

Although the large philanthropies as such are a unique American phenomenon not found anywhere else in the world, this dissertation shows that from the point of view of women's activities within philanthropic organizations, the Rockefeller Foundation nursing activities have many similarities with European and Nordic developments in small-scale, organized voluntary reform work. Midwifery and branches of nursing, which emerged outside the hospital, such as health visiting, district nursing, and visiting nursing have had diverse historical and social backgrounds (Buhler-Wilkerson 1983, 1985 and 2001; Dingwall et al. 1988; Davies 1988 and 1995 and Henriksson 1998). Studies on the predecessors of inter-war public health careworkers show that they had different relations to the voluntary philanthropic associations, different roles in relation to national governmental and municipal responsibilities in public health and diverse connections with general nursing. My study discusses certain elements in their knowledge base and modes of practice, which were further developed in the generalized public health nursing model promoted by the Rockefeller Foundation. Such elements are: the professionalization of voluntary effort, professionalization in relation to interventionist philosophies of the settlement houses, the Charity Organization Society (COS) and the municipal public health authorities. Furthermore, the Rockefeller Foundation's claim for university-based or other similar independent forms of specific training for the new

public health nurses and their leaders and educators is examined. The collective social values which were sought for the new public health nurses, who represented a new women's occupation in the local community, are examined in the context of the educational and administrative strategies of the Rockefeller Foundation.

It was not a self-evident solution for the organization of health education to be as organized as public health nursing (Dingwall 1974b and 1983). Even when health education increasingly became defined as public health nursing outside the hospital, there were several options available for its social organization. Would it be a subordinate part of the medical field, which was dominated by physicians? Would it be closely linked to the education of hospital nursing? Alternatively, should it be organized in association to home nursing (the nurse as caseworker) and district nursing (skilled specialists with nurse background), two fields which were emerging along the lines drafted by Florence Nightingale (Dingwall 1974b and 1983)? According to Karen Buhler-Wilkerson, Professor and Director of the Center for the Study of the History of Nursing at University of Pennsylvania, the significant variation in the American version of the Nightingale plan was that health nursing should be made by educated visiting nurses, not by ladies with special training and practical instruction, so called "lady health missionaries" (Buhler-Wilkerson 1985: 1156). In spite of the rather successful project in the U.S. of placing public health nursing within higher education in the inter-war period, the coordination and centralization of visiting nursing services in the U.S. was a very complex and difficult issue (Reverby 1987; Melosh 1982 and Buhler-Wilkerson 2001). It is therefore an important and interesting issue to examine how the Rockefeller Foundation supported standardized model for generalized public health nursing disseminated and maintained innovative U.S. public health nursing ideas in the Finnish context. The examination of the processes of drawing-up boundaries toward close related professional activities in social welfare and health, contextualizes the dissemination of the Rockefeller Foundation agenda for public health nursing in this study. The alternative directions for developing nursing for promotive health education and disease prevention outside the hospitals in the local community indicate that the relation between jurisdictional claims for early public health nursing and hospital medicine, hospital nursing, general nursing in the homes, midwifery and early social work, is important to consider.

The first relatively clearly defined expression of what can be termed public health nursing, from the point of interest in this study, emerged in the United States at the end of the nineteenth century (Buhler-Wilkerson 1983, 1985 and 2001). In the beginning of the twentieth century the role of the American public health nurse had expanded to include a variety of preventive services, not only for those suffering from infectious diseases like tuberculosis, but also for mothers, babies, schoolchildren, and industrial workers (Buhler-Wilkerson 1983). Public health nurses fit neatly into the system of social and medical care of the time and a variety of agencies sought their services. Even though the early health visiting that Davies (1988) studies is

similar to health nursing, a nursing degree was not required of early British health visitors. District nursing did not get the same institutionalized position and was not as publicly recognized as health visiting (Dingwall et al. 1988). However, the aim of the promoters of district nursing to professionalize voluntary effort and train specialists with initial hospital training rather than well-informed amateurs makes it an interesting prototype of the model of public health nursing which was adapted in America.

The Finnish nursing and public health context in the 1910s and the early 1920s, with a sectionalized knowledge base developed by voluntary welfare organizations, was a fertile basis to build on when the first contacts with the Rockefeller Foundation public health scouts and Finnish authorities were made in the mid-1920s. Furthermore, the Finnish well standardized model for general nursing and the determination to develop certain elements of the early Finnish public health nursing, intensified the collaboration with the Rockefeller Foundation in the 1930s. The intensified collaboration is viewed in the context of the planning of the health center project in the Municipality of Helsinki.

Even in the later stages of the development of public health nursing, there have been alternative directions concerning the core knowledge base and the modes of practice sought to characterize autonomous 'health nursing' carework. The creation of boundaries for the occupation of public health nursing at different times has reflected certain movements and negotiations in the system of welfare and health occupations. Some actors within the Rockefeller Foundation with a nursing background at times diluted the interests of general nursing. They promoted a multi-disciplinary approach to public health nursing instead. In their view, the new public health nurses should be inclusive towards promotive and preventive health work (health nursing) and towards social work instead of adopting a narrow and disease-oriented scientific approach to medicine as their knowledge base. Most importantly, in the Rockefeller Foundation strategy for public health nursing, public health nurses were supposed to be autonomous practitioners, not "handmaidens" of the medical profession.

This study examines how the variety of models for public health nursing of the time influenced the Rockefeller Foundation's agenda for public health nursing, which was disseminated worldwide. My collected materials shed light on, for instance, the Finnish nurse activists' and professionalizers', and the Rockefeller Foundation's officials' critical reflections on the contents of the first international course of public health nursing at Bedford College in London in the 1920s. The Rockefeller Foundation supported a model of autonomous local generalized public health nursing. Both basic general nursing and the new knowledge field of public health nursing were in the core of the educational and administrative strategies. Furthermore, the Rockefeller Foundation claimed for special university-based training for leaders and educators in the field, including multidisciplinary courses in medical and social sciences and education. This inspired the Finnish leaders and

educators of nursing and public health nursing as a complementary model to the knowledge base and modes of practice learned at Bedford College in London.

Finally, some of the boundary-work described and analyzed in this study reflects broader large scale developments in social and public health reform work related to power and knowledge relations in Western industrialized societies, and some of the boundary-work relates to social change at the micro-level. That change took place when individual pioneering public health nurses, educators and administrators were engaged in the professionalization process. However, the focus in my analysis is processes at the meso-level. The different institutions and organizations in my materials, which have influenced the formation of Finnish public health nursing, have disseminated macro-level and micro-level values and means concerning the occupation and have played a crucial role in institutionalizing and maintaining the existence of the occupation in focus. The relationships within the system of occupational activities that can be characterized as "proto-public-health-nursing," were part of the early social and public health reform cultures that are discussed in this volume.

1.9 The Order of the Book

In Chapter Two I discuss my theoretical perspectives in light of previous research within the sociology of professions and research relevant for my study of the educational and administrative strategies of the professionalizers of Finnish public health nursing. My principal research question and its four themes are presented at the end of Chapter Two. The methodological frame, methods and materials are presented and discussed in Chapter Three. The empirical results are presented, discussed and analyzed in Chapters Four to Seven.

In Chapter Four I describe the social and cultural background of the early professionalization of carework in the local community. Different reform cultures in the field of social reform work influenced the professionalization of traditional charitable activities. A shift toward scientific philanthropy took place in the beginning of the twentieth century. I examine both large-scale scientific philanthropy and rationalized small-scale voluntary reform work as an early fertile basis for public health nursing. I do this by examining how the motives, knowledge base and praxis of welfare building promoted in large-scale Rockefeller philanthropy were disseminated abroad and adapted in various social and cultural institutional contexts. I study how these ideas worked as a catalyst for early European and Nordic developments of organized public health work, especially in the case of early public health nursing. The dissemination process included negotiations with public authorities and educational institutions. Prevailing ideas such as 'self-help,' 'scientification' and social casework contextualize the educational and administrative strategies analyzed in this study. The forerunners of the "new" public health nurses, instructed by voluntary welfare organizations in Finland and the municipal and state contexts of Finnish

public health in the 1910s and 1920s (before the established collaboration with the Rockefeller Foundation) are also illuminated in Chapter Four. In brief, Chapter Four explores in a more general way activities within two social settings which this study about formation of public health nursing is situated in, philanthropy and small and large voluntary non-profit organizations.

Chapter Five examines the Rockefeller Foundation agenda for public health nursing. In focus is the way the objectives and methods of public health nursing emerged in the Henry Street Settlement and Visiting Nurse Service in New York City and was further developed by the discussions and negotiations between officials of the Rockefeller Foundation and other North American professionalizers of the occupation. The negotiations which took place are analyzed in the context of the Henry Street Settlement's professional magazine, in official reports and conference notes of the Rockefeller Foundation, and in the context of the university. I identify and examine two key educational strategies in this 'health nursing' model; case finding and educational social casework carried out by the early settlement nurses, and generalized public health nursing defined as an extended and independent professional area of work for nurses in the local community. The public health nurses as health educators and 'mediators' of new knowledge within preventive medicine, hygiene and public health influenced their position in the practice field of public health. Their previous relation to the other health and welfare workers was challenged.

Chapter Six examines the first contacts which Rockefeller Foundation observers from the Foundation's European office in Paris and the headquarters in New York City had during visits to various parts of Finland. They met public and voluntary administrators, educators and local practitioners within the fields of medicine, nursing, midwifery, social welfare work and education. The observations were documented in three reports, including an analysis of the state of the health care system and the social, economic and political situation in Finland of the 1920s. The reports were made to survey Finnish public health development and are used in the study to give the social pattern of the formation of public health nursing a broader context by the observations of these international scouts. The observers discussed and reported general data about the state of health and education in Finland as well as concrete data on strategic public health issues and the education of the public health workforce. Another example of Finnish-American exchange within public health in my study are the activities of Finnish nurses (and doctors) studying public health nursing (and preventive medicine) in North America in the 1930s through the Rockefeller Foundation fellowship program. I examine the negotiations around this exchange because it paralleled the planning of the model public health nursing training field in the Municipality of Helsinki outside the City of Helsinki.

The elements of formation of a knowledge base and modes of practice for public health nursing on an international arena are examined in Chapter Five, and the negotiations taking place during the first contacts between Finns and the Rockefeller Foundation are explored in Chapter Six. These elements also formed the core of the

model for public health nursing that was imported to Finland and subsequently experimented with. In Chapter Seven I study the initiation of the more purposeful co-operation between the Rockefeller Foundation and Finnish public health authorities in the 1930s, voluntary public health organizations and educators. I also focus on the process through which the idea of a local health center was put into praxis in the Municipality of Helsinki. The role of public health nursing within that institution guides my analysis in Chapter Seven. My argument is that the more comprehensive generalized modes of practice for public health nurses were implemented in Finland through the co-operation with the Rockefeller Foundation and the experiment in the Municipality of Helsinki of 1940–1944.

Finally, the conclusions present a synthesis of the used theoretical concepts and the empirical inquiry, and are discussed in Chapter Eight of this volume.



PART II

Theorizing and Tracing Boundary-Work

Making Jurisdictional Claims in the Formation of a Women's Occupation

2.1 Introduction

Two general social phenomena in the sociology of professions are examined in my study of the formation of early public health nursing in the inter-war period: (1) establishing and maintaining occupational jurisdiction (Abbott 1988), and (2) establishing and maintaining a position in the labor market as a professional project (Larson 1977). Max Weber's classical concept "rationalization" at the level of class and status group formation has been analyzed by social scientists as the way occupational groups, for example, use socially valued attributes and credentialed knowledge to shape social order (Macdonald 1995). The Weberian approach in relation to professionalization involves economic and organizational aspects as well as cultural resources such as knowledge, credentialed skills and respectability. Especially in their formative years, it is important for occupational groups to demonstrate their respectability (Macdonald 1995: 124). In the Weberian approach attention is drawn to the notion of social actors taking part in the professionalization process as holders of educational qualifications. Professionals are seen as participants in reciprocal social evaluation and as competitors in a labor market and within private or publicly supported bureaucratic organizations. The early professional socialization of public health nurses is examined in this study not only as the learning of the occupation's special knowledge, but also as the assimilation of a comprehensive style of providing a service based on that knowledge. This helped to convey the impression to recipients and the public at large that the service was "special" and its practitioners were "special people" (Dingwall and McIntosh 1979). Early public health nurses who made house calls were seen as "gentlewomen" in relation to the traditionally more dominant professional groups, which had emphasized their "specialness" by being "gentlemen" (Dingwall and McIntosh 1979; Dingwall et al. 1988 and Macdonald 1995). These women were not members of a superior occupation and they displayed different qualities than the gentlemen, but they nonetheless gained independent status by doing carework (see the discussion on "carework" in Davies 1995: 140–145), professional care or paid care in the public world of work, which was at the time strictly defined as women's work. In many

early theoretical approaches in the field of the sociology of professions, medicine and law has served as models for determining key characteristics and elements of the functional logic of professions and for analyzing successful professionalization processes (Carr-Saunders and Wilson 1933 and Parsons 1954). When male-dominated powerful professional formation such as medicine has been in focus, attention has been drawn to their closure strategies (Weber 1968; and for neo-Weberian perspectives see Parkin 1979; Saks 1983 and Murphy 1988). Processes of social closure involve exclusion on the one hand, and inclusion on the other. The social closure concept is based on the power of one group to deny access to reward, for example educational credentials, to other groups on the basis of the criteria which the former seeks to justify. By using closure strategies, professional groups gain and maintain status, and this protects the profession and increases its autonomy in controlling the knowledge base and modes of practice.

When it comes to middle-class women's occupations such as nursing, social work and school teaching, they have usually been categorized as "lower professions" or "semi-professions," occupational groups being unsuccessful in accomplishing full social closure comparable to law, medicine, and similar professional monopolies (Etzioni 1969). In accordance with this semi-profession perspective, nursing has been perceived as a homogeneous subordinated group within medicine, a failed profession. The task of attaining full professional status has been seen as a goal beyond the reach of semi-professionals. It has been argued that one of the chief obstacles for such "semi-professional" groups to achieve complete social closure has been their lack of a sufficiently developed knowledge base. According to this argument, complete professional status is only possible for occupations that have a complex body of esoteric or technical knowledge at their disposal. As Etzioni puts it, there are "powerful societal limitations on the extent to which these occupations can be fully professionalized," and he argues that there are certain inherent features of the division of labor itself that either promote or hinder the possibility of closure (Etzioni 1969: vii). In feminist research on the women's and women-dominated professional groups, in line with the neo-Weberian social closure concept, the patriarchal professional dominance of the medical profession has been blamed for the failure of professional projects of women-dominated groups (Witz 1990 and 1992). The term patriarchy is, however, a rather "ahistorical" term (Davies 1996). In my view, there might be a lack of empirical investigation into the historical and socio-cultural shaping and consequences of different gendered discursive strategies to achieve and maintain privileges in different historical periods and in different social settings.

"Semi-professional" thinking within the sociology of professions has been criticized for focusing too much on interprofessional struggles between powerful and less powerful groups within a certain division of labor, for example within medicine. Historical and socio-cultural aspects influencing the formation of professional occupations have been less focused in the kinds of sweeping theoretical conclusions about subordinate professionals which have been presented. These conclusions are

often not verified by empirical evidence. A question that is raised by those who are critical towards 'semi-profession' thinking is: how generalizable in time and across place is such a structural-functionalist understanding of occupations?

How have women's occupational groups then deployed their resources or assets in their struggle for collective social mobility? There were certain limitations for middle-class women to enter the labor market and to gain and maintain professional status in the early twentieth century and inter-war period. However, my study shows that there have been successful professional projects where occupational groups have gained subordinate but complementary positions in relation to a dominant professional group. The shaping of allied relations working for the professionalization of an occupation in middle position in the professional hierarchy with different social actors in society is in focus here. A *negotiated formation* of professional status described in this study uses credentialist and legalistic tactics based on both abstract knowledge and the implementing of modes of practice which are institutionalized first in voluntary health and welfare organizations and later in national governmental policies.

The professionalization of women's carework that occurred within the early twentieth century took place within only a few occupations available for middle-class women of the time, most of which were carework, and was limited by culturally defined values and norms. This resulted in a clear division of labor between men's and women's work. The inter-war time described in this study was characterized by an increasing faith in rational scientific knowledge. There was bureaucratic control of female employment and an unwillingness to grant full autonomy to the female workforce. Middle-class women were still seen as more attached to family roles at the time and were therefore less likely to establish and maintain a high level of specialized knowledge or to show a high level of commitment to carework outside the family sphere. However, the labor market became increasingly diversified and boundaries within the gendered labor market began to change. Therefore, both the position of women and the perception of the position of women started to transform. New rational scientific knowledge was mainly the project of men even if it influenced welfare work and public health work, two domains which opened up for knowledge-based practical women's occupations.

Research on the social history of nursing has shown that nurses are a rather heterogeneous group of carers, differentiated by internal hierarchies and social segregation (Reverby 1987; Dingwall et al. 1988; Emanuelsson 1990; Davies 1995 and Henriksson 1998). One might talk about "nursings," using the plural rather than singular. Nursing emerged as a broad umbrella of carework, and caring professionals have had a complex relationship to scientific knowledge (Davies 1995: 149) in different social settings and historical contexts. Under that umbrella diverse groupings practiced in different ways, all under the heading of "nursing." The health care activities that are now identified as specialties in nursing have had diverse processes of formation.

My study is an attempt to examine critically the notion of “nursings” by investigating historical and socio-cultural negotiations and critical boundary events dealing with the knowledge base and modes of practice in the formation of public health nursing. Nursing has been constructed in different ways by different social actors across space and time. This study focuses on *negotiated formation* in four social settings: (1) within philanthropy, (2) in small and large voluntary non-profit organizations, (3) within professions/occupations, and (4) in public/governmental agencies.

The origin of public health nursing in Finland is not seen as an obvious subordinate part of medical practice or a linear outcome of the development of Finnish national public health. It is important to uncover the critical boundary events that led to the nursing field's “capture” of certain carework in public health (Dingwall 1983: 619) as a result of negotiations in a field of many different groups as doctors interested in preventive medicine, Christian charity workers, early secular social workers, hospital nurses and midwives. The new public health nurses were first seen as socially oriented health educators, a mixture of the Nightingalean nursing vision and public health and social work with a scientific character outside the domain of the hospital.

I first examine different theoretical concepts describing institutional ordering of relationships as well as those persons located at institutional intersections connected to occupational formation. British sociologist Ann Witz's (1990 and 1992) study on gendered ordering of occupations in female professional projects and the nurses' and midwives' struggles for occupational autonomy in the beginning of the twentieth century in Britain will be used to shed light on the use of gendered resources in the struggle for a position in the division of labor. This neo-Weberian social closure approach reveals conflicts and power relations present at the bordering territories between dominant and subordinate professional groups.

I then continue to present Everett C. Hughes's (1958 and 1971) approach on the study of occupations within the Chicago School of sociology and especially how it was reflected in American sociologist Andrew Abbott's (1988, 1995a and 1995b) broad sociological work on the historical formation of professions, which deals with the jurisdictional making of claims. These approaches are used in my interpretation of the boundary-work of the professional project of early Finnish public health nursing. The expansion of traditional nursing carried out in hospitals and as sick nursing in homes, the monopolization of certain knowledge and practice elements of health nursing, and the creation and protection of autonomy for public health nursing in the community are central characteristics for this boundary-work setting.

Swedish researcher in pedagogy Staffan Selander (1989a, 1989b and 1990), suggests a model that analyzes how occupational groups which occupy a middle ground in a hierarchy use alliance strategies parallel with closure strategies in the institutional ordering of occupations. Swedish social scientist Lars Evertsson (2002) has shown

in his work on the history of welfare occupations in Sweden that organizational and knowledge alliances were built up to reach and defend autonomy and status within early welfare occupations. Alliance strategies refer to the temporary opening up of professional borders to other groups in order to gain status before the occupation is able to establish a more institutionalized position of its own. This strategy can also be used by more established occupational groups when they want to expand their territory by strategies of reducing conflict and mobilizing strength. It is important to investigate how such alliance strategies might have been the case in the professional projects of the established group of general hospital nurses on the one hand and the new public health nurses within the growing health nursing field on the other.

Together these approaches and models in the sociology of professions are partly similar and partly contrasting. They help to analyze the complex professional project of the early public health nurses and especially the educational strategies used by nursing leaders, educators and public health administrators, both international and national.

The other larger framework for my study on early Finnish public health nursing is the emergence of philanthropy and its role as a context for public health and its gendered practical applications. This development constitutes the formative context for public health nursing as an occupation. A particular focus in my discussion of organized and scientific philanthropy is its relevance to the formation of women's professional occupations in public health, which contributed to a gendered division of labor in medicine. The conditions of a "woman's place in public health" and "the health visitor as mother's friend" (Davies 1988) are discussed. An emphasis is on the social ethos of scientification in society of the time and its impact on nursing in public health.

The role of international health organizations is used as an analytic tool for understanding the impact of the institutional and interactional contexts for the transmission of scholarly knowledge on public health nursing. Previous research (see Chapter One) has to a limited extent covered the specific international influence on the development of Finnish public health nursing. The Rockefeller Foundation as a major international philanthropic health organization in the inter-war period engaged in educational exchange and acted in the shift from traditional charity toward scientific philanthropy. I will then conclude Chapter Two by presenting my research questions.

2.2 A Power Perspective on Women's Occupations

English sociologist Ann Witz (1990 and 1992) applies a neo-Weberian gender perspective to nursing. Her study of occupations discusses female professional projects in terms of what she calls the dual closure strategy. Witz studies the professional projects of both nurses and midwives in early twentieth century Britain, and con-

cludes that in the conditions of the institutionalized patriarchy which the British state of the turn of the twentieth century constituted, women's professional projects were doomed to fail. They failed because only class-privileged male actors had access to the central institutional sites of control, such as legalistic and credentialist actions which aimed at establishing a uniform system of education. These sites controlled the training and examination as well as the state-sponsored system of registration. Witz (1992: 4) examines the long and bitter campaign for a state-sponsored system of nurse registration between 1888 and 1919, the struggle for the autonomy to control and determine the standard and duration of nurse education and to control and improve nurses' pay and working conditions. She focuses on three sets of power relations when she examines the failure of the female professional project: hospital-controlled nursing (training, pay, and work conditions), inter-occupational relations of control between medical men and nurses, and a third set of power relations, the gender relation seen in the broader struggle of women for autonomous organization in the labor market.

Witz uses two pairs of concepts which relate to the hierarchy of closure and enlighten the complex field of closure strategies: exclusionary and demarcation strategies on the one hand, and inclusion and dual closure strategies on the other. The dominant social groups in the hierarchy of closure are engaged in exclusionary and demarcationary strategies. Demarcationary strategies differ from exclusionary strategies as the dominant group engages in both struggles for a monopoly of a certain area of work and dominance and control of other related or adjacent occupations. The group that is subjected to either exclusion or demarcation responds to and resists dominance and control in different ways that Witz calls dual closure strategy. Dual closure is a complex process of both upward usurpation (Parkin 1979) and downward exclusion in the hierarchy of subordinated groups. In her interpretation, Witz places nurses and midwives in the sphere of dual closure strategies applied by subordinated occupations. Her empirical study on nurses clearly shows that relations of dominance and subordination are contested relations. Although the nurses were tightly constrained within these three sets of power relations, they managed to exercise valuable closure strategies in two directions when they engaged in their professional project. The nurses did not aspire to become fully qualified medical practitioners, but their upward usurpation strategy reflected resistance to being subordinated under the dominant group of medical men. Upward usurpation was a tendency to form an interest group towards outsiders and a kind of association with rational regulations. The next step would be to change the legal order that influenced the position of nurses and midwives. The resistance showed both radical and accommodating forms of usurpation, and it is important that these groups also used downward exclusionary strategies, for example by trying to regulate entry into nursing and midwifery and other such credentialist tactics. They thus included some groups and excluded others. Another such downward exclusionary strategy in their dual closure strategy was the aim of restructuring the class-base in

nursing and midwifery by trying to transform them into suitable occupations for “educated, refined gentlewomen” or “cultural women.” This was the strategy of the elite groups of trained, middle-class practitioners seeking professional status with its associated material and symbolic rewards. These two occupational groups were engaged in female professional projects because of the two-way exercise of power, both usurpatory and exclusionary.

It is important to examine how the professionalizers of Finnish public health nursing tried to control the training of nurses for public health purposes, how they resisted the dominance and control hospital-oriented doctors and doctors in public health tried to hold. The professionalizers acted to create an autonomous organization of labor for women's public health work in the community. However, the formation of public health nursing also needs to be viewed against broader preexisting social and cultural elements which had an impact on the educational and administrative strategies of the professional project.

2.3 Negotiated Formation of ‘Nursings’

The idea of the different “nursings” and of their diverse paths of professional development link to one of the basic interactionist ideas of the Chicago School in sociology that social life should be studied as a competitive totality (Park and Burgess [1921] 1969 and Faught [1980] 1997). For the interactionists, competition is central in the struggle for existence and survival within the totality and no single causal factor can take precedence over another in the explanation of social life. However, interactionists have also drawn attention to other types of interactions than competition or conflict, such as negotiations. This makes it a fruitful basis for the study of how occupations have taken shape. Interactionist thinking about formative negotiations linked to the neo-Weberian concepts of social closure form the foundation for the analytical approach of this dissertation. German sociologist Hans Joas ([1993] 1997: 140) presents the pragmatic Chicago School sociology as rising from the work of Everett C. Hughes (1958 and 1971) on work and occupations:

[For Hughes] occupations are the patterns of activities specialized in accordance with a division of labor, in which the mediation, through different interests, relations of forces, and processes of negotiations, of structure that only apparently results from objective constraints is manifested with particular clarity. ... [Hughes] examined critically the ideologies of different kinds of professions as means for achieving freedom from control and attaining to high status. ... [T]he crucial point was that even under the most restrictive conditions, occupational activity cannot be understood without taking into consideration the workers' own definitions of their situation and their struggle for autonomy.

Hughes's analysis takes its starting point in the occupations' role in the processes of institutional regulation, “life is ordered within the security of institutions, and in modern society much of that ordering takes place within “the world of work”

(Hughes 1971: 124). The line of Hughes's thinking, to rely on a flexible set of conceptions by examining both the institutional ordering of relationships as well as those persons located at institutional intersections, highlights the mechanisms of institutional regulation. Hughes (1958) created the concepts of license and mandate within the sociology of professions for the analysis of institutional regulation of occupations. These concepts help to explain the formation of occupations and how they continue to exist or slowly disappear. For Hughes (1958: 78–79), license means an occupational group's claim to carry out certain activities which others may not, and to do so in exchange for money, goods or services. By the license, the occupations get legal permission to carry on a certain kind of work and to decide the knowledge base, both theoretical and practical, of the occupation and to define what "good work" is. The occupational license includes a great body of jurisprudence both in principle and in occupational practice. It can be implicit and of undefined boundaries, such as a basic moral attribute of society. The occupational mandate means the professional right to define what proper conduct in a general sense of others is in society (this includes moral responsibility, stated in the occupation's ethical code) and towards the matter of how to work (e.g. what the "healthy habits" are). For example, physicians have claimed to supervise and determine both the conditions of their own work and the work of other occupational groups within health care. Hughes's concepts of license and mandate thus reflect his understanding of a link between morality and the division of labor in society.

From Hughes's perspective, occupations take shape in processes rooted in their respective social contexts. Therefore a historical study which explores these processes empirically is necessary for an understanding of occupations. The actor-centered approach that investigates social action/interaction as negotiations between different interest groups needs to guide the historical analysis.

This approach fits well the way in which a historical approach to sociological studies has been outlined by scholars who have contributed to the historical turn in sociology. American sociologist Theda Skocpol (1984: 1–3), who uses a historical approach to sociology, uncovers the time and space patterns in studies on social change, and she presents four characteristics for historical analyses. Historical sociology in Skocpol's view relies on institutional analysis. First, historical studies ask questions about social structures or action/interaction and processes understood to be situated concretely in time and space. Second, they address processes over time, and take temporal sequences into account in accounting for outcomes. Third, most historical analyses attend to the interplay of meaningful actions and structural context in order to make sense of unfolding outcomes, both unintended as well as intended, in individual lives and social transformations. Finally, historical sociological studies highlight the particular and varying features of specific kinds of social structures and patterns of change.

2.4 The Shaping of Boundaries of Occupational Jurisdictions

The concepts of license and mandate have been fruitful tools in sociological research on professions (see, for example, Freidson 1970a, 1970b) and more lately used by American sociologist Andrew Abbott (1988) when he developed his study of jurisdictions. The study of how jurisdictions emerge and take shape and are reshaped is a central approach to the study of professional occupations, particularly in the Nordic countries (see, for example, Erichsen 1996; Evertsson 1997 and 2002; Wrede 2001 and Aili 2002).

Andrew Abbott contributes a systems approach to professions. In Abbott's (1988) theory on professions, the history of professions becomes a history of turf wars. He views the professions as living in an ecology. There are professions and turfs, and a social and cultural mapping—the mapping of jurisdiction—between those professions and turfs. Abbott (1988: 20) defines jurisdiction as a more or less exclusive right to dominate a particular area of work; this concept could help to explain the incredible diversity of histories of professions. In the past, there have been jurisdictional conflicts over clients, status, resources, and licensing.

Abbott's historical studies of professions and occupations show that change in social and cultural mapping is the proper focus of such studies. This social and cultural mapping happens most often at the edges of professional jurisdictions. These boundaries can be studied in three arenas: in the workplace, before the general public ("on the public opinion arena"), and within the state apparatus ("on the legal arena") (Abbott 1988: 59–60). There are different kinds of jurisdictional claims, ranging from full and monopolistic jurisdiction to looser and more unstable forms of jurisdiction, such as subordinate jurisdiction, purely intellectual jurisdiction and clientele differentiation (Abbott 1988: 71–77). The central point in this systems' theory of professions is that occupational jurisdiction is not a fixed thing based on functional differentiation from the beginning, but rather a contested, turf-driven matter. Larger social and cultural structures have produced new problems from time to time that the professions have seen as potential issues to control. Various professions and occupations attempt to shape these problems into coherent jurisdictions, which they want to define, control and expand. These jurisdictions are threatened by, for example, changes in organizations and new scientific knowledge and methods, resulting in deprofessionalizing. Abbott (1995a and 1995b) has examined boundaries and entities in traditional professions, professions-to-be and occupations by studying the origin of social groups, using social work as one example.

Abbott (1988, 1995a and 1995b) has studied both the early historical formation of social work at the end of the nineteenth century and the beginning of twentieth century in the U.S. and how social workers in the field used psychiatric knowledge in Chicago in the 1970s in their practice. His study on the situation in the 1970s demonstrates that practical and academic knowledge were quite far from one another.

Abbott noticed that social workers used academic knowledge such as psychiatry to make cultural jurisdictional claims on the benefit of social work practice as an adjustment between individual and society (Abbott 1988: 298).

Early social work was based on assumptions that successful preventive efforts based on individual adjustment and change of personal habits prevented disease. In those days, structural social factors were important only through their effect on the individual. The violation of social rules and social orderliness signified mental problems in the individual and the proper approach to these problems was individual, not social. The individual approach in psychiatry was successful because it accepted the new order of society, offered an interpretation for basic social problems, and thereby anchored the borders of the new world (Abbott 1988: 298).

The turf-based theory of professions in Abbott's study was not a question of the "social work of boundaries" but rather a question of the "boundaries of social work" which reflects an actor-oriented approach to occupational formation based on contested, turf-driven negotiations (Abbott 1995a: 552). Andrew Abbott uses the term "interstitiality" to denote the different action/interactions and actors occupied with unstandardized work activities that slowly start to shape jurisdictional claims for a new occupational group. The middle area between established professional entities forms a kind of transitional space or anti-structure in which the occupation-to-be starts to make a claim. Abbott points out that the question of interstitiality of the social work occupation-to-be was more complex than it at first seemed. Early professional social work did not just have a mediating role. It had an active self-interest and was shaped through turf-battles characterized by different power relations.

The functions of social work emerged from continuous processes of conflict and change and from a set of underlying changes in society and surrounding professions. Social change involved the emergence of cities, immigrant influx, industrialization, urbanization, bureaucratic workplaces, and social competition. The new "problems of social order and welfare" or the new problems of "personal life and social control" were conceived in legitimating values in "philanthropic terms, in hierarchical terms, by calling for science and also by calling for altruism" (Abbott 1995a: 553).

Abbott also uses social closure as a theoretical tool to understand early occupational formation. He applies the concept of "enclosure" (Abbott 1988: 96 and 1995a: 553) to his explanation of the way in which a coalition existing of both new people and people from prior professions or pre-existing occupational groups would separate itself and claim a particular defined turf within the complex area of social welfare. A classic example is nursing, as it started to expand out of hospitals and into "out-patient," "primary" or "environmental" care, thereby invading doctors', midwives' and philanthropic workers' core jurisdictions. These kinds of enclosure strategies occurred when dominant individuals (e.g. Florence Nightingale) and nursing organizations directed the process of jurisdictional claims by defining a potential area of work and created knowledge, schools and association to serve it.

Abbott explains these kinds of enclosure processes and coalition strategies in detail in his examination of social work formation. The great variety of people, who came from various backgrounds and conducted new forms of social work, were confronted with broad social agendas. These people differed by gender, class, and level of education. They represented various social agents like the leaders of the settlement houses and charity organization movements, the heads of state boards, and superintendents of institutions. Negotiations at the boundaries of social work reflected differentiation in relation to changes in knowledge about larger social structures such as gender, class, welfare and social order and in the way in which social work practice was organized in the formation of client groups, work sites and special training. Some subfields attracted social work and others were lost instead of being shaped by one "inner function" or "purpose" of the "mediating role" of social workers, the representants of whom were actively engaged in shaping of boundaries for social work. Many of the subfields of social work were simultaneously central and contested. In the formative years of 1900–1920, the profession of social work arose out of a turf competition between charity organization societies with their rather narrow and vocational "scientific" ethos of casework and the settlement houses' broad interest in reform and preventive services. Social work as an established entity came into existence over time when various social agents began to standardize sites of difference into larger proto-boundaries and then into larger units. This made itself concrete when social work professionalizers began to gather women from psychiatric work (non-medical patient work in hospitals) with the scientifically trained workers from kindergartens, the non-church group in friendly visiting and the child workers in probation, all of whom were women (Abbott 1995a: 557–558).

2.5 Alliance and Scientification as Strategies for Occupational Mobility

Selander (1989a, 1989b and 1990) suggests that the concept of alliance strategy can be used in addition to the concept of closure strategies to describe and analyze both collective social mobility and knowledge-building efforts in subordinate groups with middle positions in the professional hierarchy. These groups do not have strong professional associations behind them, so they need allies among other social groups. The alliance strategy thus involves both the knowledge base of the subordinate group and the social organization of this group. An alliance strategy with regards to the knowledge base on the one hand means that abstract theoretical terminology and concepts of practical knowledge are brought from other established occupations into the subordinate occupational group involved in early or new (re)formation. A social organization alliance strategy on the other reflects different co-operative efforts by the subordinate group to gain higher status in the system of occupational groups and in society as a whole.

Knowledge that supports the systematic scientification of the subordinate occupational group can be brought in (Larson 1977 and Selander 1990). Scientification does not necessarily mean the same as involvement within a process of professionalization based solely on scholarly knowledge. Historically, scientification has been part of a broader cultural and moral pattern of social intervention in society (Steinmetz 1993: 198–202; see also Chapter One and Chapter Four in this study). The mixture of theoretical and practical knowledge which is based on experience under the umbrella of ‘scientification,’ which has been brought in by the subordinate or occupational groups in middle positions, is further shaped into a knowledge base that reflects the actual practical work done by the group. Such a strategy of alliance strengthens an occupation’s position in relation to others.

An alliance strategy aimed at socially organizing the group can be applied on the historical as well as the contemporary social ethos of scientification in society, even if scientification has been defined in different ways during different historical periods (Selander 1990). Traditional professional social organization meant gaining control of knowledge and fields of practice. Today’s professional social organization is a mixture of professional organization and labor union activities. Different groups have been acting as “executors” of approaches such as scientification and at the same time have gained a social position and social status in the practical occupational field. This kind of occupational social control has been present in a society characterized by broad social change. The concept of an alliance strategy thus helps to analyze both the shaping of a knowledge base and modes of practice and, in a broader sense, the organization of knowledge in society, which I refer to when I examine administrative strategies in this study. I examine how core components of both abstract knowledge and modes of practice are redefined in the division of labor and the reform of public health nursing education in inter-war society, in other words how cognitive and social legitimating strategies were carried out/demonstrated in the division of labor.

2.6 Summary, Contextualization and Research Questions

To summarize, in the sociology of professions, the neo-Weberian concept of social closure has been criticized for its neglect of the broader social and cultural contexts of occupational formation and for its emphasis on the occupational group as an independent social actor in society. However, an analysis of closure strategies helps to highlight gendered inter-occupational and class-based struggles over access to education and jobs and the relative positioning of men, and women and different classes in related occupations. Andrew Abbott’s studies (1988, 1995a and 1995b) on the historical formation of professions deals with the jurisdictional making of claims in relation to broader social patterns in society. In order to identify the professional project of inter-war public health nursing it is fruitful to analyze such broader patterns. Abbott’s “turf battles” can be more thoroughly examined by introducing

three analytical developments into the analysis. These are the notion of *dual closure strategy* (Witz 1992), which is typical in hospital nursing and midwifery, the notion of *alliance strategy* (Selander 1989a, 1989b and 1990; Evertsson 2002), which is adapted by middle ground occupational groups and, finally, socio-cultural research which analyzes *gender and class* in relation to organized philanthropic carework (Davies 1988 and 1995).

My point of departure for seeking theoretical tools for my analysis of the formation of Finnish public health nursing was in the power and conflict perspective that has identified the specific forms of social closure strategies that middle-class occupational groups employ. However, a focus on power and subordination alone is not adequate for understanding the multi-dimensioned formation of a professional occupation in the context of philanthropy and associated socio-cultural movements. Previous literature on women's professions in the Nordic countries has turned to the approach of the Chicago School in sociology and its emphasis on negotiations and action/interaction. That tradition influenced the concepts of license and mandate which were introduced by Everett C. Hughes and developed by others, such as in the work of Andrew Abbott on jurisdictions in the 1980s. These concepts guide my analysis of how Finnish public health nursing took shape in the context of the exchange between the vanguard of professionalizers and other social actors such as public health activists promoting education and innovation and implementers of new public health programs within the Rockefeller Foundation and amongst Finnish actors in the inter-war period.

In my analysis, I draw particularly on Andrew Abbott's (1988, 1995a, 1995b and 2001) idea about claims-making in the shaping of a professional jurisdiction—a kind of "field of competence for a professional activity"—as a process of drawing boundaries that define the core of an occupation's knowledge base and modes of practice. The concepts of jurisdictional claims and boundaries thus help to describe the importance of understanding the formative negotiations and turf battles that take place in the early stages of the process of professionalization. The flexible conceptualization of jurisdiction in Abbott's work (1988: 112–113) makes it a useful tool for an analysis of professionalization. This framework takes into consideration not only the workplace environment, but also the intermediary public and formal legal environments to explain the evident stability of many interactions over time. It also makes it possible to uncover underlying cultural and moral aspects of the jurisdictional making of claims that are present during certain historical eras.

Abbott uncovers several layers of interaction, each operating at different speeds. The slower ones give stability or structure to the elements negotiated in the faster layers of interaction. Established social norms and values of the time structure negotiated jurisdictional claims in the faster layers of interaction. When new boundaries of public health nursing were shaped, established norms and values concerning knowledge, gender and class affected the outcomes of the negotiations which took place at the boundaries of the occupation.

The link between the formation of a knowledge base and the formation of modes of practice is central to this study, and it reflects what Abbott calls slower levels of interaction which create stability. The term "interstitiality" which Andrew Abbott (1995a and 1995b) uses to mark a kind of transitional space, can, in my opinion, be understood more broadly as a form of "intersectionality" in the complex and heterogeneous social and cultural formation of early public health nursing. The term intersectionality, which has been recently adapted in gender studies (see, for example Davis 1983; Crenshaw 1992; Omi and Winant 1994; King 1996; Omi and Winant 1994; Collins 2000 and de los Reyes and Mulinary 2005), describes power as intersectional relations. These authors stress the idea that social forces such as knowledge, gender and class are not separate and additive, but rather interactive and multiplicative. By using the term *intersectionality* as an analytic tool, the formation of new collective professional identities can be seen as a set of complex and intertwined social forces. Hence, the collective professional jurisdiction of public health nursing was not only a result of temporary separate social processes and temporary social relations between the three mentioned social actors, but was rather created in the intersections of social ordering. The negotiations between the social actors in this study were characterized by power relations based on scholarly and practical knowledge, gender and class (See Figure 2.1).

By examining the link between the formation of a knowledge base and the formation of modes of practice, it is possible to show how the professionalizers, public health activists and the implementers of new public health programs used educa-

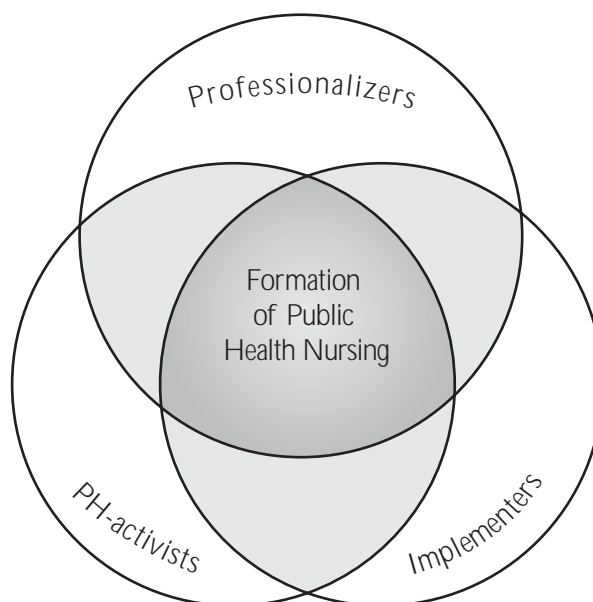


Figure 2.1 Actor-model describing the negotiated formation of Finnish Public Health Nursing

tional and administrative strategies in different ways. The different social actors in my study had different views on the role of middle-class women's carework in the community. Thus in the present study power is examined in this study in the links between knowledge and health programs in social and cultural spaces shaped by gender and class relations, at different time periods, and on different social levels.

To put it more concrete, I examine how RF observers and Finnish officials used educational and administrative strategies in different ways in order to legitimize and institutionalize public health nursing knowledge and modes for its practice during the 1920s and 1930s, and how they were adapted in the context of the local health center in the Municipality of Helsinki in the 1940s. I ask what kind of recognition the professionalizers sought for and to which audiences they directed their claims in their struggle for status, prestige, autonomy and the survival of public health nursing. The closest other social actors identified in my materials that the professionalizers confronted were PH-activists who promoted education and innovation and implementers of new public health programs.

The critical boundary events which shaped the educational and administrative strategies for public health nursing were intersectional processes such as:

- a) *the formation of a knowledge base for the occupation and the creation of modes of practice,*
- b) *the negotiated support for educational institutions and training programs for public health nurses,*
- c) *the negotiations in regards to a gendered and class-based division of labor in organizing local public health activities between voluntary organizations and public authorities.*

All these social processes included struggles in which professionalizers, PH-activists and implementers of public health programs made claims on the new type of professional status for the public health nursing occupation. These struggles need to be examined. Also, a historically-informed sociological analysis of the formation of the jurisdiction for public health nursing in Finland needs to examine the structural conditions under which this particular formation gained ground. Important focuses for such an analysis are the key ideas which shape the educational and administrative strategies that are to be identified and traced across time and space. Furthermore, significant institutional features (e.g. voluntary non-profit organizations, settlements, philanthropic organizations, public/governmental institutions, model practice fields) which shaped the jurisdictional claims of public health nursing (on the workplace and public and legal arenas) need to be examined.

The *principal research question* for my study of educational and administrative strategies used in the formation of a women's occupation for Finnish public health nursing during the inter-war period will focus on *four central themes* (a, b, c and d). I use these four themes to examine critically the educational and administrative strategies

used as jurisdictional claims for public health nursing and the social roles and social values that influenced the public establishment of a recognizable new occupation in public health. Primarily, I ask:

What kind of boundary-work did professionalizers of public health nursing within the Rockefeller Foundation and amongst Finnish actors engage in during the inter-war period?

I have an actor-oriented approach in my analysis. Therefore, I am interested in understanding the construction of alliance strategies concerning a knowledge base, modes of practice and the local organization of public health nursing in relation to the social composition which the professionalizers sought for the group of new public health nurses. My four thematic research questions are:

- (a) Through what kind of processes did the knowledge base of public health nursing take shape in the American context and how was it adapted in the Finnish context?*
- (b) What kind of modes of practice did the Rockefeller Foundation promote for public health nursing and how were they adapted to Finland?*
- (c) What kind of social strategies did the professionalizers of public health nursing use to defend and promote their professional project?*
- (d) What were the collective social values that the professionalizers of public health nursing promoted for the women's occupation of public health nursing?*

Tracing Boundary-Work

3.1 Introduction

Social studies of the formation of professional groups often involve an analysis of historical documents. Archival materials about the formation process of public health nursing provide an important source of data for understanding critical boundary events and negotiations and struggles which relate to boundary-work that aims at institutionalizing an occupation. Such an analysis needs to focus on how human practices are embedded in and yet transform both structures and meanings. My sociological study locates the analysis of the occupation in the wider social and cultural context of "nursings" (Dingwall, Rafferty and Webster 1988; Davies 1995).

The educational and administrative strategies in my materials are mostly expressed as interpretive and explanatory statements; as administrators' discussions in public, voluntary and philanthropic welfare organizations, and by the nursing leaders and educators who were actively involved in the formation process. By studying educational and administrative strategies, it is possible to make evident ideas that organize the aspirations and activities of the actors involved and the actions that follow at an early stage of the formative process.

In line with my principal research question and its four themes (see Chapter Two), my aim is to identify social patterns of public health actors with different ideas about professional women's carework as public health nursing and negotiations during critical boundary events in the formation of a new occupation for women. I also examine how social structures enter these patterns at local, national and international levels, thus shaping the occupation's knowledge base, modes of practice and the organizing of the work.

A central question I ask in my study is: how did gendered and class-based social and cultural elements either support the professional project of public health nursing or restrict these efforts at an international as well as a national level? To answer such a question, one must critically examine what it means to say that public health nursing "emerged." The aim of this chapter is to give one option of how such a significant question can be methodologically investigated in order to grasp

how a certain knowledge base and certain modes of practice which we find to be characteristic of public health nursing in the community emerged during a certain historical period.

In the rest of this chapter I explain more specifically my ontological, epistemological and methodological arguments about the actor-oriented and context-specific study which I am undertaking by the use of historical documents. I describe choices I have made in my research process and, lastly, I present my historical materials.

3.2 The Methodological Approach of the Study

There are many paradigms, strategies of inquiry and methods of analysis to draw upon and employ within qualitative research. There are no final agreements about definitions, meanings, or implications within the central paradigms of modern qualitative research (Guba and Lincoln 1994). From my point of view, the formative stage provides exciting opportunities for the qualitative researcher to enter critically the field of qualitative research. I view my research as a combination of a few approaches at examining, interpreting, arguing, and writing social research. From the large quantity of handbooks on qualitative research, one gets a rather idealistic picture of how to carry out such work. In reality, the qualitative researcher faces a rather daunting task. The challenge is in finding a way of doing research that follows both generic principles and activities and grasps a specific set of criteria that does justice to the collected empirical materials. At first I examined grand methodological narratives of sociological inquiry, which are in the background of this present study; after this, I turned to more local and small-scale adoptions of large theories that fit specific problems and situations within the sociology of professional groups, which influence the present study.

My underlying epistemology in this dissertation is interpretive. Interpretive research does not predefine dependent and independent variables, but focuses on the full complexity of human sense making as the situation emerges. The interpretive paradigm (Guba 1990: 17) I use is both constructivist-interpretive and critical. As a basic belief system that is based on ontological, epistemological and methodological assumptions (Guba and Lincoln 1994: 107), my chosen paradigm is constructivist in the sense that my chosen type of narration is an actor-oriented and context-specific interpretive case study which consists of documentary analysis of historical archival materials. Ontologically, I examine local and specific constructed realities as opposed to universal and objective realities, although certain ontological elements in my analysis are widely shared among many in my materials and even across cultures. The critical dimension in my interpretive paradigm is visible by the social and cultural factors that are reified within structures. Such contextual reciprocal determination (Abbott 1997) is present in the educational strategies presented within my materials, and either support or restrict the formation of the professional project during a certain historical period. The nature of the knowledge I focus on in my

findings is historically and more critically informed—it consists of insights about the gendered and class-based processes in occupational formation. Predominant male-centric norms and values in social sciences in general and in the study of occupations specifically have influenced not only the contents of research but also the process of creating, interpreting, and disseminating knowledge about society. The methodological aim in this study has been to conduct social research that broadens the existing view about female occupational formation in a gendered and class-based world of work and educational field in the inter-war period. The combination of a critical perspective and constructivism sheds light on both the historically situated preexistent social order, and on the new constructed social order as a result of the boundary-work shaping the new occupation of public health nursing.

A multifaceted range of complexly interrelated activities, processes, events, locations, and times is visible in my collected materials. My choice of data depends on my conceptual approach. Firstly, I look at the larger picture of relationships within a system of occupational activities and an occupation-to-be. Secondly, I look at relationships in early social and public health reform cultures surrounding occupational activities, thus creating different levels of relationships and contexts in my analysis. My interest is in uncovering the meaning-structure of social and cultural boundary-work by examining critical boundary events of the occupational formation of public health nursing.

The broader theoretical framework in this monograph, as described in Chapter Two, builds on the interactionist and context-sensitive paradigm of the first Chicago School in Sociology, which is called by some the “Golden Age of Sociology” (Cavan 1983). This school of thought developed between the First World War and the mid 1930s. Andrew Abbott (1997: 1151) describes the contextual paradigm as follows:

In a single sentence, the Chicago School thought—and thinks—that one cannot understand social life without understanding the arrangements of particular social actors in particular social times and places. Another way of stating this is to say that Chicago felt that no social fact makes any sense abstracted from its context in social (and often geographic) space and social time. Social facts are located. This means a focus on social relations and spatial ecology in synchronic analysis, as it means a similar focus on process in diachronic analysis. Every social fact is situated, surrounded by other contextual facts and brought into being by a process relating it to past contexts.

The interactionist paradigm within the first Chicago School and the second Chicago School (1945–65) involved the construction of meaning (Colomy and Brown 1995; Abbott 1988 and 2001). Two central elements of this paradigm were the understanding of the nature of social action and how the conditions of social structure act. The Chicago writers distinguished various degrees of temporal contextuality (Abbott 1997). One temporal degree of contextuality that has a large degree of contextuality is the so-called interactional field. The system of professions is an interactional field with turf wars (Abbott 1988 and 1997). Abbott states that one cannot write a

history of any individual profession because that profession is too dependent on what other professions around it are doing. Larger social forces also enter this field of interprofessional conflict, e.g., cultural developments and economic patterns give rise to changes in the interactional field of turf wars. Thus multiple levels of social and temporal context and temporal social patterns in the interactional field of professions can be identified. These patterns follow a relatively predictable course and can be understood as a whole, as temporary stability in a process of reciprocal determination.

Abbott (1997) suggests that the second Chicago School's research agenda subsequently divided into "institutionalist" and "individualist" strands. The individualist agenda is informed by the Blumerian directive which considers organizations, social structure, culture and power crucial only to the degree that they enter into the process of interpretation and definition, out of which joint actions are formed. The thickly descriptive studies of the individualist strand highlight the processes and contingencies associated with professional socialization and identity transformation. The institutional agenda, by contrast, follows the foundation laid by the first Chicago School and Everett C. Hughes. Hughes (1958) insisted that the study of occupations in "the world of work" was both important in itself and a critical medium for understanding society as a whole.

Following the lead of the institutionalist strand, the starting point for this study is that occupations cannot be studied in isolation but have to be understood in terms of their social and cultural environments and contexts such as historical circumstances, cultural values, work organization, concepts of health, and gendered and class-based social patterns. The context-sensitive perspective makes it possible to see the formation of the occupation both as action/interaction between constructive social actors in active interpretive and negotiated situations and as the institutional ordering that models these actors' behavior (Giddens 1984). To make such an analysis possible, the collection of data needs to support the study of process and the use of historical and structural reflection in the analysis. I have consciously looked for data indicating change in conditions or reproduced relations between the social actors in the archival data (see presentation of the materials in Section 3.9) Furthermore, in my collection of data, I have sought to enable the study of action/interaction at different social levels. The examination of the way that the process at the meso level (organizational and institutional level) reflects processes at micro and macro levels gives the study a dimensional character with different levels of abstraction. This is done in order to map the larger picture of jurisdictional conditions in the interactional field of the occupational formation of early Finnish public health nursing identified in my materials.

In order to achieve an actor-oriented and context-sensitive analysis, I have created qualitative categories and concepts that describe multiple levels of temporal and social context in my empirical documentary material. This kind of grounded approach works as an analytic tool to structure my large and scattered historical

materials and to make my study comprehensive, because concepts have different meanings during different historical periods depending on the level of social change in society. My empirically constructed qualitative categories (See Table 3.1 in Section 3.7 about categories in this chapter) help me to give specific content to the broad empirical context and enable me to observe relations to earlier research in this area of sociological knowledge. An example of such an actor-oriented and context-sensitive perspective is when rigid and rooted forms of embeddedness are altered, new possibilities for action are opened up, and new frames of reference are disclosed. This happened when female philanthropic work confronted traditional nursing ideas and resulted in the broader view that there are different "nursings." General nursing in hospitals and homes was complemented by a new kind of 'health nursing' in the community.

3.3 The Role of the Researcher and Finding the Research Questions

An epistemological criticism of my study could be that my position as a researcher in sociology with a personal background in public health nursing knowledge and practice, which carries with it certain internalized professional values, will influence the inquiry. For this reason, I need to reflect upon how this background as an insider in public health nursing influences my study.

One initial reason for my interest in the occupational formation of public health nursing is my personal experience of both nursing and public health nursing in the 1980s and 1990s. At that time, I experienced a kind of shift back to early generalist thoughts in public health nursing, both in my vocational nursing education and later in my work as a public health nurse in municipal primary care settings. Another reason for my interest in doing research on my previous occupation is my academic background in natural sciences, philosophy, social policy and, more than anything, sociology, which has become my major interest. Choosing a research problem more or less through the route of professional or personal experience might be more hazardous than if one were to be given or assigned the work, or if one were to approach it from a purely academic perspective. My strategy has been to combine my personal work experience with its multidisciplinary, vocational learning process and my academic, more specified and abstract training. Suggestions from colleagues in my field of sociology about inquiring into certain phenomena and the parallel findings in literature about relatively unexplored areas and topics in need of further investigation guided me towards my final research question and its four themes. Even though there are obvious advantages to having actual, first-hand experience in the field of public health nursing, it has been necessary to make an elaborate knowledge-construction and reconstruction of my preconceived ideas throughout all of the research process. A historical reflection that is applied in my study enables

me to keep a distance to current issues and problems surrounding the occupational group of modern public health nursing, a reality I have recently been a part of.

There is a kind of transformative dimension in my inquiry that is usually linked with a critical interpretive paradigm. I have not been a part of the developments described in my historical materials, but my personal occupational background influences my critical interpretations, sometimes making my constructions rather sophisticated. The constructions in my analysis reflect subjectivist expressiveness and conscious action/interaction rather than proof and objectivity when I argue their position. My chosen interpretive paradigm is thus rather pragmatic and reflects ontological relativism and my interpretive accounts have been judged by asking whether they are fruitful, well-suited or whether they generate further inquiry.

3.4 Uncovering Critical Boundary Events in the Formation of an Occupation

A study of a new women's occupation at a middle ground in the work hierarchy highlights the particular and varying features of class backgrounds and gender structures and women's efforts at bringing about social change. A social entity of an occupation's core zone is, according to Abbott, created by "pulling certain boundaries together in certain ways" (Abbott 1995b: 555). Central for Abbott's (2001: 263) perspective on the formation of entities like occupations is the realization of how boundaries come first, and then give entities shape. Enduring events like professionalization can arise from internal or ecological reproduction when these events keep happening in the same way. What Abbott calls thingness, or an entity-like quality for an occupation-to-be, has essential properties like endurance and repetition. Broader historical processes can be reconstructed by identifying important or critical events to which social causal authority can be assigned (Abbott 1995a and 1995b).

Abbott (1995b: 861 and 2001: 267–268) argues furthermore that the real moment of an occupation's "structuration," the moment when the very shape of tasks begin to become fixed, might happen long before there are schools, professional associations or professional journals. The ideal type of "occupation" in early formation includes three things: (1) a particular group of people, (2) a particular type of work, and (3) an organized body or structure capable of some kind of reproduction (i.e., knowledge transition). Abbott also argues that one of these foundational attributes in the formation process of an occupational entity can be lacking, but the occupation-to-be can still be reproduced and have independent causal consequences. In the case of public health nursing, these foundational attributes can be examined by uncovering the particular social circumstances that exist in relation to:

traditional and new knowledge in medicine and nursing and related subject fields as well as lay knowledge;

traditional and new health occupations and welfare occupations;

*private and public ordering and regulation of health;
voluntary and public organization of health-related welfare work;
and, finally, in relation to different types of educational institutions.*

Norwegian political scientist Vibeke Erichsen (1996) has adopted Andrew Abbott's notions on boundaries and entities in occupational formation. She contextualizes Abbott's model of occupational entities and boundaries. Her example is of the way that Norwegian health care services took shape, and what roles different health occupations played in that process. Her approach is to reveal social demarcation processes at a macro level that constitute the broader context of occupational formation. Erichsen examines boundary processes in different historical contexts of the formation of health services and health occupations. Such boundary processes are those that are constructed towards other occupations in other sectors that have another knowledge base, boundaries towards lay knowledge, and boundaries between voluntary and public political action. The shaping of such boundaries demarcates one sector from another in society.

While Erichsen examines the formation of what could be described as a system of professions in relation to the formation of the institutional structure in which they practice, my study focuses on the formation of one occupation and the boundaries of its jurisdiction. I study how practical knowledge in philanthropic social work, general nursing and public health nursing have confronted abstract knowledge in medicine and related disciplines about public health and what kind of occupational knowledge the professionalizers of public health nursing have picked up to form an own field of work for public health nurses. Nursing can thus be viewed in a broader way than by studying it only as a group of subordinate professional and educational activities in the field of medical work led by doctors or by seeing public health nursing as a linear outcome of general nursing.

Several professionalizing processes take place within one sector and produce the formation of new occupations and a continued existence of established occupations or result in the gradual disappearance of occupations. An unclear division of labor, the lack of collective responsibility and other deprofessionalizing conflicts are typical at these boundaries. For example, work tasks are defined and re-defined when private and voluntary activities become public ones, or when tasks connected to the knowledge area of one particular occupation are transferred to another perhaps new occupation in another sector. At the same time, boundaries between different sectors might be reshaped.

Erichsen (1996) also points to boundaries between the professional and the political that are constructed in the formation and development of professional groups. New specific social and health problems and political issues during different historical periods might become potential material for professionalization and knowledge formation. Such links between the professional and the political are also evident

in the formation of public health nursing. Changes in ideas of family, children and the environment influenced knowledge structures within specialized medical fields such as preventive medicine, hygiene, public health, pediatrics and obstetrics (see, for example, Lasch 1977; Donzelot 1979; Armstrong 1983 and 2002). The new ideas also influenced to professionalize women's carework through the formation of such fields as public health nursing and modern professionalized midwifery (Davies 1988; Dingwall et al. 1988; Wrede 2001).

The actor-oriented and context-sensitive approach to the analysis of the formative process of an occupation can be summarized as follows: the researcher's task is to search for "boundary entities" instead of boundaries of already existing entities. Such boundary entities are, for example, the opening and closure mechanisms of alliance strategies that are central to my study. The formation of new occupational groups at certain historical times and in specific spaces, for example in national and international spaces, can be studied primarily as how sequences of critical events reflecting multiple levels of social and temporal contexts at the boundary zones of the occupation-to-be take place. The time and space position of critical events determines whether the events lead to some sustainable social occupational construction or not. The central task in such a method of studying occupational formation (Abbott 1988, 1995a, 1995b and 2001) is to observe critical events in the boundary zones and then study how different social actors shape the core zone by "binding together" these critical boundary events into entities. Similar and repeated critical boundary events make the formation of more sustainable entities, in this case an established institutionalized occupation, possible. The main task is to present an understanding and interpretation of how the boundaries and later core zones of the occupation have been shaped.

3.5 The Collection of Materials

Philanthropic organizations that have supported the formation and development of different "nursings" provide important sources of archival material for historically sociological research on nursing. I collected most of my data during two visits to the Rockefeller Archive Center (RAC), which is situated in North Tarrytown, just outside New York City. My first visit, in 1998, was for three weeks and the second visit, for two weeks, was in 2001. The RAC holds a great deal of material, among them the Rockefeller Foundation Archives. The records contain program and policy files, histories, program files dealing with U.S. and international nursing and medical education, midwifery programs, local public health projects around the world where nurses worked, and correspondence, official diaries (travel reports, meetings, conferences) and files about the administration of the Foundation's fellowship program. You may find a more detailed presentation of my material at the end of this chapter.

The Rockefeller Foundation's impact on Finnish nursing was an early question in my research process and by using the internet I easily came across valuable basic information about the Foundation's history and available archival material related to my research interest. The internet also made it possible for me to contact the archivists at the RAC for the first time. Their support and professional guidance during my visits at the RAC in 1998 and 2001 and the later e-mail consultations have been of great value in my research process. Available funding for data collection in the U.S. has also been necessary for me to study this topic.

The large collections of the RAC are categorized, sub-categorized and described in several catalogues.⁵ A staff member, usually an archivist, supports the researcher with descriptions of the scope and content of relevant materials in the collections, and also responds to inquiries on more specific issues. The researchers make written orders on the documents needed and photocopy requests for the archivists. A satisfactory collection of materials is thus based on good planning and cooperation with the staff when necessary. It took quite a long time during my first visit to the RAC to get to know what kind of collections there were and to judge which parts of the large collections would be fruitful for my study on Finnish public health nursing and the role of the RF in public health nursing formation. Materials on Finland were largely found using the country code; Finland's was "787." More general materials on the RF and public health nursing were found by examining topics in the categories and subcategories in the catalogues which the RAC had created, and by discussing my research with the archivists. Gradually the collection of materials became a routine for me, and during the second visit I was able to fill all the gaps that existed in my data after my first visit.

During my second visit in 2001 I also visited other archives in New York City. To get more insight in the occupational activities in New York, to which Finnish RF fellowship holders took part in the 1920s and 1930s, I collected data about the Henry Street Settlement and Visiting Nurse Service at the library of the New York Academy of Medicine and their historical archives. The third American archival source I have used for my study is the histories of local public health activities in New York, which I collected at the New York Public Library in 2001.

Apart from the two visits to New York I also collected some complementary data in Finland at the city archives of Vantaa in 1998. The health center project examined in this study took place in Malmi in the Municipality of Helsinki (Fin. *Helsingin maalaiskunta*, Swe. *Helsinge*).⁶ Some parts of the Municipality of Helsinki are today a part of the capital of Helsinki and other parts belong today to the city of Vantaa, a city which neighbors Helsinki. In Vantaa I collected a project report and a local history on public health developments.

Whose voices are heard in my materials? Ideologies and visions for the occupational group, expressed by the professionalizers, PH-activists and implementers of public health programs, who influenced this process, are not likely to be identical to

those of the rank and file. These strategies are not always received with enthusiasm. Nevertheless, the strategies designed by the leaders and initiators are significant in the institutionalizing process of an occupation. This does not mean that the leading pioneers of public health nursing would have been unaware of the views of grassroots workers. Typically, many of the pioneer actors in my materials had their own occupational history within public health nursing or general nursing and preventive medicine or social medicine as health workers or educators before entering educational and administrative posts in these areas.

3.6 Possibilities and Limitations in Using Historical Documents About Formation Processes

“It is no linguistic accident that ‘building,’ ‘construction,’ ‘work,’ designates both a process and its finished product. Without the meaning of the verb that of the noun remains blank” (John Dewey in *Arts as Experience*, 1934: 51).

I have chosen to consider the archival documents in a qualitative way; I hope to say more about the process and less about the product and state. By doing so I believe it is possible to uncover negotiations and decisions that informed the “product” or outcomes of the formation process of public health nursing. Such a method of analysis uses data not just to simplify them and place them into static categories (like in studies with a quantitative emphasis), but to engage in an act of qualitative synthesis of action/interaction, attempting to summarize the overall meaning of the text and its impact on the reader. My analysis operates mostly at a meso level (organizational and institutional level), but it also reflects processes at the micro and macro levels when it is necessary to grasp the broader significance of the phenomena studied in the texts.

In documentary materials, the text and its author and audience become three essential components in a process of what British sociologist John Scott (1990), following the works of Anthony Giddens (1979 and 1984), considers as meaning constructions. Those three meaning constructions are intended, received and content meanings. The intended and received meanings are central in my analysis. The shaping of ideas of public health nursing on international, national and local levels during the occupation’s early formative period took place during a historical time, when there were not any standardized models on how to organize public health nursing to follow. There were many possible options. Within documentary analysis, an approach that has informed the way different materials were approached in this study, it is common to warn researchers about trying to focus on interpreting what the author intended when he or she was producing the document. Furthermore, documentary analysts also argue that the producer’s intention determines the impact of a particular document only to a limited extent. Therefore, it is important to identify a document’s different audiences and examine the meaning it is given by specific audiences (including the researcher, who by an act of reading, is part of its

audience and thus needs to act reflexively). To focus on the text itself is yet another perspective, but for documentary analysis this is not in itself an adequate approach. Jennifer Platt, who has written a pioneering texts on documentary analysis in social sciences, underlines the analysis of the genre as a necessary element in the analysis of documents. She states that "a document's meaning cannot be understood unless one knows what genre it belongs to, and what this implies for its interpretation" (Platt 1981: 53).

Texts on public health form a particular genre of social engineering texts which are written, not just in the form of reports, plans, programs, but also others, which borrow from both the language of policymaking and the language of science. These texts also include a lot of statements that build on moral assumptions about values and consequences as they relate to preventive medicine and health education in different social and historical settings. Health education has been used as a tool to "civilize" or control entire populations. It is very clear that the shaping of public health nursing reflects broader social, cultural and political patterns of social change and social regulation.

3.7 Grounded Procedures as Theoretical Sensitivity and Thick Description

As described above, my analysis of the formation of Finnish public health nursing focuses on critical boundary events and is consequently based on a deductive framework. However, when I initiated the collection of materials for my study, I had not yet formulated that final analytical framework. Rather, the process of formulating my specific theoretical tools has involved moving between the collection and initial analysis of materials, which were conducted along the lines of the grounded theory approach (Glaser and Strauss 1967), and my reading of previous research on the formation of occupations.

The grounded approaches to empirical work in sociology presently range from the strictly defined inductive approach (Glaser 1998) to a direction that combines inductive and deductive elements (Strauss and Corbin 1990 and 1998). I have used inductive elements in a more limited way, mostly in the collection and organization of my large materials, and combined it with deductive elements in order to ask questions about the collected materials and make sense out of the created core categories. I have used the grounded approach for two central functional reasons. First, in my initial empirical work the grounded approach worked as a tool for theoretical sensitivity in the process, through which the notion of critical events was selected as the primary concept that then came to be applied as "critical boundary events" in the choice of materials for a closer analysis. Second, the grounded approach served as a tool in the selection of the scattered materials and in the organization of the large amount of archival materials, I was faced with.

Theoretical sensitivity is a useful tool that refers to the attributes of having insight, the ability to give meaning to data, the capacity to understand and the ability to separate the pertinent from that which is not (Glaser and Strauss 1967; Glaser 1978, 1998 and 2003). Broad abstract social patterns are given a context. This is done in conceptual rather than concrete terms. Theoretical sensitivity in my research process comes from several sources, such as sociological literature, personal professional experience and the continuous analytic process itself in reading the material. Parallel reading of the theory and the documents have “sensitized” me to what is going on in the phenomenon studied. To reflect on phenomena in light of the theoretical framework chosen for the study the aim for me has been to discover relevant categories and relationships among them by constant comparisons, and to put together categories in new, rather than standard, ways. This procedure helps to discover where there are unrecognized assumptions associated with previously developed theory. The need for such an approach is motivated by the state of research in this area of study. The developers of the grounded theory approach emphasized that it was best suited for areas of study that were under-theorized in previous research (Glaser and Strauss 1967). Even though previous literature on the formation of similar occupations exists, public health nursing can be described as an under-theorized phenomenon in the social sciences, and it thus demands new perspectives.

The use of the grounded approach in the collection and organization of the materials also served as an analytic tool. Understanding the large amount of collected archival materials by conceiving of the interplay between data collection and analysis keeps the study actor-oriented and context-sensitive. My interpretive procedures include techniques for conceptualizing data. One such technique is categorizing. Viewing conceptual relationships and writing memos are other ways in which I have interpreted the different processes in the phenomenon studied.

The broad concepts of “public health” and “philanthropy” can be taken as examples. In different documents these concepts are used in different ways, and these definitions vary from a broad concept of welfare building to narrow definitions relating to medicine or society relevant to local public health action, and all the definitions between. To understand the position of public health nursing in this broad field of health-related activities I have looked at how the boundaries of public health nursing are drawn and how its core is defined through critical boundary events and negotiations which occur in the framework of “public health” or “philanthropy.”

Every research study, whether it be qualitative or quantitative, must be evaluated in terms of the specific canons and procedures of the research method that were used to generate findings. Although this message is familiar from all handbooks on research, it is not an easy task to grasp. Integrating all the interpretive work done over the course of one’s research is perhaps the most difficult task. This can be done by interweaving description and interpretation.

How much interpretation should there be of the data? The interpreter is faced with data that are simultaneously patterned along a number of different dimensions. One principle could be to use a lot of quotations from the texts and let them speak for themselves. Another strategy could be to present an accurate description of what is being studied and combine one's own interpretive comments in and around long descriptive passages and quotations from the documents. I have chosen to use this method. The illustrative material of quotations is meant to give a sense of what the "observed historical world" in the documents is like. The interpretations made of the descriptive materials are usually connected to existing theories in the field of interest or they might at times be attempts toward generating new theoretical models (Blumer 1969 and Glaser 1978). However, even the descriptive passages are constructs and are grounded in the researcher's interpretations. They relate to the research questions and the theoretical and analytical approaches chosen for the study. The selection of what to include and what to exclude and the order of presenting the materials and the interpretations suggested result from choices I have made. Even when seeking to be accurate about sources and aiming at a balanced portrayal of the critical boundary events and the identified abstract social actors, a description always privileges some perspective of others (see, for example, Kalela 2000: 126–127). As stated above, it is the perspectives of the pioneers and leaders that are privileged in this study, a fact that is a result of both the research questions and of the limited availability of materials on rank and file RF-related public health nursing experiences in the inter-war period.

The concept of thick description helps to orientate the interpretation. Social events, institutions, and processes are part of a cultural context and can be intelligibly or "thickly" described (Geertz 1973; Denzin 1994 and 2001). It is important that different dimensions of the phenomenon being studied are identified. For example, the empirical concept of 'health nursing' has both similar and different meanings in the American and the Finnish contexts. A thick description of this phenomenon includes identifying boundaries of American health nursing versus Finnish health nursing. The "two cultures of health nursing" are comparable in my materials by an examination of the negotiations that took place between the Finnish and American actors when they were confronted with each other in joint programs, both in the U.S. and in Finland.

Professional and personal experience helps the researcher to move into situations and gain insight more quickly than others who are unfamiliar with the phenomenon studied. On the other hand, this kind of personal experience can also block the researcher from problematizing things that have become "obvious" or normative for the professional. But there are techniques to break through these blinders. These will usually be noticed at the stage when the researcher, his or her colleagues and his or her supervisors begin to question and open up the data and to think more analytically rather than descriptively about the data.

3.8 The Shaping of Categories

An analysis with a grounded approach combining induction and deduction is composed of three major types of coding: (a) open coding; (b) axial coding, and (c) selective coding (Glaser and Strauss 1967; Strauss 1987; Strauss and Corbin 1990 and 1998). I here describe these to show how secondary data in the historical documents can be opened up and interpreted by using such a categorization technique. The different types of coding do not necessarily take place in sequential steps during the research process. They can be applied flexibly according to different circumstances, and alternatives are available at different stages of the study. Open and axial coding are most likely to take place in the project's earlier phases, but can be used as a part of the third coding type, i.e. selective coding. The reason for doing this is that you might find later in the process that some concepts are poorly developed or not integrated.

The conceptualizing and the bringing of context to the analytic process are the outcomes of open and axial coding. Concepts are identified, developed in terms of their properties and dimensions, and finally put back together in new ways, by making connections between the categories (Strauss and Corbin 1990). Open coding is done by scrutinizing the document very closely. The aim is to produce concepts that seem to fit the data. Ideas and events are given a name, which stands for or represents a phenomenon. The basic analytic procedure by which this is accomplished is to ask questions about the data. Another central step is to make comparisons to find similarities and differences between each event and other instances of phenomena. Finally, labeling and grouping similar events is essential in the forming of categories. At this stage of the study the proposed relationships are considered provisional. The categories can be developed in terms of properties, which can be dimensionalized. These properties and dimensions in turn are important for making relationships between categories and subcategories.

The aim of axial coding is to specify a category or phenomenon in terms of the conditions that gave rise to it, in other words, the context (its specific set of properties) in which it is embedded; the action/interactional strategies by which it is handled, managed, carried out; and the consequences of those strategies. The so-called intervening conditions are important because they describe the broader and more general conditions that bear upon action/interactional strategies. Intervening conditions stand between the context and action/interaction and act to facilitate or constrain the latter. They include things such as time, space, culture, history and economic status. Finally, contingencies such as unexpected events or problematic situations change conditions and should be integrated into the analysis.

The third type of major coding, selective coding, aims at analytically defining the so-called core categories. This stage orders the empirically constructed open and axial categories into an analytically defined form that is labeled a core category (see

Table 3.1 below). This process is a result of theoretical sensitivity and thick description, which I have described earlier in this chapter. At this stage, the theory and research questions are actively integrated in the analysis.

Table 3.1 An example of shaping the empirical core category ‘health nursing’

Open coding →	Axial coding →	Selective coding →
Identification of properties and dimensions of data	Specification of phenomena and categories	Shaping of core categories
Identification of phenomena and categories		
“Prepare the nurse for public health”	Public health nursing included in undergraduate studies and as a postgraduate specialty	Health nursing as a knowledge base for public health nursing
“Prevention of disease, promotion of health and emphasis on the health and social aspects of nursing”	The home visit: medical, sanitary and social procedures	Health nursing as a foundation for the mode of practice of the new public health nurses called generalized public health nursing
Health “teacher and investigator” for the individual, family and community	The public health nurse in the setting of the local health center	Health nursing as knowledge base for an independent professional co-worker in the local community—civil servant and social caseworker practicing local generalized public health nursing
“Establishment of a field of practice for public health nursing (comparable to the hospital ward for the practice of clinical nursing)”	The RF and the model training field in the Municipality of Helsinki	The knowledge base of health nursing institutionalized in educational and administrative strategies for new public health nursing

3.9 Presentation of the Materials

In the following, I present the materials I have collected for the present study. My discussion of the materials aims at explaining the different dimensions of the materials. A more general presentation and orientation of materials which are connected to the public health and nursing agendas of the Rockefeller Foundation at the Rockefeller Archive Center is included in Appendix 1 of this volume.

My collected materials include the three social actors, professionalizers, PH-activists and implementers of public health programs and their ideas which involve many critical boundary events and negotiations. They illustrate North American ideas about the education and work of public health nursing and the role of the public health nurse within local public health work during the first decades of the twentieth century. When utilized for a study of Rockefeller influences on the formation of public health nursing in Finland, the collected materials allow the examination two central dimensions of the process. I ask, firstly, how were ideas of public health nursing shaped by the particular social space in which they were expressed? Secondly, how were ideas concerning public health nursing disseminated?

The American and Finnish actors in my materials include collective actors such as voluntary organizations and public agencies as well as important individual actors, such as pioneers of public health nursing and public health. By reading the materials it becomes clear that public health nursing was relatively invisible in early twentieth century debates of policy, especially when compared with, for example, the medical profession, which had a high status and a powerful position in policymaking. Unlike the medical profession, with its well-established organizational resources, public health nursing was not subject to repeated official investigations or national governmental initiatives (for medicine in the U.S., see Starr 1982; for medicine in Finland, see Vuolio 1991). Historical documents concerning public health nursing are not preserved in major national archives, but in the scattered records of professional organizations, voluntary organizations, philanthropic organizations, professional magazines, and local medical histories. To get a grasp of this diverse field, I decided to build up my study around the identification of action/interaction among the different social actors which I have identified in the boundary-work around the occupation-to-be. My materials include formative negotiations that are associated with the Rockefeller Foundation in North America and the Foundation's link with the formation of early Finnish public health nursing.

List of Archival Materials:

My materials were collected at: (1) the Rockefeller Archive Center in North Tarrytown (NY, USA), (2) the New York Public Library, (3) the Library of the New York Academy of Medicine, and (4) the city archives of Vantaa in Finland. My materials include different types of archival records, presented as follows.

A. Materials Directly Related to Rockefeller Foundation Activities in Finland

Travel Reports

Travel reports are reports authored by officials of the Rockefeller Foundation while on assignment to collect information on different features of Finnish society, its political system and the state of its public health. The reports include RF representatives'

views on the Finnish health care system and the education of its doctors and nurses in the 1920s. The reports are based on visits to different parts of Finland, meetings with voluntary and public administrators, educators, public health workers, policy makers and members of occupational associations. The reports are described in greater detail in the empirical chapters where they are used as materials.

Official Diaries of Rockefeller Foundation representatives working at the New York and Paris offices of the Foundation who had a stake in the Finnish projects

This material include documentation on: (1) visits, meetings and conferences that describe the discussions of the training of public health nurses and midwives and the organization of local public health nursing (in North America, Europe, Scandinavia, and Finland), (2) Personal contacts with Finnish RF fellowship holders (nurses, doctors, educators and administrators). The Rockefeller Foundation's officers and staff kept diaries of their day-to-day contacts and impressions in order to maintain an accurate record for guidance of the staff and to assist the trustees in funding decisions.

Correspondence

Correspondences include official and more casual official letters written by RF representatives in Paris and New York City and by Finnish officials employed by the Finnish State Board of Health, the State School of Nursing/Graduate School of Public Health Nursing in Helsinki, and doctors and nurses in charge of the model training field in the Municipality of Helsinki.

Records of Rockefeller Foundation fellowship holders

The records document in detail the individual curricula of the nurses, doctors and administrators who visited the U.S. and Canada in the 1920s and the 1930s while on RF fellowships for public health studies. The records also include information about their educational and social backgrounds and their planned careers within public health.

The Project in the Municipality of Helsinki (Fin. Helsingin maalaiskunta, Swe. Helsinge)

Records on the planning, realization and evaluation of the "Helsinge" project, as it was labeled in the Rockefeller Foundation archives. The project's budget documents were also collected from the RF archives.

B. General Documents of the Activities of the Rockefeller Foundation

Rockefeller Foundation Annual Reports

The annual reports list and describe RF aid to state and local health services in the U.S. and abroad.

Organizational program and policy documents of the Rockefeller Foundation

These documents describe different officials' views of the role of the RF in county (local/municipal/rural) health programs initiated by the RF which were planned together with local actors and funded for a limited period. The policy documents include international comparisons of public health organizations and public health nursing and the divergent opinions on how to train public health nurses. The policy documents also analyze the role of the RF in Europe and the Nordic countries during different time periods. Principles and policies of the different boards and divisions of the RF are also described in these program and policy documents.

Reports on nursing education

These documents are RF-initiated investigations of nursing in the U.S., Canada, Europe and Finland; they reflect the RF's visions of the training and work of nurses and public health nurses:

The Goldmark Study

The Grading Study

Reports on nursing in Europe/Scandinavia/Finland

These documents are described in greater detail in the empirical chapters when they are used as materials in the analysis.

Source History/Material of the Rockefeller Foundation

The Rockefeller Foundation Source History/Material in bound volumes was compiled by Catherine Lewerth. She was an assistant (a "secretary," to use the term of the day) to the RF's President, Raymond B. Fosdick, and under his direct supervision she compiled the history, which was completed in 1949. Lewerth was born in 1912 and received a B.A. from Smith College in 1933 and an M.A. from Columbia University in 1934. The contents of the Source History/Material volumes are in chronological order and are viewed as thematic sections. (RAC, RF, RG 3.1, Series 900, Hist-1, volumes 1, 8, and 9 are used in this study)

C. Materials on Rockefeller Foundation-Related Contexts of Public Health Activities in New York

Public health in New York City

Documents that are related to the context of the domestic activities of the Rockefeller Foundation in the area of public health include: 1) Histories of public health organization in New York, which was the pioneering city for American public health in large urban areas; 2) Histories of the Henry Street Settlement, the first large-scale visiting nurse service; 3) Occupational magazine of the early visiting nurses, *The Henry Street Nurse* bulletin; and 4) documents related to the development of nursing education in the U.S.

1) Histories of public health developments in New York City:

- a) *A History of Public Health in New York City, 1866–1966.* (John Duffy, 1974, New York: Russell Sage Foundation)

The book dates the initiation of public health in New York to 1866, and describes the developments of public health in New York City in the hundred years that follow. The book discusses maternal and child health reorganization, progress, health reform and health districts. Its argument is that the concept of public health became much broader than it was initially. The book includes illustrations and statistics.

- b) *One Hundred Years of Health: New York City, 1866–1966.* (Leona Baumgartner 1969, In: *Bulletin of the New York Academy of Medicine*, Vol. 45, No. 6: 555–586.)

Professor Leona Baumgartner was Chairman and Commissioner of the Board of Health of New York City 1954–1962. She identifies, in retrospect, seven critical elements of the public health developments in N.Y.C. which reflect the professionalization of public health.

2) Histories of Henry Street Settlement

- a) *The House on Henry Street* (Lillian Wald, 1915, New York: Henry Holt)

- b) *Windows on Henry Street.* (Lillian Wald, 1934, Boston: Little Brown, and Company)

These books describe the new concept of a public health nurse. Immigrants and the social change associated with immigration are discussed in the local context of the East Side of Lower Manhattan near Chinatown. These books describe the settle-

ment activities on Henry Street and the visiting nurse services in a large district of Manhattan. Public health nurses are described as professionals participating in social reform work.

3) *The Henry Street Nurse* bulletin (1921–1924), Library of the New York Academy of Medicine

The Henry Street Nurse bulletin was an occupational magazine for public health nurses and their leaders. Its contents describe and discuss different dimensions of visiting nursing and its role in local public health work. The role of the nurses and their supervisors as educators and civil servants in the local community transmitting expert knowledge to the population is also widely discussed in the bulletins.

Collected bulletins:

1921, Vol. II, No. 1, 3, 4, 5, 6–7, 8–9 and 12.

1922, Vol. III, No. 2–3, 4–5 and 11–12.

1923, Vol. IV, No. 1–2.

1924, Vol. V, No. 11–12

D. Complementary Materials on The Finnish Public Health Context

Additional materials were also collected to gain a more comprehensive understanding of the context of RF collaboration and public health nursing in Finland. These include:

Documents from Vantaa's city archives

These materials are related to the history of the Municipality of Helsinki (today some parts belong to the city of Vantaa), and the public health developments in that municipality. Materials on the health center in the Municipality of Helsinki which was the first Rockefeller Foundation project in Finland were also collected.

Articles in occupational journals

Articles dealing with the education of public health nurses and with the experiment in the Municipality of Helsinki were collected from occupational journals for nurses, public health nurses and midwives. Additionally, a few articles about the health center model in the Municipality of Helsinki, written by doctors working at the center, were collected from miscellaneous magazines.



PART III

Windows of Opportunities

Scientific Philanthropy As a Catalyst for Early Public Health Nursing

4.1 Introduction

The interplay between large philanthropic organizations, charity organizations' networks and settlements allowed conflicting values concerning humanism versus science, purpose versus knowledge, social action versus theory, and function versus cause to continue in the beginning of the twentieth century (Germain 1970 and Pettersson 2001).

As stated earlier (see Chapter One), some social scientists have viewed organized philanthropy as an embryo of modern social policy (see discussion in Förhammar 2000: 32–33) and as an opportunity for charitable women and female philanthropists to enter the public professional field and to have an impact on the professionalization of social welfare and health work and primary education as well (see, for example, Jordansson and Vammen 1998; Hatje 1999). As described in the introduction chapter, philanthropists had a stake in the project of creating "a better world," and their activities influenced public welfare policy makers as well. This made room for a public health nursing which had a broadly defined jurisdiction. Therefore it is important and interesting to examine the role of the activities of the Rockefeller Foundation (RF) as a possible catalyst for local public health policy and the formation of public health nursing for the community in the changing scope of public health.

In the next section, I will discuss different reform cultures in the field of social reform work. The shift from traditional Christian charity toward organized scientific philanthropy as models for welfare reform work in the local community in the beginning of the twentieth century influenced the professionalization of carework in the community. In particular, I analyze the interplay between these two shifts of overriding values in the philanthropic and the public health nursing fields in the inter-war period.

The division of labor in the local inter-war social reform work that took place, both in Europe and the U.S., meant that the different social actors redefined their positions

and that the role of the state and regulatory legislation was discussed. This trend towards a new division of labor created vacant jurisdictions also for nursing.

Unlike earlier charity that was parallel to poor relief and based on Christian convictions, scientific philanthropy was based on rational scientific knowledge and an analysis of how social and health problems could be alleviated and prevented. This shift was of course a complex and slow development, but it was an explicit outcome of larger social change that was going on in the industrializing and urbanizing society. The scientific medical model concerning early welfare work and adopted by the Charity Organization Societies (COS) among others in England and the U.S. confronted the more pragmatic social science model which the settlements represented (Pettersson 2001: 63–65). Furthermore, there was a division between more theoretically oriented and practice-oriented fractions within the “social science” model. The different reform cultures were all engaged in and motivated by a struggle for a “better world.” The endeavor was to produce a type of knowledge about society that could be used for preventive efforts aimed at constructive social change in poor districts in both urban and rural areas. Areas that were facing rapid social change or areas with slow social development, were typical social settings where the welfare reform workers were active.

The COS and settlement settings of welfare work provided a gateway for gradual growth of public responsibility and government-supported collective social reforms, although the focus in the work of both the COS and the settlements was on the individual and change in the morally conducted individual behavior (see, for example, Owen 1964). These activities contributed to the establishment of new counseling occupations in the fields of social welfare and public health.

In the third section, I present a short analysis of the role that large philanthropic foundations, particularly the RF, played in the U.S. in cooperation with federal governments or states with regards to welfare building and how the Foundation’s ideas disseminated abroad. My purpose is to show, by following the notion of formative negotiations, that the dissemination of ideas of morally coded scientific philanthropy, scholarly scientific knowledge about public health and of thought outcomes of scientific philanthropy on social reform work, were used to build an international understanding between very different states and cultures in the inter-war period. The foundations played a part in international social reform work which sought to influence regional and local political decision making.

It is important to think about the ways in which the RF influenced health policy-making with regards to the training of public health personnel in the inter-war period. One critical boundary event in my dissertation that can be traced in my collected materials is the philanthropists’ negotiated support for educational institutions and training programs for both doctors and public health nurses in the U.S., and in foreign countries, among them Finland. Another critical boundary event is the philanthropists’ negotiations with voluntary organizations, public authorities and

educational institutions in the shaping of local institutional settings which would adopt and maintain the new ideas of health nursing. The local rural health center model, where the public health nurses were seen as central actors, is one example of such an administrative strategy. Both of these critical boundary events had their initial phase in the broader international developments and cooperation in the field of education, social welfare and public health.

I have listed here both general and specific questions that summarize the focus which I have chosen to describe the role of a large foundation as an international health organization that operates on both international and local arenas. What were the developments that enabled the emergence of large-scale foundations? What were the motives, and how and for which audiences did the foundations introduce innovative approaches? How did the RF work with governments, voluntary organizations and educational institutions? Did it take a direct advisory role or did it build networks? In what ways did the policies and programs of the RF support or restrict the professional project of public health nursing at an international as well as at national and local levels?

In the following three sections, I view the type of welfare work that became professionalized and was traditionally categorized as women's carework similar to women's domestic work. The traditional carework was however extended by issues that had their background in the scientification of society. Ideas such as case-finding scientific philanthropy were a basis for the reform-oriented settlement work that nurses performed. I view different meanings of the three empirical notions of 'scientification,' social casework and 'self-help,' through an analysis and interpretation of my collected materials, and by making a link to earlier and more recent scholarly knowledge which social scientists have developed about the social history of these notions.

I finish the chapter with a short orientation into the Finnish situation in the 1910s regarding social welfare and public health. As the particular context for Finnish public health nursing is Finnish society, which, during the 1920s as a young independent nation, followed international ideas more closely, it is interesting to examine the idea of scientific philanthropy as an elementary form of welfare policy that precedes the activities of the Finnish welfare state.

The kind of analysis of boundary-work presented in this chapter helps to shape idiosyncratic knowledge about how the formative stage of public health nursing was related to broader social and public health reform work in the beginning of the twentieth century. In this chapter, scientific philanthropy is viewed as a fertile basis for early welfare state building in Finland. The role of specific 'scientification,' social casework and 'self-help' as ruling ideas for women's professional carework is also explored.

4.2 The Shift From Traditional Charity Toward Scientific Philanthropy

Early nineteenth century religious philanthropy and its “ideology of help” can be described as a bridge between two different social formations: an older society dominated by agriculture and a modern society molded by industrialization and urbanization, with its more materialistic values and objectives (Owen 1964 and Himmelfarb 1991). The new kind of philanthropy of the late 1800s reduced its dependence on religious motives to help and assist. The focus shifted from charity work among the poor and sick to more focused social, economic and cultural activities in the fields of social reform, health care and education. There was a radical change in the relative domains of private charity and public action. The treatment of poverty in industrialized societies first involved voluntary agencies but the role of early public social services in a state that renders social aid started to change from a supplementary form into a more responsible one (Owen 1964: 211–215). The term “scientific charity” was used in British research to draw attention to a particular variant of secular philanthropy, which had its roots in late nineteenth century England (Owen 1964: 215). This new philanthropy has been termed “the science of charity” by American historian Himmelfarb (1991) in her study of Late Victorian England; in the Swedish context, it has been called “organized philanthropy” (Swe. *ordnad filantropi*—see Förhammar 2000: 23–28, 46–51). Bremner (1994: 139) uses the term scientific philanthropy.

In England (Owen 1964), the laissez-faire state was transformed into a state which renders social aid in around 1870. Norwegian social historian, Anne-Lis Seip (1984), has identified the period 1870–1914 as a development from seeing the individual as a norm for social organization towards more collectivist ideas about social responsibility. In this new context, social problems were to be solved as interactions between private and public actors who had a mutual understanding of a civilized, healthy society. However, the roots of social change were still seen as a change in individual behavior, not as a creation of supportive public social structures and institutions. In early nineteenth century philanthropy, social problems were perceived within a moral framework in the terms of the shortcomings of individuals. David Owen (1964: 211), who has examined English philanthropy from early modernity to the 1960s has characterized the early nineteenth century philanthropy as follows: “Broadly speaking, the Victorian ethos ascribed such evils as poverty, destitute old age, and even much of the suffering from unemployment to individual inadequacies rather than to any more general failure of social mechanism.” Social thinking about social problems was limited; it lacked social knowledge and social imagination. According to Seip, health promotion remained long as a responsibility for private and voluntary organizations (Seip 1984: 183, quoted in Förhammar 2000: 15).

Swedish historian Staffan Förhammar (2000) has investigated the Swedish public debate on philanthropy during 1870–1914. He investigated the shift from charity

based on compassion with the joy of giving as focal point toward a professionalized and scientifically based philanthropy (Förhammar 2000: 229). According to his study, ideas concerning public responsibility for the well-being of individuals within philanthropic work began to emerge at the end of this period. The ideas behind this new scientific philanthropy were, as in England, oriented towards self-help. Among philanthropists, there were divergent views on the issue of how much cooperation there should be between private and public efforts to struggle against poverty and other social problems. Another central issue in the Swedish debate was to what extent philanthropic activities were a case of traditional Christian charity directed towards the individual or part of broader social reform work aimed at social change with both governmental and private initiatives and responsibilities. Actors preferring aspects of the new scientific philanthropy emphasized criteria such as knowledge building, long-term planning, education and information to reach the goal of producing "responsible citizens" (Förhammar 2000: 46-51)

American researcher in history and philanthropic studies Lawrence J. Friedman (2003: 4-5), states that it is difficult to define the distinctions between individual charitable acts and more organized philanthropic ventures. Charity and philanthropy themselves can have multiple and shifting meanings depending on what social field is in focus; for example, there are more general public discourses, religious experiences or reformist climates; there are also more institution-bound phenomena such as singular philanthropic institutions, social service systems, war relief administration or educational institutions. For example, in a recent edition of Webster's dictionary "philanthropy" was defined as a "service, act, gift, [or] institution" (quoted in Friedman 2003: 8). From a sociological point of view, an examination of the kinds of dichotomies that were challenged by the shift from individual charitable acts towards more organized philanthropy is of interest. Such dichotomies are the relations between private and public and the separation between church and state in modern society. Another interesting sociological point is to analyze how the shift voices concerns about different subordinated and less powerful social groups. In the context of this dissertation, namely the formation of a new women's occupation in public health, gender relations and the knowledge base are challenged, and the class composition sought for the new public health nurses is debated when the boundaries for the new occupational activity are shaped.

Some social historians of the 1970s, who usually are oriented on class-conflict and social control, define and use the concept of philanthropy as a relation between rich and poor, a relation with a disciplinary and regulatory aim (see the discussion on definitions of philanthropy in Förhammar 2000: 23-28). They emphasize the transmission of values present in the upper classes during certain historical periods into the lower classes in society. The "well-being of society" did mean the control of lower-class and deviant populations to enhance the profits of the ruling-class and social stability (Friedman 2003).

The understanding of public health as primarily downward social control has been altered by research that, although critical, has sought to study the actors' own understanding of their activities as work with society's best interests in mind (Oakley 1984 and Wrede 1991). The social actors involved in different kind of philanthropy, both donors and recipients, defined their own actions and purposes in the social context where philanthropic activities took place. This kind of grassroots-level reflection supported the shaping of practical knowledge based on individual experience.

Similarly, the English historian Frank Prochaska (1980) has examined philanthropy with the hopes of understanding the basics of how different actors in philanthropy view their moral obligation to perform altruistic acts. Prochaska has examined the women's role in philanthropy in nineteenth century England. He emphasizes the deep religious commitment of the women who engaged in this early philanthropy to "do good" and to care for different groups in the society. In this setting, philanthropy was defined as "love of one's fellow man, an action or inclination which promotes the well-being of others" (Prochaska 1988: 7).

Hewa (1998a and 2002) provides a concrete theoretical and empirical framework that helps to identify the intricate contours of large-scale American philanthropy and its wider cultural context. Hewa examines donors' motives, the unfolding dynamics in the relationship between the donor and recipients, as well as the cultural and social values that shaped the activities of individual philanthropists and major philanthropic foundations around the world in a broader social context. He emphasizes that the Christian tradition was still present in the new form of scientific philanthropy, but was transformed to fit the Protestant ethos on rationality (Hewa 2002). From this perspective it becomes important to understand how the actors define the public good, which they define as their goal in the industrialized and urbanized societies, and how they acted to reach their goals.

Scientific philanthropy offered a new solution to what has been described as the "most urgent moral dilemma" of late Victorian society (Owen 1964: 212). Collective action designed at remedying social abuses and the promotion of individuals' well-being needed to be designed so that personal responsibility and the individual's initiative are maintained and encouraged. Specific issues to be reformed were the conditions of the aged and the unemployed who were permanently or temporarily unable to earn their living. Education, housing and medical care were to be improved, in order to improve the life conditions of all groups in the population.

There was a general movement at the turn of the twentieth century toward viewing all aspects of life, including social welfare, in scientific terms. The motto of the philanthropists was to give those in need of social assistance help so they can help themselves. Three fundamental features characterize the optimistic and progressive spirit of middle-class social reformers of this historical period (Himmelfarb 1991). First of all, they believed that science was a solution to social problems. Secondly, they perceived their task as that of reforming those who suffered from social problems

into civilized people. Thirdly, they perceived their own role in society as privileged members of the middle class who should be dutiful members of society and who were fulfilling their obligation to mankind. The scientific management of society entailed that not only scientific phenomena in nature be discovered and explained, but also social conditions and the social environment should be charted, described, classified and illuminated. The scientific method was the means and social action the goal (see Figure 4.1).

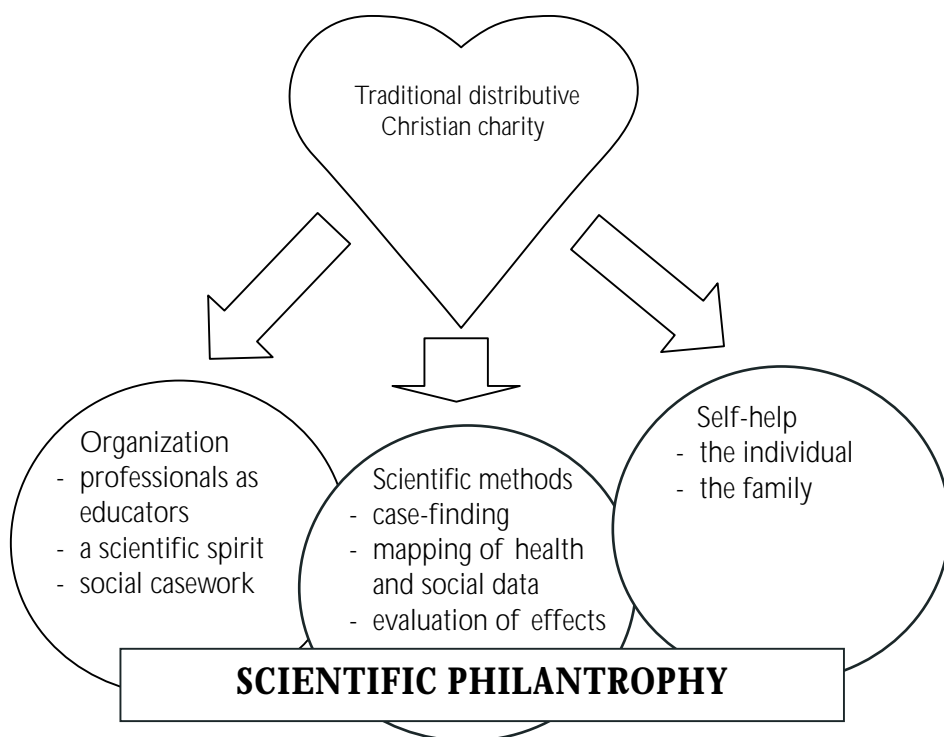


Figure 4.1 Shift from traditional Christian charity toward scientific philanthropy

Present-day analysis of philanthropy of the early twentieth century locates it in a wider social, cultural and historical context. Myron Magnet (2000), editor of the *City Journal* in New York City, reflects over the role American philanthropic foundations have played in initiating social reform while at the same time applying social control to prevent feared social conflicts:

Philanthropy in the nineteenth and early twentieth centuries concentrated on education and acculturation, on moral reclamation and rehabilitation—on turning lives around and getting people on the right track. It cared as much for the mind and soul as for the body. Abhorring the idea of dependency, it aimed to make its beneficiaries self-sufficient. Unwilling to leave the poor marginalized, it sought instead to bring them into the mainstream, to make them fully American, fully working class or, whenever possible, middle class (Magnet 2000: viii–ix).

4.3 Instrumental Roles of Scientific Philanthropists in International Welfare Building

Large foundations, such as the Carnegie Foundation and the Rockefeller Foundation, had a stake in formulating educational strategies which have had an impact on the knowledge base and modes of practice in the medical division of labor in the U.S. and elsewhere. Some investigators point out that larger foundations in the U.S. have played a critical role—either alone or in partnership with governments and businesses—in funding scientific research, implementing new social service programs, bridging the gap between programs' pilot stages and full program implementation, supporting social movements, sustaining many of the non-profit organizations in the U.S. and elsewhere and the designing and testing of new policy ideas. Other social investigators view foundations as powerful organizations which have had close relationships with actors at the top levels of power in the political economy of health care. The partnership between medicine and corporate capitalism has been especially criticized. According to these critical viewpoints, foundations' activities have restricted access to services and limited medical science's ability to improve the general health of the public. Critical analyses emphasize that the foundations supported an increasingly technological market system of medicine which failed to deal with the chiefly socio-economic causes of illness.

By the 1920s and 1930s, reform-oriented philanthropists and welfare workers in Europe not only recognized that their own position was changing but suspected that, as the trend to regulatory state action accelerated, it might be revolutionized. It was evident that the state could intervene more decisively in social affairs than before and that the scope of private charity needed to respond to such social change. In the inter-war period, the production of social services gradually passed from voluntary agencies to legislative public services. Both large and small philanthropic foundations developed into "junior partners in the welfare firm" and "auxiliaries of the welfare state," as David Owen (1964: 527, 554) describes this process in his characterization of twentieth-century philanthropy.

Social historian Merle E. Curti (1963) has studied American philanthropy abroad. He emphasizes the special impact of large-scale foundation-funded philanthropic work on welfare building. Large charitable trusts whose commissions allowed them to pursue broad agendas had an important role for changing the scale of philanthropy as new resources were brought to the field. The rapid industrialization and urbanization in the United States and its transformation into mass production resulted in the emergence of a new type of industrial tycoon, whose private wealth was more substantial than that of previous capitalists. Two particularly influential organizations were the Carnegie agencies/Foundation and the Rockefeller Foundation, of which the latter was the only major inter-war American foundation to act worldwide.

The RF included in its programs work that it defined as activities for improving international understanding. It contributed indirectly to these activities through the promotion of research in the field of health in many countries. Direct support entailed subsidies to agencies that were in its view committed to the advancement of international understanding. Such agencies included the Foreign Policy Association, the Council of Foreign Relations in New York City, the Canadian Institute of International Affairs, the Geneva Research Center, the International Studies Conference at Paris, the Institute of Economics and History in Copenhagen, and the Royal Institute of International Affairs in London (Curti 1963: 305). According to the RF, these institutions operated, as did the Foundation itself, on the assumption that “the increase and diffusion of knowledge” was an essential factor in promoting international peace and understanding (Curti 1963: 305). In the 1930s, a period characterized by worldwide growing tension, this interest in promoting international understanding increased. In the Annual Report of 1938, the Rockefeller Foundation policy abroad is described as follows:

Friendly relations between nations must be based on an intelligent understanding of the contribution *which each is in a position to make to the other. Too often cultural values have been conceived as something that one nation offers to another, and the other, if enlightened, thankfully accepts. But this one-sided arrangement, if it works at all, is apt to produce unhappy results.* Moreover, it sacrifices at the start half the advantages that could accrue. (Rockefeller Foundation Annual Report 1938: 56, emphasis added)

Three developments which enabled the emergence of foundations at the end of the nineteenth and the beginning of the twentieth century have been identified by social historians and social scientists. First, the emergence of the great industrial fortunes in America resulted in a concentration of wealth. Without this, wide-ranging philanthropy would have been impossible (Karl and Katz 1979).⁷

Raymond B. Fosdick, who was the president of the RF for twelve years, from 1936 to 1948, and a trustee since 1921, later published a history of the RF, in which he focused on the early period of the RF and his term as its president (Fosdick ([1952] 1989). During his years in office, the RF founded institutions of advanced scientific research at home and abroad. As a very large grant-making endowment in the world during that period, its influence was considerable.

Fosdick gives a detailed historical description of the early formative period of the foundation. A triangular, long lasting partnership between John D. Rockefeller, Sr., his son John D. Rockefeller, Jr., and Frederic T. Gates, a former Baptist minister, led to the establishment of a group of foundations to which Rockefeller Sr. ultimately contributed nearly half a billion dollars (Fosdick [1952] 1989). On June 29, 1909, Rockefeller Sr. signed a deed of trust, turning over to three trustees—his son, his son-in-law Harold McCormick and Mr. Gates—Standard Oil Company shares valued at \$50,000,000. The trust was to be known by the name of “The Rockefeller Foundation.” Its purposes were stated in a charter at this point, and and this was included word for word in a bill that was introduced in the United States Senate

in March, 1910, which made the Rockefeller Foundation an incorporation. The purposes were stated as follows:

That the object of the said corporation shall be *to promote the well-being and to advance the civilization of the peoples of the United States and its territories and possessions and of foreign lands in the acquisition and dissemination of knowledge*; in the prevention and relief of suffering and in the promotion of any and all of elements of human progress. (Fosdick [1952] 1989: 17, emphasis in the original text).⁸

Representatives of Rockefeller Sr., who participated in the attempt to secure a federal charter, expressed the purpose behind this request by asserting that:

The donor is perfectly content to leave this great foundation in the hands of Congress, that it may at any time in the future exercise its protecting power, not merely to protect his wishes, which are solely that his fund shall always be used *for the public welfare and for no other purpose*, but also that Congress may have the power, if at any time in the future this fund should get into the hands of men who might seek to use it for improper purposes, to exert its authority and bring this fund back again to the use for which it was intended (Fosdick [1952] 1989: 16, emphasis in the original text).

In Fosdick's view, the RF's programs should be grounded in national and local democratic decision making:

The motive actuating the incorporation of The Rockefeller Foundation and expressed in its charter, is the desire to make this munificent gift directly *to the whole American people, and forever subject to the control of their elected representatives*. This provision not only possesses a sentimental advantage which the charter of a single state would not afford, but it expresses an implicit confidence in the stability of our national life and in the will of the people to deal justly now and forever with the high purposed foundation (Fosdick [1952] 1989: 17, emphasis in the original text).

However, it took more than three years for the bill to be accepted at the Congress. During this three-year period the bill was at the center of violent public controversy. Discussions in Congress reflected bitterness and distrust. One reason for this was the scandals that surrounded the Rockefeller-owned Standard Oil Company, which had led to a Supreme Court decision upholding the government and ordering the dissolution of the company. This decision was made while the question of the RF charter was being debated in Congress. An earlier statement of the purpose of the RF was shortened when the act finally passed in Albany in 1913, with the motto "to promote the well-being of mankind throughout the world" (Fosdick [1952] 1989: 20).

The second development to make large philanthropic institutions possible was the rise of modern science and the emergence of the modern research university that placed a new emphasis on research into the causes of social problems. Philanthropists' wealth derived from or increased by scientific discovery. The researchers placed the development of philanthropic institutions into the context of the social reform movement of the Progressive Era. Furthermore, they emphasized

the importance of the transition from the idea of charity to the idea of philanthropy (Karl and Katz 1979) and the spirit of capitalism (Hewa 1997 and 2002). This shift was similar to that which had come about in England. The new social reformers aimed at broad social and economic change through fundamental reorientation of basic social, economic, and political institutions, by which it was hoped life at both individual and public levels would improve. Extending the reach of public education and promoting public health were reforms that aimed at helping people to help themselves and permit the public wheel to co-exist with industrial progress. The foundations developed programs designed to deal with the local community and its concerns, not with the problems of federal government, and in a sense they created a national system for doing what the local community was supposed to do. One example in the U.S. of their investment to the local community is the establishment of local health centers which provided general public health services.

According to Hewa (2002), the broader historical background of the educational reform is inadequately understood. Hewa points out that medical education reform in the U.S. was part of the broader social changes which took place in the late nineteenth and early twentieth centuries. In a time of rapidly expanding industrial economy there was a need for modern scientific education to provide a well-trained industrial labor force, including properly educated medical professionals, scientists and engineers. Long before the Flexner report (Flexner 1910), prominent educational reformers such as Charles W. Eliot, William R. Harper, Daniel C. Gilman and William H. Welch worked for the establishment of scientific education. These educational reformers and their schools implemented scientific education and promoted the development of a new generation of scientifically oriented universities in the U.S., such as Harvard and Johns Hopkins University. Educational reform in medicine was proposed by the Rockefeller Foundation as early as the late nineteenth century by Frederick T. Gates, a trusted advisor of John D. Rockefeller's. Gates proposed fundamental aspects of educational reform in medicine; this was influenced by the growing biomedical model and the germ theory of disease.

A third development identified which laid the groundwork for philanthropic institutions was the kind of collectivism and corporate politics that emerged in American public life during the early twentieth century (Karl and Katz 1979). This was an American alternative to socialism and the welfare state, in which the American private sector could retain its dominant position in the formulation of public policy. Cooperation among corporate management, the federal government and the labor movement were constructed to harmonize disparate social interests (see also Hofstadter 1955).

John A. Ferrell (1933) who worked as Associate Director of the IHD of the Rockefeller Foundation for several years and was President of the American Public Health Association, delivered a presidential address before the American Public Health Association's sixty-second annual meeting. He pointed out some major movements in the advancement of public health and scientific medicine that, in his view, have

been distinctively American. America had steadily gained ground as leading nation in the application of knowledge to the control of communicable diseases. The RF's International Health Division and its studies of and systematic control of yellow fever for several years, for example, had resulted in new scientific knowledge that could be used for effective control of this virus disease. The scientific movement of applying etiological, serological and bacteriological knowledge in the development of standard methods and control measures of disease (e.g. diagnostic laboratories and pasteurization of milk) had stimulated the establishment of boards of health in many states in the U.S. during the 1860s and 1870s. Already in 1873, 134 cities had some form of public health services in the U.S. (Ferrell 1933: 1116).

An other major movement which Ferrell reflected on, was the effort to disseminate popularizing public health knowledge to the masses, aiming at spreading of "the gospel of health" (Ferrell 1933: 1117). Educational divisions within the official health agencies had produced printed health education materials for magazines, newspapers, bulletins and leaflets. The radio had begun to spread health knowledge and courses in hygiene were given at colleges and other schools. Even advertisements and product labels included health messages.

Ferrell (1933: 1117) noted the influence of the interplay between numerous voluntary health organizations, philanthropic foundations and official health agencies. Ferrell saw these joint actions as stimulating for the research, for health demonstrations and for the training of personnel within public health. The passing of progressive legislation and the provision of increased health appropriations in the U.S. were dependent on established voluntary actions and the experiences they had brought. Governmental agencies had an important role in the maintenance and expansion of the public health work that the voluntary actors had initiated and promoted. Ferrell argued that the long-term administrative and financial responsibility of public health activities should lie in the hands of the governmental agencies.

The causes to the developments which enabled the emergence of philanthropic institutions and their impact on public health developments that I describe above are viewed more critically by Richard Brown (1979), who adopts a political economy perspective in his book *"Rockefeller Medicine Men."* In Brown's view, American foundations and governmental leaders in the field of medicine had failed to create a health care system that would serve the majority of the population. Instead, the organization of health care served the needs of capitalism and the interest of capitalist economic and social interests (see also Navarro 1976). Capitalist and corporate managers believed that scientific medicine would improve the health of society and society's work force and thereby increase productivity.

Through his analysis, Brown demonstrates that the rise of scientific medicine and the reform of medical education at the turn of the twentieth century required the support of both the medical profession and wealthy capitalists. Brown (1979: 3) argues that scientific, biomedical research and the development of technological

medicine funded by foundations such as the RF was not the determining force in the development of modern health care. Rather, members of the medical profession and the corporate class used it as a tool to serve their perceived needs. Brown assigns the RF a prominent role in this development: "With the Rockefeller philanthropies in the lead, these foundations developed strategic programs to legitimize the fundamental structure of capitalist society and to provide for technical needs" (Brown 1979: 9).

Brown puts forward an important argument about the role of the RF for the social shaping of the medical profession. He claims that the Carnegie Foundation funded Flexner report of 1910 had a negative impact on both medical education and the opportunities for women to enter the medical profession. Brown illuminates the background and consequences of the Flexner report from a critical perspective. Other researchers, who have investigated women's position in the American medical profession, have also called attention to the way that the Flexner report limited the opportunities of women to enter the field of medicine (Walsh 1977; Morantz-Sanchez 1985; More 1999 and Riska 2001).

Critical analyses of American philanthropy help make the gendered power relations in a patriarchal, capitalist and mainly market-based health care system visible. However, it fails to keep in sight the less powerful social actors that nevertheless influenced health care reform. In the shadow of the actions of the powerful "medicine men," there were other less powerful but still important social actors both inside the RF and in close collaboration with the RF. They played important roles in the complex negotiated processes through which the shaping of the policies and programs of the RF took place. They acted as mediators, investigators, educators and implementers, whose task was to build and maintain networks between the different actors. One such group of social actors was the RF officials with a nursing background who were involved in a domestic and international network of nursing reformers. Also RF officials with a background in medicine and who promoted public health nursing in the local public health organizations had a stake in the key negotiations on the issue of public health nursing education. This group of RF actors are part of my empirically created categories of "professionalizers," "PH-activists" and "implementers" of public health programs with regards to Finnish-American co-operation.

4.4 Social Casework—Supporting Self-Help

Two empirical characteristics within scientific philanthropy which are observable in my materials are social casework as a way of organizing health nursing in the community and the support of 'self-help' as an educational strategy for early local health educators. These notions are important to outline in order to build an understanding of the knowledge base and modes of practice in inter-war public health nursing. There is both a charitable and scientific spirit built into the measure of

social casework and means of supporting self-help which was adapted at the Henry Street Settlement where the Finnish RF fellowship holders studied American public health nursing in the 1920s and 1930s. Patterns of this kind of early welfare work were also part of the generalized public health nursing model supported by the RF and adopted in the activities of the health center experiment in the Municipality of Helsinki in the beginning of the 1940s.

Swedish social scientist Ulla Pettersson (2001) shows in her comparative historical research on the formation of social work in the U.S. and Sweden that there were two contrasting traditions in social work in the early twentieth century U.S.; the charity-based or social casework tradition directed towards the individual and the family, and the social reform tradition or settlement tradition directed towards the local community and society as a whole. When it comes to health nursing, a combination of the individualist and the collectivist approaches towards carework in the local community can be identified in my materials on the RF and early public health nursing. The social casework tradition was introduced in Finland by RF fellowship holders (Härkälä 1992: 53–58). Although the nurse/social workers who had an American education implemented this new method in Finland, it was further developed by Finnish social workers in Finland in the 1950s.

Two of the pioneering professionalizers of Finnish public health nursing, Venny Snellman and Tyyne Luoma, have interpreted and evaluated the role that the RF has played in nursing developments in Finland during 1930–1950.⁹ Luoma states that “the new philosophy of education,” and “new teaching methods” and “principles of individual and group work” that she studied as a RF fellowship holder in North America in 1932, produced an entirely new way of looking at public health nursing education in 1930s Finland (Tyyne Luoma in December 1950, see note 9). New trends such as family health service, which were adopted in the generalized public health nursing model, “had a very remarkable influence towards a new and more advanced concept of public health nursing service,” Luoma continues. Snellman declares that the demonstration of such social casework, an earlier “unknown concept,” was an “eye-opener” to leaders of both public health nursing and social work in Finland (Venny Snellman in January 1951, see note 9). Snellman also emphasizes that the teaching of the principles of social casework at the University of Helsinki by a nurse-social worker and former RF fellowship holder, “no doubt [influenced attitudes] toward nursing at least in some university quarters.”

American social historian Gertrude Himmelfarb (1991) has examined the ideology behind one of the direct precursors of scientific philanthropy in England, the Charity Organization Society, otherwise known as the COS, in her work *Poverty and Compassion—The Moral Imagination of the late Victorians*. A case-study of COS illuminates the shift from traditional charity toward scientific philanthropy and also how traditional domestic “women’s work” became defined as a more public issue. The COS in Britain redefined the concept of poverty and pauperism by its function within a larger social framework that comprehended both the private and the public

sphere. It made a distinction between poor relief (under the New Poor Law of 1834) and charity (under philanthropic organizations). Similar activities were carried out in the Nordic countries. One prominent example is the international Goutte de Lait movement, but there were many voluntary child welfare organizations founded at the turn of the twentieth century (Weiner 1995 and Wrede 2001).

The strategy of the COS and similar Nordic philanthropic organizations was to reserve charity for the “deserving poor,” people who were employed and might even have savings or possessions (Himmelfarb 1991:189). Poor relief should be given only to indigent and dependent laborers. The sick and elderly were not to be entitled to charity; they were the responsibility of the state under the poor law. Character remained an important criterion for charitable assistance because only those of good character were “helpable.” The “cases” that were entitled to charity were “selected” by using social casework as a “scientific” technique or tool. The early form of social casework was a method used to identify those poor who were in need of temporary assistance and who were worth charity and to give them the kind of charity which suited them.

The COS believed that the needs of applicants were to be carefully assessed (Pettersson 2001). Also, their ability to profit from assistance was essential. Registers of detailed case records of the applicants and their families were created. The method of social casework used was a process of collecting data about each family’s condition and needs, the disposition of the case. This was followed by follow-up investigations. These “visitors,” who obtained this information, were at first volunteer workers and later paid employees. They reviewed the eligibility of applicants for receiving aid, monitored their progress and gave them counseling on how to avoid problems in the future. Visitors also contacted neighbors, relatives, parish ministers and school officials in order to examine the lives of applicants.

Support of self-help remains a central principle in the COS’s statements in the revised edition of their *Principles of Decision*, published in 1905. The text states: “We have to create charity to create the power of self-help” (Himmelfarb 1991: 190). The principle of philanthropists was that when charity is to be distributed, the character of the potential recipient needs to be taken into account. Those individuals who will become self-supporting from assistance are to be selected for charity. COS distributed a form to the applicants which stated that “The Society desires to help those persons who are doing all they can to help themselves, and to whom temporary assistance is likely to prove a lasting benefit” (Himmelfarb 1991: 190).

The moralistic ethic that guided the COS’s social casework may appear reactionary and controlling, but from the perspective of the formation of new professional jurisdictions it was pioneering. The casework techniques that were to become the staples of social work were developed. Contemporaries perceived COS casework activities as “organized forms of purpose and method” (Himmelfarb 1991: 193). Casework and visiting were perceived as the necessary means to achieve the COS’s

objectives. The goal was to select the families that qualified for being a “case” for charity. Once selected, the casework helped to determine their needs, and to make sure that the charity was given in the most suitable form possible—a grant or loan for the purchase of clothing, coal, tools, merchandise, a sewing machine, a mangle, a surgical appliance or a stay in a convalescent home.

The COS prided itself on being rehabilitative rather than merely palliative. Visitors maintained contact with each family and exerted the kind of personal influence that helped the family become and remain self-supporting. In this kind of early social work activity, a social doctrine based on the family and an economic doctrine based on the individual co-existed.

The “visiting” aspect of social casework is another interesting feature to examine from the viewpoint of “scientific charity.” The technique of visiting became part of the professional apparatus; the visitors themselves acquired the status of professionals, even when they were unpaid volunteers. There was a dispute about whether or not volunteer visitors were to be paid, like their supervisors and trainers. Another matter that was discussed was what kind of professional qualities should be required of visitors. Paid or not, the visitors were expected to follow “professional standards,” which determined the way that they collected information and conducted themselves in relation to the poor.

In the COS Annual Report of 1870, the visitors were told to behave toward the poor as they would toward people of their own class: “well-to-do strangers should no more knock at the door of a working man without some distinct object or introduction than they should at the door of one in their own rank of life” (Himmelfarb 1991: 195). However, efforts to cultivate a professional attitude did not imply the kind of objectivity that is today identified with professionalism. The warnings of inquisitiveness and intrusion did not limit visitors from inquiring into the specific habits and character of the applicants, or from trying to influence them. On the contrary, these were the “mission” of the visitor.

Donzelot (1979) suggests that an alliance between women and the state was mediated by the activities of philanthropies. The ideologies of domesticity and motherhood were intended to act through women to influence the conduct of men.

4.5 The Friendly Professional Visitor with a Scientific Message

‘Scientification’ presented a new cultural value and provided a context for legitimating jurisdictional claims for occupations such as nursing. The term scientific philanthropy helps us identify and position different jurisdictional claims of the occupation in this formative process. The knowledge base of public health nursing was influenced by the shift from traditional charity toward scientific philanthropy. The trend of scientification of women’s occupations can be traced back to the period when scientific philanthropy was used to demonstrate how promotive and preven-

tive welfare work could be carried out in practice, as social casework with a scientific spirit, which supported self-help. How did these changes towards rationalization affect women's professional carework as nursing?

About thirty years before the establishment of the Nightingale School in London at St Thomas's Hospital in 1860, there were already significant changes in the social environment for nursing care (Dingwall et al. 1988). There was a growing interest of a rather heterogeneous body of women reformers who were concerned with how to make people "good human beings" and how to use social reform work and public health to help to maintain order in society. These leaders were religiously motivated professional upper-middle class women who governed voluntary philanthropic associations at that time alongside male physicians and surgeons. These medical-hygienic reformers engaged lower, middle and upper class women in philanthropic work.

In focus here are the ideas of a knowledge base and modes of practice that were seen as central in philanthropic welfare building and the new professionally coded 'health nursing.' Early women's work outside the domestic field, such as traditional nursing, had been bound to a Christian morality and a rather limited, essentialist view of women's practically oriented occupational activities outside the private sphere. The scientification of female philanthropic work opened up a new kind of occupational authorization that legitimated female occupational activities in the local community.

The scientification of health education described above implied that the knowledge base for a professional jurisdiction for this emerging field was composed using what might be described as a "multi-disciplinary approach." Preventive medicine or "public health medicine" in itself built on the combination of biomedical knowledge with a social perspective and the idea of surveillance as a method for medicine (Armstrong 1983). Public health nursing emerged as a parallel activity, engaged in putting the surveillance into practice. Social research of British society shows that it was divided into the men's public sphere and the women's domestic sphere, and public health nurses were able to enter private homes as missionaries to medical men (Dingwall et al. 1988). Unlike doctors, they could be "mother's friends," even though the relationship was conceptualized as hierarchical (Davies 1988). It was middle-class women who were to be the educators, whereas those in need of education were women of the lower classes.

The family and especially children became the targets of female philanthropic welfare work and health nursing. The knowledge base of these early philanthropic workers interested in promoting health and pioneering visiting nurses was influenced by developments in scientific knowledge within social sciences, social medicine, preventive medicine and pediatrics. The modes of practice adapted the method of social casework. Such inter-war welfare work done with a scientific spirit could deal with health and social problems that were seen as "endangering others" such as tu-

berculosis, alcoholism, prostitution and venereal disease (Steinmetz 1993: 198–202). Other defined areas of welfare work, sought to solve social problems for groups of people in specific “vulnerable or exposed” situations, were youth policy, housing inspection, and health programs for mothers, infants, and schoolchildren.

The main focus was still on the individual but there was a growing interest in broader social reform. One important feature of nineteenth century philanthropic carework was the image of women’s “specific nature,” which made them “especially suited for caring activities” both in the domestic and public spheres (Prochaska 1980; Satka 1995 and Kidd 1996). Prochaska’s (1980, 1988) research shows that caring activities provided by women in nineteenth century philanthropy in voluntary organizations took place both within the lower and middle classes, and between the different classes as well. This conclusion suggests that small-scale philanthropy carried out by women seemed to have a quite democratic and emancipating moral fiber.

American social historian Susan M. Reverby (1987) and Swedish social historian Yvonne Hirdman (1990) identify the idea of “women of character” in early female welfare work, including nursing. According to Reverby, the American medical profession of the nineteenth century wanted to view nurses and other female professionals as its handmaidens (Reverby 1987). In the end of the nineteenth century, however, middle-class women entered different occupations with a social mission. They were not willing to be subordinate. From the point of view of these women, the hospital was an authoritarian social institution where nursing was confined to a narrow role. New kinds of professional roles were made possible by work in the context of different kinds of philanthropic associations.

Reverby (1987:1) investigates in her historical study the creation of a crucial dilemma when it comes to American nursing—namely, how to be “ordered to care” in a society that refuses to value caring. She argues that nursing is a form of labor shaped by the obligation to care and that the history and identity of nursing can be understood only by studying its bond to womanhood. “Women’s work” as nursing has been attached to the relationship between the womanly duty and desire to care for others and the right to control and define nursing as work. The obligation to care has been at the definitional core of nursing, but during different historical eras the balance between nurses’ duties and rights has shifted. In nineteenth century philanthropic women’s carework, the right they gained to control and define a public task, although limited, can be seen as an attempt to challenge the more traditional view of domestic caregiving activities as a “duty.” Nursing reform offered not only practical help to women carers but also a stable and respectable alternative to domestic employment.

These different views about measures within women’s welfare work also influenced the position of nursing. Nursing leaders, educators and administrators in the inter-war period explained problems of nursing, such as unstandardized and disordered occupational activities, as a failure to obtain a professional status and to control the

gateway to the occupation (Reverby 1987; Emanuelsson 1990 and Henriksson 1998). They worked at strategies for upgrading educational standards, obtaining public licensure, introducing efficiency and separating the link between nursing education and the hospital's nursing service. Nurses in the rank and file had a different view of the problems of nursing and the low status of nurses in society. Rank and file nurses' conceptions of the problems of nursing stemmed more from periods when they lacked work and respect for their individual skills and efforts than from a failure to obtain professional autonomy. Hospital officials and physicians saw professional autonomy for nurses as a threat and thus reproduced social relations appropriate to a charitable social welfare institution.

An important development for professional women in America was the introduction of the Sheppard-Towner Act in the late 1910s (see Chapter Five). The Sheppard-Towner Act created conditions for American public health nurses in the 1920s to acclaim the role of a "mother's friend." The legislation assigned them the mandate to carry out child and maternity health care. However, this legislation was not long lived. In 1929, the Sheppard-Towner Act expired.

Even though the rise of American public health nursing as a governmentally mandated profession ended, this short period enabled the formation of a knowledge base which was developed from preventive medicine, hygiene and public health. It also made possible development of its modes of practice which had taken shape in settlement work and with scientifically oriented social casework at its core (Muncy 1991).

The RF's role was to disseminate innovative ideas about the education of public health personnel and administrative models for local public health nursing. The leading vision of the professionalizers within the RF about the new public health nurse, can be stated as "the friendly professional visitor with a scientific message."

The RF started in the early 1920s to study and evaluate European nursing more comprehensively. Through Elisabeth Crowell's study of nursing in nine European countries during the years 1922–1923, an increase in cooperation between European and RF nursing activists took place.¹⁰ She made, for example, a broad study on English sick nursing and health visiting and the thorough notes reflect differences between the traditional Nightingale program on nursing and a more modern program promoted in the U.S. As an American and foreigner, she argued that it was difficult to realize how Florence Nightingale's memory lived on so strongly in English hospitals. Making the patient comfortable in hygienic surroundings, in a hierarchical hospital setting, where the district nurse and private nurse were at the bottom of the hierarchy, was still the model in 1920s hospital nursing. Theory and science were secondary. The emphasis in the education was on the character formation, with elements such as duty, self-sacrifice, discipline and the power of hard and efficient manual work. Crowell views the social change in society and the extension of the nurses' field of action into various social welfare work and health work in

the community. She argues that without special experience and training the nurse is not qualified to do either welfare work or health work.

It may be advanced that the original conception of a nurse has been broadened and modified to correspond to the modern development of preventive medicine, and educational, preventive health work for well people, on a community basis, with the control of communicable and preventable diseases ... through popular education, through the use of social agencies for the social rehabilitation of those whom poverty and misfortune have forced below the safety line of normal family life and living, is just as much a nurse's function as the care of the sick. ... [T]he technique of social welfare work or of public health work is so far a sealed book to her. (Notes on Study of English Sick Nursing and Health Visiting 1922: 4)¹¹

The RF has contributed to studies similar to the Flexner report within nursing education. A few major projects aimed at educating nurses were initiated by the RF, while in other, similar projects the RF had an important role in forwarding the findings of the studies on national and international conferences and meetings.

Firstly, The RF paid for a study titled "Study of Nursing and Nursing Education in the United States. Report of the Committee for the Study of Nursing," which was made and finished in 1923 by Josephine Goldmark (the report is usually called "the Goldmark study"). Goldmark worked with a committee comprised of doctors, health officers and nurses. In the report, the committee presents 10 recommendations on how the education and work of nurses and public health nurses should be organized. The recommendations went abroad as well. I discuss the outcomes of the Goldmark study in relation to public health nursing in Chapter Five.

After this period, the profession adopted academization as its strategy to continue its professional development (Mary Beard, September 29, 1937, in "Nursing Needs": 3–4, 8).¹² Support from philanthropic organizations such as the RF helped public health nurses to establish themselves in the context of the university. The American university had entered a new period in its development. This was the situation of American public health nursing at the time when some representatives for it worked within the RF to export it to other countries, including Finland.

A second important study to which the RF contributed was that made by the Committee on the Grading of Nursing Schools, which is known as "the Grading Study" and was published in 1930. This had two significant outcomes: the establishment of a national committee on accrediting schools of nursing, and an experimental curriculum to be incorporated into all schools of nursing (Mary Beard, September 29, 1937, in "Nursing Needs": 4).¹³ In this curriculum, public health nursing was a part of the basic course.

The transition of all nursing projects within the RF to the IHD in 1931 led to the establishment of three bureaus of nursing in Europe in France, Poland, and Hungary. After this, new RF educational projects within nursing were connected to the needs of local IHD programs in Europe. Through these coordinated efforts, RF nursing

activities gained a central role in the shaping of public health nursing in the U.S. and internationally.

Since 1918, the RF had made appropriations to the National Organization for Public Health Nursing (NOPHN), and in 1933 a survey of public health nursing was published. Central elements surveyed as part of this study were the family approach, public health nursing technique, effectiveness of teaching, the adequacy of the care given during visits and the nurses' awareness of the relationship between the individual, the family and the community (ibid: 4).

The IHD of the RF also initiated studies on English nurse education and planned a new international school of nursing in London in the 1930s.¹⁴ The London project was seen as "an exceedingly difficult undertaking." The aim of establishing a new international school in London was to make the teaching of public health nursing more effective and to standardize its knowledge base.

4.6 'Health Nursing' in a Finnish Context

In the beginning of the twentieth century Finland was an agrarian country, sparsely populated and poor. Regarding hygiene, preventive medicine and public health reforms in Finland in the inter-war period, the wounds of the Finnish Civil War in 1918 (see brief summary on Finnish inter-war political history in Section 6.2 of this volume) made the situation different than in the other Nordic countries with politically more stable circumstances (Kaprio 1990). Political violence and hostility between different social and political fractions of Finnish society slowed down the social welfare and public health reform efforts. The first decades of Finnish independence, the 1920s and 1930s, was thus a period of relatively slow development of social policy (Jaakkola, Pulma, Satka & Urponen 1994 and Karisto, Takala & Haapola 1998). Public health work at the local level, however, underwent an intensive stage during which new activities and a new type of coordination were initiated. The innovations reflected an intensive exchange of ideas between professional public health workers and educators both at the national and international levels (Kaprio 1990; Hietala 1992; Sorvettula 1998; Wrede 2000, 2003; Bell and Hietala 2002; Helén and Jauho 2003; Nieminen, Henriksson and Wrede 2004 and Laiho 1995 (and forthcoming 2005)). These aimed at creating fruitful models of public health work and training of personnel for the future.

At the turn of the century, public health was still very much a project for the elite. Political, administrative, educational and professional leaders engaged in promoting hygiene and public health (Karisto 1981a, 1981b; Karisto, Lahelma and Rahkonen 1990). The professionalization as an essential part of modernization was a Helsinki based phenomenon. The total of people employed by the state, city and church in Helsinki in 1910 was 10.1 % (Bell and Hietala 2002). Broader groups in society engaged in public health and welfare reform, but it still remained a project primarily

for the educated middle class within voluntary non-profit welfare organizations (Helsti 2000; Helén and Jauho 2003 and Jauho 2003). Institutional change in the state and surveyed poor social and health conditions in large parts of the population coincided with each other and influenced the formation of the new occupation of public health nursing in Finland.

One aim of this section is to describe the institutional setting regarding the training of professionals for nursing activities that can be categorized as "proto-public health nursing" and were present in Finland in the 1910s and early 1920s. This was the period before first official contacts were established with the RF in the mid-1920s. The RF aimed at building up strategies for possible future co-operation in the public health field and at uncovering the state of public health nursing training in the 1930s, when the RF-supported project in the Municipality of Helsinki was planned.

Central parties in the institutional shaping of public health nursing in the early twentieth century Finland were voluntary organizations in the fields of public health, public authorities at the level of the state (cf. U.S. federal government), the province (cf. U.S. state) and the municipality (cf. U.S. county), institutions in the field of education and occupational organizations.

Maternal and child mortality were high, and communicable disease and malnutrition were prevalent. The largest health problem of Finland was tuberculosis, and it had the highest death rate from this disease of all the Nordic countries (Savonen 1957 and Pesonen 1980). Tuberculosis was more prevalent in the poor social classes, whose living conditions were poor. Vaccinations against tuberculosis in Finland started late, in the 1940s, and before health education concerning tuberculosis, which was primarily aimed at shaping healthier life habits and living conditions. The fight against tuberculosis (1880–1930) meant a starting point for modern health education in Finland. Such social reform through public health was a part of the nation-building process and a popular enlightenment project in the young Finnish republic (Savonen 1941 and 1957; Kuusi 2003).

Two voluntary welfare organizations were founded in 1907 in order to control the spread of tuberculosis in Finland and to give economic support for poor patients and families that suffered from the disease. They were The Anti-Tuberculosis Association (later The Finnish National Anti-Tuberculosis Association, Fin. *Tuberkuloosin vastustamisyhdistys*, Swe. *Föreningen för tuberkulosens bekämpande*) and the Society for Aid to Poor Consumptives (Fin. *Keräystoimikunta Vähävaraisten Keuhkotautisten Hyväksi*, *Vähävaraisten keuhkotautisten avustamisyhdistys* (1921–1930), Swe. *Föreningen för understödjande av mindre bemedlade lungsjuktiga*). One central part of the program of The Anti-Tuberculosis Association was to arrange special courses for nurses and deaconesses for district anti-tuberculosis work. The training program of this association is one example of how health and social work were combined in the early district nurses' training and their daily work. The special courses (1–2 months long) included both theoretical training and practical instruction about mass-examinations,

house inspections, social work and health education in the context of preventive anti-tuberculosis work (Savonen 1957 and Sorvettula 1998). The tuberculosis nurses had a rather tough and independent work, especially in the countryside where they did home visits alone in sparsely populated areas and under primitive conditions. They often had to deal with the work tasks without any direct assistance from the municipal doctor. The work of the district tuberculosis nurses was continued by the trained public health nurses in the mid-1920s, but the anti-tuberculosis association continued its courses until 1931 (Sorvettula 1998).

Two other voluntary welfare organizations, which influenced the training of health nurses, were founded in the inter-war period. The General Mannerheim League for Child Welfare which was founded in 1920 (Fin. *Kenraali Mannerheimin Lastensuojeluliitto*, Swe. *General Mannerheims Barnskyddsförbund*), started public health nurse training in a more comprehensive way in 1924, and the Finnish-Swedish Public Health Association (Swe. *Samfundet Folkhälsan i Svenska Finland*, which promoted and provided public health and welfare services for Swedish-speaking Finns), which was founded in 1921, did the same in 1926. Before that these associations had trained child welfare nurses and school nurses (for a detailed presentation of these training programs, see Siivola 1984; Korppi-Tommola 1990 and Sorvettula 1998).

The new Finnish Red Cross was founded in 1922 as a war relief organization and welfare organization in line with the program and policy of the League of Red Cross Societies (established in 1919) (Rosén 1977).¹⁵ The League established a nursing division in 1924 and the Finnish Red Cross got its own nursing division in 1926. Before that Finnish nurses, among them, Venny Snellman, Sigrid Larson and Maj-Lis Edgren, had taken part in the international course in public health for nurses at Bedford College in London, a course arranged by the Red Cross League. They broadened their international experience later as RF fellowship holders in North America as did Birgit Kansanen and Liisa Hakola, who studied at the Bedford College in the 1930s (for study of Bedford College curricula see Punto 1991 and Sorvettula 1998).

The Red Cross nurses in Finland were general nurses and health nurses. The nursing division had intense cooperation with the national nursing organizations and the establishment of a personnel reserve of nurses within the Finnish Red Cross helped to create an up-to-day register on nurses. This had an important impact on the organization and coordination of nursing work in Finland, especially during wartime, but also during peacetime. There was a debate among the members of the Red Cross nursing division and the nursing organizations whether nurses with shorter training or "amateur nurses" should be used in the activities. Such demarcation strategies sharpened the national and Nordic nursing organizations' claim for well-educated nurses, but in time of crises assistant groups of nurses with shorter training were a necessity (Sorvettula 1998: 190–194).

The Mannerheim League for Child Welfare established close cooperation with the Finnish pediatricians in the 1920s and developed local child welfare and health work. The league established a network of health centers for these purposes under the leadership of the pioneering Finnish pediatrician and Archiatre Arvo Ylppö (1887–1992). Arvo Ylppö had studied and worked at Kaiser's children's hospital (Ger. *Kaiserin Auguste Victoria-Haus*) in Germany. Ylppö also learned to know the child welfare work carried out by the nurses of the Kaiser's children's hospital. He and Sophie Mannerheim (central nursing leader of Finland, "the Florence Nightingale of Finland") and Finnish nurses were sent there to study this work (For German influences in Finnish nursing see Punto 1991; Tallberg 1991 and Sorvettula 1998).

By the paralleled activities of these mentioned voluntary welfare organizations, the training of health nurses got a fertile basis in the Finnish context. Doctor Severi Savonen was a central public health activist and leader of the tuberculosis work and the rural health program in Finland and became one central key actor in the co-operation with the Rockefeller Foundation. This study shows that the support of Savonen regarding training of, first, tuberculosis nurses, child welfare nurses and school nurses, and later, generalized public health nurses, was important for the institutionalization of public health nursing in Finland. Thus the Central European model of nurses as handmaidens of doctors, and the modern American public health nursing model which viewed the nurses as independent co-workers of doctors, entered the Finnish context through both pioneering doctors and pioneering nurses within the voluntary health organizations (Kaprio 1990: 198).¹⁶ This study shows that the influence of the American model for public health nursing supported the creation of an independent work field for Finnish public health nurses.

Before the standardization and the development of a national educational program in public health nursing took place, there were several types of public health nurse predecessors. These four groups of predecessors of the new public health nurses worked in different public health fields and had diverse educational backgrounds in the 1910s. The predecessors were deaconesses/district nurses, tuberculosis nurses, school nurses and child welfare nurses. The new curriculum in 1924 followed a kind of generalized scheme and was adopted for health work in rural districts, because Finland was mainly rural at that time. The six month-long postgraduate course in public health nursing could also be taken as a minor specialty option (for a smaller group of students). It gave training in all branches of public health work (Siivola 1984 and Sorvettula 1998). This training became nationalized in 1931 and the State School of Nursing/Graduate School of Public Health Nursing (Fin. *Valtion Terveystieteiden opisto*) was established in 1932 in Helsinki (Tallberg 1991; Sorvettula 1998). The training of midwives in Finland developed independently from the nurses' training and was separated from medical training in 1934 (see Wrede 2001: 107). By the same time, the maternity services were included in the state budget (Ibid: 107). The National Board of Health issued its first by-law for midwives as maternity educators in 1935 (Ibid: 106).

Sigrid Larsson began working as an inspector of public health at the General Mannerheim League for Child Welfare in 1929, and she is author of the course book "Public Health Nursing" (Original Finnish title: *Terveystenhoitajataitoiminta*), published in 1938. In this book, Larsson describes the history of public health nursing in Finland, central principles in public health nursing, and basic public health nursing organization and administration for different population groups in the community. Larsson also considers other fields of nursing, where public health nursing knowledge is an important element. Such fields were: medical social work at hospitals; the field of industrial nursing, and psychiatric nursing in the community. She also describes administrative issues connected to public health nursing practice, such as documentation, salaries, work dress, public claims on the public health nurse, relationships with other professionals in health care and social welfare fields, and public health nurses in relation to the local population. The book also includes the charter (Fin. *johtosääntö*, Swe. *instruktion*) for public health nursing, stated by the General Mannerheim League for Child Welfare in 1924.

In the case of general nursing, undergraduate training came under national governmental control in 1929 (Tallberg 1991 and Laiho 1995). In the same year Finnish nursing got its first inspector at the State Board of Health. In 1945, the first governmental position of Inspector of Public Health Nursing was established at the State Board of Health. Since 1929, the large part of nurse training in Finland took place at schools of nursing that were funded by the government. There were a few privately funded Schools of Nursing as well.

The scientification of welfare professions and occupations has had different developments in different countries and cultures. In the U.S. model, academization has been adopted as a central educational strategy. Abbott (1988) considers the university as the central institution of the scientification of knowledge. The transformation of practice-based occupations into academic educational programs might support and increase the public recognition of the occupation, and open up new opportunities for cooperation within the academic field.

In the Nordic countries, however, the public educational policies regarding academization in the inter-war period has been different than in the U.S. The university sector was narrow compared to the U.S., and other educational strategies than academization were carried out. Practice-based occupations, such as primary school teaching, social work and nursing got university-based educational programs quite late in the Nordic countries. In Sweden and Norway, university-based undergraduate programs in nursing started earlier than in Finland. The Finnish strategy was to develop the curricula for nurse training at independent governmentally supported schools of nursing ("Institutes" in the Finnish and Swedish vocabulary) which were in close cooperation with universities.

4.7 Summary

This chapter has examined how scientific philanthropy came to be a catalyst for the emergence of public health nursing. This development was particularly evident during the Progressive Era in the U.S., even though it can be discerned also, for instance, in Britain and in the Nordic countries. The new notion of health nursing arrived early to Finland, and its central scientifically oriented method, social case-work, and the reform culture of supporting self-help in the local population, was at the core of this development. 'Scientification' of social reform work, 'self-help' as an educational strategy and organized 'friendly visiting' in the local community were early elements of the knowledge base of 'health nursing' and of generalized public health nursing as female professionalization, which were to be the mode of practice for the health nurses that are examined in this study. The social and cultural developments explored in this chapter were important early critical boundary events for the formation of the public health nursing occupation. Figure 4.2 (next page) illustrates the shift from Christian charity toward scientific philanthropy, and how patterns of philanthropic reform cultures can be seen in early inter-war health nursing.

The philanthropic organizations provided resources, arenas and organizational power for the actors interested in developing public health nursing as a professional occupation, and implementing the new ideas in a broader scale than would have been possible otherwise. At the turn of the century, public health in Finland was still very much a project of the political, administrative, educational and professional elite, engaged in promoting hygiene and public health. These leaders were very active in the different voluntary welfare organizations that were founded in Finland in the beginning of the Finnish independence. For the organizations, like the Rockefeller Foundation, investment in public health nursing offered a means to achieve more effective welfare and public health programs. Many Finnish pioneering nurses joined international collaboration through these voluntary organizations besides their occupational organizations.

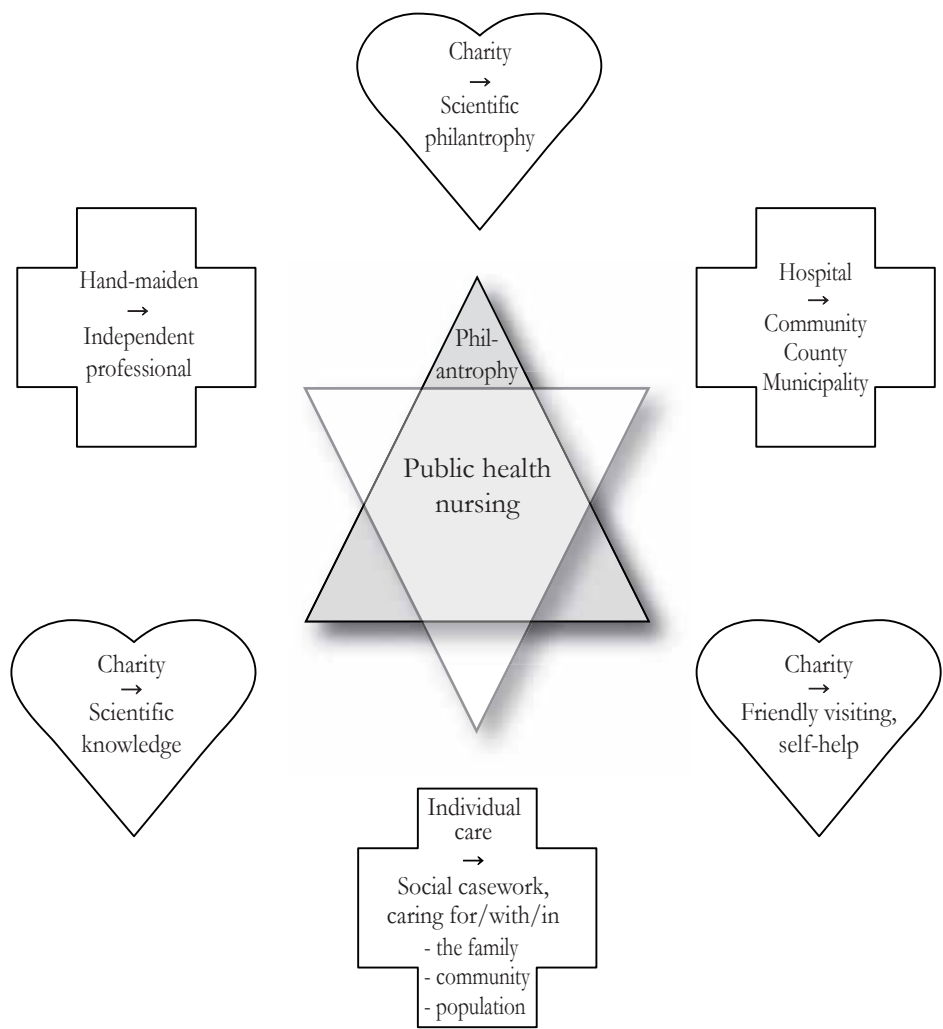


Figure 4.2 Shifts in overriding values of the philanthropic and the public health nursing fields in the inter-war period

The Rockefeller Foundation Agenda for Public Health Nursing

5.1 Introduction

At the turn of the twentieth century, nursing in the United States, like elsewhere in the western world, was a diverse occupation that lacked clearly defined qualifications (Dingwall et al. 1988; Glazer 1991 and Henriksson 1998). In the United States, nurses were trained in hospital-based schools where their education consisted primarily of practical work, namely the basic care of patients' bodies and cleaning wards. However, there were many activists, nurses and others interested in the occupation who wanted to change its role and social composition (Reverby 1987).

The primary aim of this chapter is to describe the role of the Rockefeller Foundation (RF) in the inter-war shaping of public health nursing and to identify what specific elements the Foundation promoted regarding the knowledge base and modes of practice in public health nursing. The promotion of the position of public health nursing as a new independent field in nursing in the medical division of labor was a central theme on the RF agenda for local welfare and public health work.

The second aim is to examine two key elements in the RF's policies and programs, which are central in the RF model for promoting public health nursing in the inter-war period. These are: implementation of 'health nursing' as knowledge base, and 'generalized public health nursing' as mode of practice in the community including visiting nursing and the scientifically oriented social casework method. These key elements were shaped in the different reform cultures in the field of social reform work in the beginning of the twentieth century, described in Chapter Four of this volume. I examine the critical boundary events in the development of the RF's educational strategies for public health nursing and the policy and programs that were applied to public health nursing. These strategies are important for the case of Finland, as these were the ideas that were imported to the Finnish context from the mid-1920s onwards.

The next section views the social setting of the conference on nursing, where the professionalizers of nursing confront the "nursing problem" from different per-

spectives and backgrounds that also include the views of the PH-activists and the implementers of health care programs. These actors raise questions about the nature of nursing activities, the knowledge base, the modes of practice, the organization of local nursing work, and the role of nursing in the local community as well as in society in general.

The third section discusses health nursing in the context of the Goldmark study, which is officially titled *Nursing and Nursing Education in the United States: Report of the Committee for the Study of Nursing Education*. My main interest is to analyze how the concept of health nursing was constructed as a central jurisdictional claim for the North American model of new public health nursing.

I also include a section about the early formation of public health nursing in the context of the nurses' settlement and visiting nurse service in New York, The Henry Street Settlement, an important socialization arena for both U.S. and foreign nurses. Furthermore, I describe the use of the method of social casework in this setting, the way it was carried out at the nurses' settlement. The remaining sections of the chapter examine how the concept of the visiting nurse became implemented at the national level in the U.S. and how the RF adopted it as a part of its program.

5.2 Reform of General Nursing Education

The RF had a central role for both the reform of general nursing education and the development of public health nursing. Even though the RF was itself not directly concerned with the upgrading of nursing, RF officials considered its commitment to public health to be hampered by poorly trained and unskilled nurses. Therefore, RF's agenda concerning nursing was soon broadened to deal with the overall status of general nursing, a fact that nursing leaders felt was an opening wedge (Reverby 1987: 164).

In December 1918, the RF arranged a conference for those interested in the development of public health nursing in the U.S. The purpose of the meeting was to discuss the status of public health nursing, and what type of education would be advisable for training the necessary personnel.¹⁷

Many of these actors came together again when in February 1920 the Rockefeller Foundation organized a conference on the training of nurses. In the report of this RF-initiated conference on nursing education, the arranger declared the importance of exchanging ideas, discussing encountered difficulties, and clarifying opinions (Conference on the training of nurses, February 28, 1920: 1).¹⁸ As an outcome of this conference, it was decided that the Committee for Study of Public Health Nursing Education, established one year earlier (1919), would conduct a study of general nursing education in the U.S.

The report of the 1920 conference contains all of the statements of the forty-nine people present. These represented a variety of organizations which were active

within the fields of nursing, public health nursing and medicine as educators or as health care or social service providers. The remarks of every speaker at the conference were submitted for revision or approval before the report was compiled (Conference on the training of nurses, February 28, 1920:1). Many of these actors can be categorized as PH-activists and implementers of health care service programs who the professionalizers of nursing confronted and with whom they negotiated in order to shape clearer boundaries of general nursing and the new specialty of public health nursing (cf. Dingwall et al. 1988). The educational organizations that the speakers represented were: the national associations of nursing education in the U.S. and in Canada; university and hospital schools of nursing; state departments of education; state boards of nurse examiners; the Army school of Nursing and different schools of medicine (Conference on the training of nurses, February 28, 1920: 36–38). Furthermore, some occupational organizations of nursing, nursing service employers, and one nursing magazine were present at the conference: the national organizations of nurses and public health nurses; district nursing associations; university and city hospitals; social services departments at hospitals; the American Red Cross; the Henry Street Settlement, and the American Journal of Nursing.

The consensus at the 1920 conference was that general nursing education needed to be reformed. Mr. Augustus Downing, representing the New York State Department of Education, described the existing training system as apprentice training rather than education (Conference on the training of nurses, February 28, 1920: 27):

Speaking of nurse training schools, it is fair to say that eighty per cent of such so-called training schools are not schools at all. The training ... is what may be called apprentice training.

Instead, nursing was to be made a university education. Sophia F. Palmer, Editor-in-Chief of the American Journal of Nursing, demanded a new strategy of nurse education: "It seems to me that we have simply come to the end of the apprentice system and that we need to make radical changes that will take nursing out of the apprentice class and put it into the 'university' class" (Conference on the training of nurses, February 28, 1920: 28).

The aim of the reform of general nursing was to define its boundaries, both in relation to medicine and in relation to untrained personnel. Nursing was no longer to take the position of a handmaiden to medicine, and some tasks were now delegated to auxiliaries. At the same time, the usurpation or take-over tactics, described by Ann Witz (1992), were applied to friendly visiting and case-finding social casework (Leiby 1978: 115–116, 122; Davies 1988; Pettersson 2001: 34). These activities that completely differed from traditional sick nursing were discussed in the Goldmark study as central domains of nursing.

In the end of nineteenth century, a new type of women was entering nursing. Younger middle-class women who looked at nursing as a potential lifetime career had new kinds of expectations about both the training and their future work

(Reverby 1987). This is how one of the delegates of the 1920 conference, Dr. Alexander Lambert from New York, interpreted the development of nursing (Conference on training of nurses, February 28, 1920: 21):

Look back to 30 years ago. Then nurses were socially minded, very distinctly so. They gained satisfaction from helping people. It was one of the few professions open to women at that time by which they could earn a livelihood. Since then it has not developed in its opportunities to those going into it as other projects have. The student nurse has been made jack of all trades with less and less individual training. That I think is where the trouble is.

In the early twentieth century, the “socially minded nurses” had come to take up central positions in their occupation and wanted to improve its conditions, making nursing a profession among others. Miss Elizabeth G. Flaws, President of the Canadian Association of Nursing Education in Toronto, viewed a reform of nursing education as an undoubted fact:

The profession of nursing is just as important to the state and to the community as those of medicine, law, dentistry, etc. Why should not Universities more generally provide specialized courses in nursing and public health, and confer degrees of different rank according to the proficiency and advancement of the students? This is a progressive step, which must be taken before nursing can be placed on an equal footing with the other professions. (Conference on training of nurses, February 28, 1920: 5)

Sara E. Parsons, Superintendent of Nurses from Massachusetts General Hospital, states that the “nursing problem is a community problem” and there (Conference on training of nurses, February 28, 1920: 9):

... must be a reorganization of our schools; a sound theoretical foundation constructed on which to build the practice of nursing ... and the maximum of experience given in the minimum of time. (Conference on training of nurses, February 28, 1920: 9)

Defining the core of what nursing is implies drawing its boundaries. While nursing was compared with the established professions, nurse professionalizers wanted to “clean” it from work that they considered to belong to orderlies, and stated that hospital schools did not provide a proper learning environment where independent nursing studies could take place:

The tendency to the over-use of the nurse for ward routine has resulted in a general acceptance of her function being limited to manual procedures and a failure to grasp the body of knowledge required if she is to practice her profession intelligently (A.W. Goodrich, Conference on training of nurses, February 28, 1920: 12). ... Hospitals have exploited and are exploiting nurses (Frederic A. Washburn, Resident Physician at Massachusetts General Hospital, *ibid*: 24).

Miss Annie W. Goodrich, representing the Department of Nursing and Health at Teachers College of Columbia University, exemplifies this problem by telling how nurses in the field of mental care had “little or no instruction in mental nursing” and

that the “history of the patients was not open” to nurses who wanted to specialize in this field (Conference on training of nurses, February 28, 1920: 12).

The reform of education was needed in order to attract more middle-class women to the occupation, and to make the position of the women already in the occupation more favorable. From the point of view of the early professionalizers, among who were medical academics, the reform of nursing should become “a much more clearly defined educational matter rather than a mere collateral part of running a hospital and the care of patients” (Dr. David L. Edsall, Dean of Harvard Medical School, Conference on training of nurses, February 28, 1920: 2). Their thinking linked to the campaigns of the women activists of the time. At this point, middle-class women in America were entering the professions (Preston 1995). Nurse activists wanted to make nursing one of the professions fit for them, firstly they wanted to “place the training of nurses on a par with the education of women for other professions and other fields of service” and secondly they wanted to “place the education of women on a par with that of men!” (Ira C. Wood, President of Illinois Training School for Nurses, Conference on training of nurses, February 28, 1920: 31).

Educational reform was linked to the reform of the practice of nursing. This was deemed necessary for making it a desirable job for the type of applicants that nurse professionalizers wanted to attract:

... desirable young women of education and ability ... after years of difficult preparation the positions open while rich in opportunity for service are made unattractive by long hours of work, short vacations, with consequent breaking away from outside interests (Elizabeth G. Flaws, Conference on training of nurses, February 28, 1920: 4).

The problem for the professionalizers of nursing was that they had a shortage of applicants of all kinds, and especially of the desirable kind. While the traditional hospital nursing was socially renewed according to a strategy similar to that of the creation of the “lady nurse” in England (Davies 1995), the knowledge base of nursing was getting redefined in ways that broadened the scope of nursing outside its traditional boundaries, which were set by the medical discipline and hospital practice. The university setting provided opportunities to study the new discipline of preventive medicine and detach nursing’s close ties to clinical medicine by linking it to new preventive medicine and other scientific disciplines outside medicine. This implied a new strategy for the formation of a knowledge base that would help making nursing a profession:

We have given them such courses as are worthy the giving of academic credit. Besides the nursing courses and the anatomy and physiology we give psychology and sociology, a laboratory course in foods and nutrition, a course in bacteriology and hygiene and other courses which prepare the nurse for public health as well as institutional work. (Laura R. Logan, Director of the School of Nursing and Health at Cincinnati University, Conference on training of nurses, February 28, 1920: 19–21)

While nursing was to be relieved of its identification with bedside nursing, knowledge-based tasks and public health nursing's educational status as a specialty were being emphasized:

Adequate financial support ... shorter hours ... more instructors ... larger force of maids and orderlies [are needed] to relieve the nurses of the work which has no educational value ... libraries, laboratories, and class rooms well equipped with teaching apparatus ... more time in the third year for training them in executive and administrative duties, or in public health work. (Elizabeth G. Flaws, Conference on training of nurses, February 28, 1920: 3)

The professionalizers of nursing sought arguments that would persuade more skeptic actors, such as some of those within the medical profession and hospital administrations. One of the delegates of the 1920 conference on nursing education, Dr. Alexander Lambert from New York (p. 20), was convinced of the ignorance of doctors on nursing education:

I think most of the medical profession [is] ignorant of the type of education given nurses nor have they formulated ideas as to what should be given them. ... There is an unwillingness to face the situation and an inability to get together and make up their minds just what kind of medical knowledge a nurse should have.

Another delegate felt that the challenge for nursing professionalizers was to influence the attitudes of all of the actors surrounding nursing. Among the groups "to be educated," potential future nurses and their parents were an important group, but the general attitude towards nursing and building of recognition for nursing was important too:

It seems necessary to change the general attitude of the public toward the nurse, the methods of her preparation and the importance of the work that she will ultimately perform. We shall need to educate boards of trustees, the medical profession and the people at large. (Clara D. Noyes, Director of the Department of Nursing of the American Red Cross, Conference on training of nurses, February 28, 1920: 8)

The parents need to be educated as to what nursing is. They are not willing to let their daughters go into this sort of work, because of the conditions that exist today in the training schools. (Herbert E. Mills, Professor at Vassar College, Conference on training of nurses, February 28, 1920: 15)

To attract good recruits, the image of nursing needed to be reformed so that a nurse would be perceived as a professional with good personal qualities:

... useful and interesting career instead of feeling that "they who enter here leave hope behind." The knowledge that each student is acquiring a wider vision and broader understanding of meaning of life prevails, and aids in keeping up the necessary professional tone. (Anna C. Maxwell, Director of the School of Nursing at the Presbyterian Hospital of New York, Conference on training of nurses, February 28, 1920: 11)

The mental and spiritual qualities needed in the young women who shall do our health work, merit the recognition given to other professions (Sara E. Parsons, Superintendent and Director at the University Hospital of Ann Arbor, Conference on training of nurses, February 28, 1920: 10).

At least some delegates of the 1920 conference still believed that also future nurses would need practical housemaking skills. They were not satisfied with the type of students they currently had in nursing schools. As Mary C. Wheeler, Superintendent at the Illinois Training School for Nurses stated:

One of the noticeable things in training school work I find is that the young woman who comes into the school is almost always lacking in knowledge of housekeeping and home making. ... Also she has not the spirit of self-control and she has not the spirit of service. ... We need, in other words, the woman who has a background of maturity and education. ... We must find some way of developing the young woman before she comes into the school.

Nurse professionalizers were convinced that it was necessary to remove nurse education from hospitals. For the kind of investment that would make this possible, public support needed to be secured:

... the necessity of making the training school independent of the hospital cannot be too strongly emphasized. ... We must differentiate clearly between the assignment of work which is designed for the efficient administration and functioning of the hospital, and that which is needed to equip students as quickly as is compatible with good teaching for the fields in which they are so urgently needed and from which they are being held in the name of their education. (Josephine Goldmark, Secretary of the Committee for the Study of Public Health Nursing Education, Conference on training of nurses, February 28, 1920: 23–24)

Not only nursing but nurse education was to be professionalized and for this aim the university granted opportunities to autonomously develop new forms of expertise:

The training of nurses is fundamentally an educational problem and educators must be brought into it. The superintendent of the hospital is not primarily an educator. ... There are many more fields of activity in specialized branches open to nurses than ever before and the women are choosing them. The nurses' training in many of our schools is practically the same for all whether they intend to be training school educators, public health workers or private nurses. This is not as it should be ... (Frederick A. Washburn, Resident Physician at Massachusetts General Hospital, Conference on training of nurses, February 28, 1920: 25).

The position of nurses as practitioners who would be able to practice in different settings was emphasized. Nurses were not to be a workforce trained for one particular workplace:

... if we could have one or two good college affiliations or central schools, give the students ... proper preparation before putting them into the hospitals, give them a variety of hospital experience such as they should have to be all-around trained

nurses, and graduate them from the universities and not from the hospitals, so that they stand before the world as university graduates in nursing, we would improve the education and social status of the nurse, lack of which is back of all this difficulty more than anything else. (Sophia F. Palmer, Editor-in-Chief of the American Journal of Nursing, Conference on training of nurses, February 28, 1920: 28)

It was assumed that university-based education would give nurses easier access to public health work. By tradition, the tasks that were at this point associated with 'health nursing' had no clear-cut linkage to nursing. In fact, both the tasks and the methods were mainly social in their orientation and the work had been performed by both volunteers and professionals under the umbrella of friendly visiting and other charitable activities. As philanthropy was becoming more professionalized, there were other groups, most notably social workers, who made claims on the same or similar tasks (see discussion in Chapter Four).

5.3 'Health Nursing'—The Construction of New Boundaries

The conference delegates of the 1920 conference, viewed in the previous section, requested that the Committee would commence a study of general nursing education, "with a view to developing a program for further study and for recommendation of further procedure" (Conference on the training of nurses, February 28, 1920: 1-2). The result of the work of this established committee became known as the Goldmark Study, and was published in 1923.¹⁹ As mentioned earlier, the field of nursing education at the time was very heterogeneous. Therefore, nursing professionalizers wanted to engage in a comprehensive study of the entire field of nursing education.

As a result of the drawing of new boundaries of general nursing and the associated making of claims, a new jurisdiction, that of professionalized public health nursing, started to take shape.

For the professionalizers of nursing, the Goldmark study, published in 1923, was the central document on nursing to be used during the 1920s and 1930s. The Goldmark study presented the results of a major survey on nursing education in North America. Its importance depended on the fact that it was the first comprehensive study of both the practice and the education of general nurses and public health nurses. Furthermore, the coordinating activities of the RF and its committee on public health nursing which preceded the report had prepared the Foundation for its recommendations. In the nursing education discussion of the final report of the Goldmark study, the radical change in training was stated as follows: "to provide for all student nurses a new stress on methods of *prevention as well as cure*, and that *minimum of social interpretation of disease which is indispensable in modern health movements*" (Goldmark 1923: 148–149, emphasis added). It also proclaimed, "we recommend *higher entrance requirements*, better teaching, a reduction in the length

of the undergraduate hospital course, above all, the *endowment of nursing education as all other conceivable education has been endowed*" (emphasis added).

The Goldmark study emphasized public health nursing as a central jurisdiction within nursing. The public health nurses were to have comprehensive knowledge in health education and an ability to work using the method of social casework. In the study it was stated that:

It is abundantly evident that however good her clinical training, however accurate her knowledge of disease and even of prevention, she is at a grave disadvantage, if not totally at loss, without a thorough grounding in principles of teaching and in the principles of social casework. Without the first, her own personal services may be totally inadequate to affect a cure or to improve injurious conditions; without the second, her work with families is necessarily halting and uncertain (Goldmark 1923: 148–149).

In the context of settlement work at first and later in the RF, nurse professionalizers had an opportunity to develop friendly visiting into health nursing, and thus make powerful claims on a new jurisdiction in public health. The settlement movement and the setting of nurses' settlements were the first important context for the emergence of the new specialty, particularly as it allowed the development of a new mode of practice. Later on, the RF emerged as a powerful ally for public health activists and the idea of public health nursing implemented in local public health. The Foundation's importance was most vital for the way it helped to reform nursing education. Thus the knowledge base for nursing was transformed and the contents of public health nursing were defined.

A leading American proponent, C.E.A. Winslow, expressed the vision guiding the development of public health nursing as the new type of nurse who was to be the perfect professional to carry out the core task of public health work. The "new idea" of the public health campaign was to "bring hygienic knowledge right to the individual in his home, where the information taught could be adapted to the particular circumstances of each individual and presented in words of the kitchen or the sitting room" (Winslow 1935).

Health nursing was outlined in relation to the traditional concept of hospital-based sick nursing and in relation to the idea of visiting nursing. The latter originated from the philanthropic visiting services that applied scientific charity ideas, which I discuss in the introduction and in Chapter Four. The development of health nursing was an international campaign, influenced by the ideas that Florence Nightingale presented in England and in the U.S. in the 1890s. Her ideas about district nursing dating from the 1880s and 1890s came to be distributed all over the world by the International Red Cross and Bedford College for nurses that it founded in London in 1919 and by the ICN (Sorvettula 1998). In England, the "health missionaries" who were supposed to carry out the new scheme of health nursing did not have nurse training; they were "ladies with special training and practical instruction." In Britain

it was health visiting that gained the public's support, whereas the Nightingalian district nursing was more based on the work of voluntary organizations and traditional Christian charity (Dingwall et al. 1988). Furthermore, unlike in the U.S., midwifery was in the British context an officially recognized occupation whose services were publicly sponsored at the time when ideas about public health and social work were first emerging (Dingwall et al. 1988). Reflecting these different conditions, health nursing remained less central for British nursing than it was to become in the United States. In that country, a separate specialty—that of the public health nurse—began to appear.

In the American version of the original Nightingale plan, the aim was to make the visiting nurses the “teachers of positive health.” This idea was central in the policies of the RF, supporting public health nursing not only in North America but also around the world. The RF was actively involved in the discussion about both general nursing (sick nursing/bedside nursing) and public health nursing. The RF-initiated and funded Goldmark study stated that the visiting nurse/health nurse was the “logical choice, to serve as the relay station, to carry the power from the control stations of *science*, the *hospital*, and the *university* to individual homes of the *community*” (emphasis added).²⁰ The health nurses were to be “generalists” who could bridge the gaps between science, health policy, and the people. Health nurses were presented as both effective and cost-effective in ensuring the overall health of the public by health promotion and the prevention of disease among different population groups.

C.E.A. Winslow (quoted in Buhler-Wilkerson 1985: 1157), active nursing professionalizer, argued in a speech 1917 that unlike the social worker, the visiting nurse knew the human body and its reaction to external conditions and to the hygienic conduct of life.²¹ Her approach was far superior to that of the physician because she was trained to see the body as a whole, while the physician's vision was distorted by a preoccupation with special pathological conditions (Ibid: 1157). Many nurses shared this viewpoint, and some suggested that this new field of health nursing differed so greatly from sick nursing that it might one day constitute a distinct profession (the public health nurse). These nurses declared an end to “the old teaching” of the nurse as the handmaiden of the physician (quotation in Buhler-Wilkerson 1985: 1157; Wald 1934). She was instead a physician's associate or co-worker, who helped him produce results which he could never accomplish alone (Wald 1934). A similar reformulation of the nurse's relation to the doctor as this one has been described in Britain by Celia Davies (1995), who claims that the gendered model for the new division of labor in medicine was taken from the idea of the bourgeois family of the era. Health nursing seemed particularly well-suited for those nurses seeking the opportunity for autonomous practice.

I will now examine issues concerning the mode of practice that the education of general nurses and public health nurses for community purposes sought after. These issues reflect the changing social and cultural jurisdictional circumstances of the

nursing profession in the 1920s in North America. The material used for this contextualizing purpose describes the views of the PH-activists as “educators” in the public health field, and the “innovators” such as the representatives of the RF. My purpose is not to give a detailed analysis of the content of nurse training in North America in the 1920s, but to make visible those key elements that these actors identified as a part of their educational strategies for promoting general nursing and especially the foundations for public health nursing.

5.4 Agents of Democratic Education

The Visiting Nurse Service of the Henry Street Settlement in New York was the first institution of its kind in the U.S. (Baumgartner 1969; Duffy 1974; Rosner 1994 and Jackson 1995). The work at the settlement combined what is today called primary care with social work in an innovative way, separate from traditional hospital work. It had its beginnings in the work of two nurses, Lillian Wald and Mary Brewster, who in 1893 started to offer free nursing help to their neighbors on the Lower East Side of Manhattan, most of whom were new immigrants. For the professionalizers of U.S. nursing, the two nurses became pioneers for a new mode of practice—health nursing. The new form of nurses’ settlement work established at the end of the nineteenth century also gained wider attention and was perceived as a central activity in general campaigns to improve welfare in society:

Among the two or three greatest achievements for the welfare of humanity in the last century [nineteenth century], the development of Public Health Nursing has been one (Gertrude Hodgman in *The Henry Street Nurse*, June–July 1921: 1–4).²²

The visiting nurses of Henry Street worked in the slums on the Lower East Side where “workers in philanthropy, clergymen, Orthodox Rabbis, the unemployed, anxious parents, girls in distress, troublesome boys, came as individuals to see us,” as Lillian Wald described this community work in its early days (quoted in Trachtenberg 2000: 79). They encountered their clients face-to-face, and their work aimed at helping people to help themselves. To be effective, the philanthropy was considered in those days to consist of personal supervision, “for it is unlikely that others can carry into practical effect our ideas and intentions as well as we can ourselves” (Trachtenberg 2000: 82).

The Henry Street Settlement was intended to serve and shape a diverse community. In its first decade of operation, the settlement saw the ethnic composition of the immigrants of the Lower East Side of Manhattan change from roughly half Jewish from eastern and central Europe to mostly Asians and Latin Americans. In 1920, over one-third of the foreign-born women receiving maternal health care by the Henry Street Maternal Service were Russian (*The Henry Street Nurse*, No. 5 1921: 11).²³ Other big immigrant groups at the time were Italians, Austrians and Irish.

The case of the Henry Street Settlement and its visiting nurse service illuminates that ideas of public health nursing developed in an urban community characterized by rapid social change which resulted in major health and social problems. The melting-pot type of slums of the big cities was a challenge to the unity of the nation in an era when many reformers worried about its future. A rising number of immigrants flooded the country at the turn of the twentieth century. This occurred at the same time as the segments that considered themselves the core of the nation, i.e. descendants of the “settlers,” had a decreasing birth rate (Koven and Michel 1993). The strategy of the settlement movement was to integrate new arrivals to the nation. In its early days, the Henry Street Settlement provided clubs for boys, girls and mothers. It operated a dance school, a playground (one of the first in the U.S.), a gymnasium, debating clubs, literary societies, a kindergarten, a savings and loan fund, and a cooperative food store. In 1915 the Neighborhood Playhouse opened, and this developed into a leading experimental theater.

In her book, *The House on Henry Street* (1915), Lillian Wald defines the mission of the settlement for the shaping of the lives of immigrants and their communities. This book was widely used as a teaching text in nursing, sociology, and social welfare. In *Windows on Henry Street* (1934), Wald analyzes the role of public health nurses and outlines their modes of practice. Wald and Brewster to capture the new jurisdiction they envisioned for nursing probably used the term “Public Health Nursing” for the first time. Ideologically, the early formation of public health nursing was linked to pragmatic ideas of social reform. An important example of these ideas is the concept of “democracy in education,” which was often used among the pragmatic philanthropic public health nursing reformers. The concept originated in John Dewey’s widely spread pragmatic ideas of the philosophy of education during the Progressive Era in the U.S. (Dewey 1916). The new public health nurses were to educate their clients and relieve the conditions of the poor and the disadvantaged in a way that helped them to help themselves.

The ideas and concepts that were essential in the public health nursing activities of the time were presented to the nurses themselves through the bulletins that the settlement published. The articles in the bulletin interpreted the relatively abstract and visionary ideas of the leaders of the public health movement into practical guidelines. The guidelines were intended for the new public health nurses who carried out the day-to-day activities of the visiting nurse service.

The Henry Street Nurse bulletin in the 1920s reflects the transitions in the roles that were depicted for the public health nurse. She was first to shift from being mainly a “remedial agent” to become an “agent of prevention” that would revolutionize medical practice. Eventually she was to become an “agent of education in homes of the community” (Gertrude Hodgman in *Henry Street Nurse*, No. 6–7, 1921: 1).

Ann Witz (1992: 203–204) has in her discussion of female professional projects considered internal demarcation as a strategy for gendered division of labor within an

emerging professional field, radiography, in Britain in the early twentieth century. Within public health, the role of the public health nurse needed to be carved out in relation to that of the physician. Gertrude Hodgman states in *The Henry Street Nurse* bulletin in 1921 (no. 6–7, pp. 1–4) that the public health nurse, in her capacity as an “agent of education,” could not be an independent practitioner on equal footing with the medical doctor. Public health nurses could however accomplish their goals, gain independent collective strength and get their voices heard in the field of public health by working closely through voluntary public health nursing organizations. Organizations could offer a more cost-effective base and provide more efficient service. The burden of responsibility and demand could be collectively shared in such organized public health nursing work at a local level in contrast to traditional hospital-based nursing. These public health nursing organizations could offer broader expert and skilled services within public health in comparison to sickness-oriented medical services. Supervision and administration should not be separated, according to this “democracy-concept,” but treated as a whole, thereby influencing both the quantity of provided service and the quality of curative, preventive and educational public health nursing work (Ibid: 1–2).

The public health nurse should participate in discussions concerning development of the work, decisions of policies, methods and techniques, in order to develop her interest, “further her growth” and also develop in her a respect for expertness in her own field (Ibid: 2). The notion of a “respect for expertness” was seen as a valuable attitude toward all “democratic relationships” (Ibid: 3). The democratic relationship between, for example, supervisor and supervised, demanded the adoption of a flexible approach to dialogue between the two, which presumed mutual respect of each other’s expertise and experience. Gertrude Hodgman states that “the work itself” is the most important goal, but she also believed that a “very special danger” in nursing work was forgetting the “worker” behind the work:

The nurse as an *individual, a citizen, a person with certain rights and obligations*, is forgotten entirely and only her function as a nurse is remembered. ... No person is compelled to be a nurse. No person already a nurse, is compelled to enter the public health nursing field. *By neglecting the right of the individual so constantly*, many women who might otherwise desire to become nurses and public health nurses are deterred from so doing. ... It is for the supervisor to help balance these two demands; the demands of the sick and *the demands of the nurse as an individual*. ... She [the supervisor] must *become the educator* of the public, bringing them to see their responsibility for illness, as well as the nurse’s, and making them *sharers of a common problem*. (Gertrude Hodgman in *The Henry Street Nurse*, No. 6–7 1921: 3–4, emphasis added)²⁴

One aim of the supervisor as an “agent of democracy” was thought to be to bring the persons that directed and financed public health nursing organizations and the practicing nurses into as common an understanding as possible about the real needs of the work and of the nurse. Essential aims for the supervisor were to reach a wholehearted interest of the nurse in her work and the “education” of the individual

and to support the nurse in finding work that she would enjoy. The problems that the public health nurses faced in the public health nursing field were quite different from those of the hospital, and co-operation with other agencies in the field was essential. The business of a supervisor was therefore “to develop a common basis of knowledge and scientific nursing, and understanding of the facts of this special field, in order that her help and advice may be most effective” (p. 3). The “expert-supervisor” of the public health nurses should have high qualifications, such as

... broad experience within the work, and training for such supervision. She must be familiar not only with the best methods in nursing practice, and knowledge of the best approved medical and scientific facts, but also she must have some knowledge of the basic concepts of modern social work methods, sociology, sanitary science, economics, teaching methods, psychology, philosophy, all applied to her special problems. Only with some such background, can she base her suggestions and criticisms upon sound (and understood) principles, rather than upon opinion, authority, and position. (Gertrude Hodgman in *The Henry Street Nurse*, No. 6-7 1921: 3)

The nurses at the Henry Street Settlement did curative, rehabilitative and preventive work, and taught health. The nurses lived in the neighborhoods where they worked and their services were available throughout the city from 9 a.m. to 6 p.m., seven days a week. They visited patients daily or as often as needed; night nurses, cleaning, and laundries were provided for the gravely ill. At the beginning, nurses ran first aid stations where they treated burns, infections, and injuries. They also maintained convalescent homes. In some sections of the city they provided assistance twenty-four hours a day to women about to give birth. They also held health conferences for the mothers of infants. In the 1910s, the settlement developed into a neighborhood center for civic, social, and philanthropic work. Its citywide visiting nurse service continued. By the time of Lillian Wald's retirement in 1933, the staff of 265 visiting nurses reportedly made 550,000 home visits to 100,000 patients in a year. Wald's successors, Helen Hull and Marguerite Wales, continued the settlement activities, and the nursing service achieved independent municipal status in 1944, and became known as the Visiting Nurse Service of New York. The Visiting Nurse Service of New York and the Henry Street Settlement still minister to the people of New York City.

Lillian Wald stressed the purpose, the growth, and the importance of public health nursing in the general progress of public health activities. She stated that: “they [the public health nurses] are the indispensable carriers of the findings of the scientists and the laboratories to the people themselves, using their sympathy and training to make as intelligible as language permits the facts of health and life. What a change is this from the priestly secrecy of the old-fashioned medical practitioner!” (Wald 1934: 73). As pointed out earlier in this study, one central element of scientific philanthropy and visiting services was the collecting of data and the keeping of records about the health and social status of the “case” unit, which was a family. *The Henry Street Nurse* bulletin presented annual statistics produced by the nurses. By collecting

and presenting health data and social data on a regular basis, the visiting nursing service could document its outcomes and claim that their activities could be analyzed scientifically. This new method to study the effects of nursing presented it as an activity comparable to medical practice, giving its mode of practice a scientific foundation and linkage to a knowledge base.

5.5 Public Health Nursing in the Legal Arena

The Sheppard-Towner Act, more popularly known as the “Mothers’ and Babies’ Bill,” of the 1920s was welcomed by the Henry Street nurses and their supporters who were discussing the role of preventive public health work to decrease the high infant mortality rate and maternal mortality which was connected with child birth. The long process of the negotiations around this bill before it passed in January 1921 was followed in *The Henry Street Nurse* bulletins. Their great disappointment with the public’s opposition to the bill was expressed in the bulletins. Organizations such as the Christian Scientists, the American League for Medical Freedom, and the United States Public Health Service were pointed out as enemies to maternal and child health reform. The struggle for the bill was seen as the women’s struggle and the “hopeful, nation-wide, life-saving campaign” was hoped to stimulate rural communities in the states, counties and county seats “to provide for health centers, for instruction in the hygiene of maternity and infancy everywhere as municipalities and philanthropies are doing in congested city populations,” or other suitable consultation methods (Florence J. Kelly in *The Henry Street Nurse* bulletin, No. 1 1921: 2).²⁵ A similar improvement of democratic rights as maternity benefits to all mothers and suitable medical and nursing care, regardless of social or economic standing, had already been considered in other countries by this time, and this the authors in the bulletins also recommended for the U.S. The need for an acknowledged health program for children contrasted with the small political efforts regarding maternity and child health in the U.S. This resulted in microscopic appropriations for women’s and children’s bureaus and the lack of a welfare department at the highest governmental level. The opposition to the law had managed to restrict its implementation by making it a voluntary program, by cutting the proposed \$4 million to \$1.2 million, and by funding only for a period of five years (Lemons 1973; Meckel 1990 and Muncy 1991).

The federal Sheppard-Towner program supported maternalist and child welfare reform work in the United States and reflected on the work of the occupational group of public health nurses. The Sheppard-Towner program, between 1921 and 1929, embodied a woman-friendly vision of public preventive health care that had been worked out by activists such as social settlement reformers, women doctors, public health nurses and civilly engaged female club members. What was once domestic action was extended into a new understanding of governmental action for societal welfare and for the supporting of professionalization of the public health nursing occupation for community purposes. The content of the Sheppard-Towner

program in the history of early twentieth century U.S. maternal and child health care has received less attention from social scientists and medical historians than the law-drafting process around the Social Security Act that passed in 1935. However, feminist-oriented social historians and sociologists have brought valuable reflections and knowledge to this important critical boundary event. Their work illuminates gendered strategies in health and social policies (Lemons 1973; Reverby 1987; Muncy 1991 and Skocpol 1992).

Activists in the Henry Street Settlement, somewhat disappointed about the way the plan was implemented, argued that the general need for improved maternal and child health services was reflected in the opinions of families in New York City. "Anxious fathers appear at the nursing office [The Henry Street Visiting Nurse Service] on Sundays and beg to have the nurse come to demonstrate the care of a two or three weeks' old baby to their wives" ("J.R." in *The Henry Street Nurse*, No. 4, 1921: 5).²⁶ The role of the nurse as "teacher" and the need for a wider academic multi-disciplinary knowledge base [besides medical knowledge] among the nurses, who provided not only preventive health service but also social service, was announced as an important objective:

With the growth of the nursing service the educational and social work has also developed. It is no wonder that physicians, training school superintendents and directors of nursing organizations are pleading for higher education for nurses, for academic instruction in psychology, social science, and dietetics; all needed to round out the coordinated training of the head and hand which makes the nurse so valuable as a teacher in the home. In visiting nursing "the care of the patient in the nurse's absence" is a large factor, and the choice of the most responsible member of the family to instruct in this service is always in the nurse's mind and stimulates her teaching." ("J.R." in *The Henry Street Nurse*, No. 4 1921: 1-5)²⁷

At the same time as the Henry Street Settlement gained a symbolic importance for public health nursing and its activities were a model for its mode of practice, there were other innovative health centers which provided preventive public health nursing activities as well. One such health center was the Red Cross Health Center on Morris Avenue, where, for instance, "all questions of patients' diets are referred to the dietitian who visits the home and instructs the families in the proper preparation of special food" (Miss Leverich in *The Henry Street Nurse*, No. 1 1921: 5).²⁸ There was collaboration between the different health centers. The Red Cross Health Center acted as a teaching center for the Henry Street Settlement student nurses, and students taking certain courses at Columbia University did their fieldwork there. This integration of the innovative health centers to the education allowed practical development of the mode of practice for public health nursing. In this kind of setting it was possible to develop models for a specific element in the mode of practice for public health nursing, a coordinator role in relation to other forms of expertise. This was at play in the example above involving dietitians: "[I]n this way we hope to show the close relationship which should exist between the two

professions [nurses and dietitians] and the dependence of the one upon the other resulting in a saving of the nurses' time and greater knowledge on the part of the families of the values of foods and their proper preparation" (Ibid: 5). This model of the division of labor within health work was planned to continue for a two-year period. By that time, the necessary statistics to evaluate the outcomes of this model would be available.

In 1923 Dorothy Deming reports about many experiments on the generalized model, both in city and county health departments. Dorothy Deming quotes a definition on the "generalized nurse" in 1922 in *The Henry Street Nurse* bulletin (No. 11–12, p. 1),²⁹ which had been put forward in the RF administrated Goldmark report and applied in practice for example at the East Harlem Health Center and in Bronx at the Red Cross Health Center in New York. The generalized nurse is one who:

is equipped with a rigorous training in bedside work further supplemented by special studies along the lines of public health and social service, employing these abilities to establish herself in the community as its trusted advisor, its best friend, caring for the sick, securing medical aid, counselling as to hygiene, resolving difficulties of a hundred sorts with a touch of a practiced hand.

Deming argues that a reorganization of specialized departments was needed. She continues, "we used to speak of the district or visiting nurse—we now use the term public health nurse—implying an all inclusiveness, a broader interpretation of her services, and a universality of demand which forces the thought of generalization (Dorothy Deming in *The Henry Street Nurse*, No. 11–12: 1).

The public health nurses' vision was to develop modes of practices to keep records of visits, and to maintain a regular survey and surveillance of the health status of families. They used individual case history files and tried to reach out to the networks surrounding the patients by inviting "girls, neighbors, relatives, and friends to the Health Center for care and advice"; their ultimate objective was "to increase the health and happiness" of the community. The adequate unit of population per nurse in relation to outcomes of the health work was discussed: "How far we can succeed in solving the total family health problem is the task that the generalized nurse doing instructive or bedside work among a population not exceeding 2,500, preferably 2,000, has assumed" (Naomi Deutsch in *The Henry Street Nurse*, No. 1, 1921: 5–6).³⁰

Child welfare movement, an international reform movement of the time, formed a framework also for the activities of the Henry Street Settlement. "What does society owe the child?" was the topic of one long article of "J.R." in *The Henry Street Nurse* in 1921.³¹ The article argues that the vision that the child had been neglected in earlier public health activities, and that the family was the central unit and objective for preventive health activities. The popularizing of certain phases of health education is seen as essential and the relation between education as a responsibility of the community and health as an individual concern is discussed:

The health problem as related to the individual child must and does involve the family group. The child in his first contacts in a social relationship outside of the home reflects the family atmosphere, its advantages as well as limitations, and in turn he carries back to the family group his impressions and experiences. In New York City, especially among Italians, the child is an invaluable interpreter and teacher. ... [W]e need the co-operative support of the child, the adult, and the community. ... [I]n every department of welfare work we should stress the need for and value of preventive effort. ("J.R." in *The Henry Street Nurse*, No. 4, 1921: 1-2)³²

The child-friendly vision expressed by the author in the bulletin includes efforts to provide preventive health care during all the different stages of a child's life ("J.R." in *The Henry Street Nurse*, No. 4, 1921: 1-5).³³ Advice and skilled care for mothers during pregnancy and adequate care for the period of infancy and the first two years of life, "a habit forming period," included issues such as feeding, sleep and rest, exercise, fresh air, and the important transition from breast-feeding or bottle-feeding to a properly balanced diet. Observation during the formative period of pre-school age, often called "the neglected age," aimed at efforts to build up proper health standards of curing childhood diseases and preventing defects and serious handicaps. Health observation should continue in the schools, and should include both medical examination and school nursing service. The author summarizes by stating that the child "shall live to be born, shall be safeguarded by proper care through infancy, shall have particular oversight and necessary corrective work during the neglected pre-school age, shall have health supervision during school life that will insure his being fit to appreciate the opportunity for mental growth along with a just claim for leisure and the right and freedom of play."

These statements published in *The Henry Street Nurse* bulletin illustrate that this local reform movement tapped from the same ideological sources as did the nation-spanning women's organizations of that era that came to play a central role in the establishment of federal social programs for mothers and children. Theda Skocpol (1992) who has examined the early formation of social policy in the U.S. has emphasized the role of women's civic action in the political reforms of progressive era. Women's professional action was closely connected to these reforms, offering models for how maternalist ideas could be implemented in practice.

The federal Sheppard-Towner program "for the protection of maternity and infancy," implemented between 1921 and 1929, was an attempt to create a national program for preventive health care for families (see, for example, Reverby 1987 and Skocpol 1992). It relied on the work of the occupational group of public health nurses. This new form of governmental action for public health purposes supported the professional project of public health nursing in the U.S. and implemented many of the ideas from the innovative health centers and visiting nurse services in a federal program. From the perspective of this study, it is important to note that the idea of an extended role of female professional welfare work (Muncy 1991) also influenced

professionalizers and PH-activists within the RF, who collaborated actively with different actors in this field.

5.6 The Rockefeller Educational Strategy

While the RF's work in scientific and epidemiological research and medical education has received a great deal of attention from historians and social scientists, its sponsorship of nursing activities has been relatively neglected. This can be explained by a combination of pragmatics and politics (Lagemann 1983; Stapleton & Welch 1993; Rafferty 1995 and Weindling 1995). Both in terms of the size of the research communities and investment by the RF itself, nursing fell behind the shadow of disciplines such as medicine and social science, but the importance of its development of nursing and especially public health nursing is not as of yet acknowledged. One explanation for the Foundation's focus on public health nursing was its increasing reliance upon public health nurses as the "close bond of contact" between health authorities and the general public.³⁴ This view is stated frequently in different kinds of policy documents of the RF according to its public health programs between the 1910s and 1930s. The mediating or bridging role of the occupational group of public health nurses is emphasized in the process of carrying out scientific knowledge about health and disease or morally coded health propaganda to the "whole population" or to certain groups such as families with small children. The idea of the importance of the public health nurse in the general progress of public health grew thought. It manifested itself repeatedly in many of the program and policy documents of the RF relating to public health work in both North America and other parts of the world.³⁵

Although the administrative control of nursing issues within the RF had been divided between three Divisions with four General Directors during the first fifteen years of RF aid (1913–1928) in the formation of better public health, there had been one central goal during this early period, namely "to prepare the nurse for public health."³⁶ A focus on the training of public health nurses continued to be one of the key issues for the RF within its work on public health programs, although it was not a very visible strategy in comparison to medical issues.

In a survey about the Foundation's work done in Europe in 1913–1946, Thomas B. Appleget describes the 1929 reorganization of the Foundation.³⁷ There were now five divisions altogether working in different scientific areas: the International Health Division (IHD), the Division of Medical Sciences, the Division of Social Sciences, the Division of Natural Sciences and the Division of the Humanities. Here the interest lies in the IHD.

The service of the public health nurse was woven into the fabric of human life. In spite of the forces of depersonalization that had accompanied industrialization and urbanization, public health nursing still offered both the nurse and patient

an opportunity for individual contact and an individual relationship with a nurse. Individually, the public health nurses were to render fundamental, intimate and complex care and service, which had an impact on others' lives.

Dorothy Deming, expresses in a very practice-oriented way the main elements in generalized public health nursing that were also evident in the educational strategies of the RF.³⁸ She had worked as a generalized nurse herself in New Haven. Deming was convinced that the generalized model saved time and expenses, but even more important was the experience that the value of preventive work was increased by the generalized program. In her daily rounds of calls, the generalized nurse could get a comprehensive view of the health status and social situation of the individuals and their families. Deming presents tuberculosis work, "the hardest kind of public health work," as an example of not just being an opportunity to "detect early symptoms, the predisposing environment, and unreported cases," but also to identify "the undernourished child, the anemic mother and the overworked father" (Dorothy Deming in *The Henry Street Nurse*, No. 11–12, 1922: 3).³⁹ Compared with the specialized nurse the generalized nurse could experience shift of attention required by a variety of cases, treatments and situations.

When the group of nurses in her district were asked if they would like to go back to the specialized field they answered "that the generalized field was more interesting, offered more varied experience, presented more opportunities for self-development and finally that they themselves felt more satisfaction in their work because they were meeting the family problems more constructively than possible in the special field" (Ibid: 4). A broad knowledge base alone did not strengthen public health nursing but the knowledge of methods. A nurse who knows what step to take when her detailed knowledge failed was of great value in the public health field. The specialized workers were there for consultation, for advice, and for supervision and the generalized nurse in her capacity developed her roles of being "the research worker" and "the teacher" in the field (Ibid: 10). Finally, Deming views the service of the generalized nurse as a social service in its widest sense which required thinking in terms of the family, community, state and country, and in a long run "struggle toward a real democracy" in giving people an opportunity to reach better health (Ibid: 10).

Through their cooperative efforts and collective actions together with other health workers, and enlightened with a "scientific spirit," they were supposed to have a possibility to influence the shape of public policy at a local level and, in the long run, at the national and international levels as well, according to the several public health programs planned by the RF on the national and international arenas.⁴⁰

The RF's interest in nursing was stimulated by demands of related programs in public health and medical education. Modernizing medical training depended in part upon modernizing bedside nursing. The development of public health nursing was crucial to the success of public health campaigns. The "Hookworm campaign"

in the southern states of the U.S. began in 1909 with subsequent development of county health units under RF stimulus (Fosdick [1952] 1989). This increased the demand for public health nurses. The importance of including a nurse in a public health team undergoing work in rural sanitation work was recognized. The program, named *Commission for the Prevention of Tuberculosis in France* (1917–1922), included support to the training of nursing personnel and to the development of a country-wide, active, and efficient outpatient dispensary service.

Broader plans of public health work and the training of health visitors continued to receive RF assistance even after the "Tuberculosis campaign."⁴¹ Among the projects of the RF and its International Health Board (the predecessor of the IHD, hereafter IHB) and later of the IHD, were surveys of nurse training, financial support for schools of nursing to facilitate re-organization and to improve teaching and the development of new programs. The Foundation helped government agencies and nursing schools to establish local health departments to operate "for the control of disease and the protection of rural communities," as it was often formulated.⁴² The program of the IHD aimed to influence the creation of experimental health centers and training fields as a model for generalized public health work. These were considered likely to have a large influence on the formation of public health administration at a national level and the national training of both public health nursing students and medical students

Although high officials in the Foundation did not consider nursing an aim in itself, there were a few female RF officials with nursing backgrounds and interests who committed to issues such as general nursing and public health nursing, including child health care and maternity care (defined as "maternity nursing" by some nursing activists).⁴³ These persons belonged to a large network of officials from different national and international health and welfare organizations, such as the National Organization for Public Health Nursing (N.O.P.H.N.) and the National and International Red Cross. The aim was to influence the pattern of nursing and to build up an international infrastructure for nursing education. This process was characterized both by interplay and by rivalry. There was a lack of agreement among nurse leaders and health administrators as to what constituted proper training. On both sides of the Atlantic throughout the inter-war period many organizations, including the RF, were engaged in this discourse. The place that public health nursing was to occupy within the overall structure of nursing education remained controversial during the inter-war period.

Despite this controversy, there was enough support for public health nursing within the Foundation to enable the granting of a relatively large number of fellowships for foreign public health nursing professionals. The IHD of the Rockefeller Foundation and its predecessors assisted in the development of nursing education in forty-four countries.⁴⁴ They, along other actors in the public health field such as doctors, teachers and administrators, were able to study public health issues and work within public health abroad, primarily in North America, and bring new ideas back to their

home countries. The Henry Street Settlement was an important socialization factor for the nurses to be trained in the generalized public health nursing model which was promoted by the RF. They practiced local health work in this setting in New York City during the 1920s and 1930s. The Finnish nurses who came there were no exception.⁴⁵ In the Henry Street, they learned to perform their social role as public health nurses, and internalized values, norms and a workplace culture that differed greatly from their Finnish workplaces. For the Finnish RF fellowship holders the social casework method was the central element of public health nursing that they brought to Finland. The adaption of social casework in public health nursing is one example of the formation of modes of practice that the Finnish nurses saw as a way to support the early professionalization process of public health nursing in Finland with health nursing as its knowledge base. For them it was a kind of temporary alliance strategy described in Chapter Two. Social casework was one of the innovative educational strategies adopted in the public health nursing training field in the Municipality of Helsinki and also experimented in the RF-supported model training fields of the schools of nursing in the cities of Pori and Oulu and the province of Uusimaa in Finland. Later, the concept of social casework was further developed by the social workers and became central in their education and practice, and is still used today (Härkälä 1992 and Karvinen 1996).

5.7 Summary

This chapter has examined negotiated occupational formation of both general and public health nursing reflecting the Rockefeller Foundation agenda for public health nursing in the inter-war period. These processes took place in the social setting of professions and occupations and the social setting of voluntary and public agencies providing local health care services. Scholarly and practical knowledge, the type of educational institutions and the social organization of the practical work sought for the new public health nurses have been focused here.

The two identified key strategies that were vital for the formation of educational and administrative strategies in the RF-supported model for public health nursing were: (1) Supporting university-based training including a multi-disciplinary specialty training in 'health nursing'; (2) Generalized public health nursing (non-sectionalized work for a local population) with the application of the method of case finding social casework, and the public health nurse as a physician's associate or co-worker in approaching both individuals and families in the local community. The central elements in the RF-supported model for public health nursing are viewed in Figure 5.1 (next page).

This chapter shows that the new jurisdiction of 'health nursing' and 'generalized public health nursing' were claimed within processes and negotiations that sought for recognition of the new public health nurse in the public opinion arena, supporting legislation and governmental strategies and finally an independent field of local public health work.

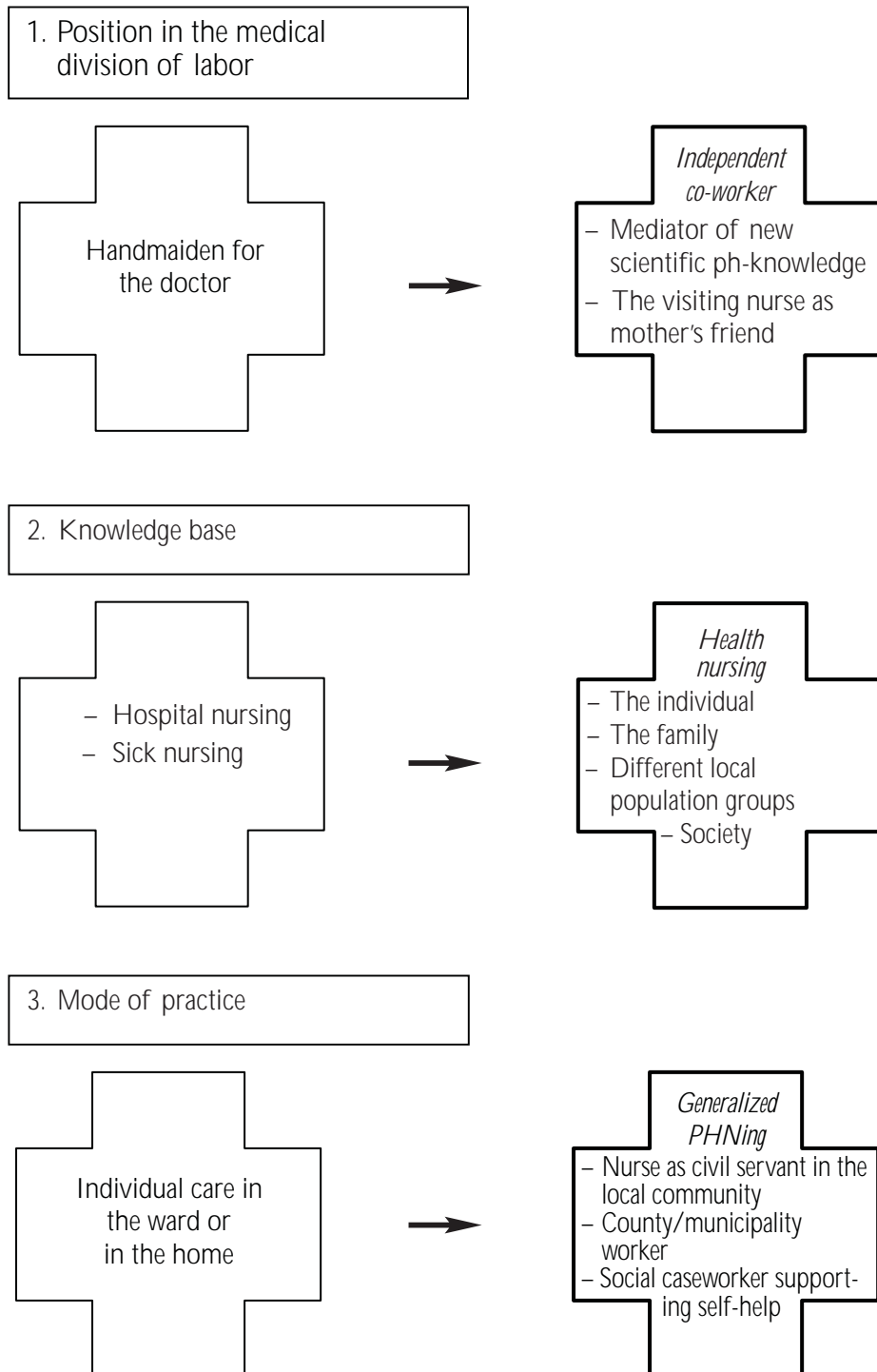


Figure 5.1 The new public health nurse

The Dissemination of Generalized Public Health Nursing

6.1 Introduction

In this chapter I examine how Rockefeller Foundation (RF) officials and Finnish voluntary non-profit organizations, public administrators and educators, who worked to professionalize public health nursing, used the concept of generalized public health nursing in order to institutionalize the knowledge base of 'health nursing.' In focus here is the way generalized public health nursing was defined in these interactions. Three central elements formed the core of generalized public health nursing and its negotiated implementation in Finland. First, public health nursing was not to be a specialization in any particular field. Rather, a public health nurse's practice would be directed at a particular district in the municipality and she would work for its population as a whole. In the Finnish context, this kind of nursing in a district of the municipality was called "centralized public health nursing." Instead of many different nurses visiting the same families and schools in the whole municipality area, centralized health care in the smaller districts of the municipality, done by a single professional, was thought to increase quality while also being economical. Second, the focus of her activities was to be the health and social status of a social "case" (usually a family), not a particular disease or symptom of illness. This health-view was in line with the multi-disciplinary knowledge base of the nurses and with work methods such as the "scientific" collection of health and social data about different population groups. The nurses were seen as a kind of "social doctor," but they had a unique way of dealing with the "whole" person or "total" life, meaning that the social environment (other human beings, the physical environment and the cultural environment) of the recipients of care should be mapped or surveyed.⁴⁶ Third, her practice centered around "demonstration," i.e. practical guidance taking place in health center consultations and in the homes of the recipients of their services. These "demonstrations" were early forms of promotive and preventive health education in the community. Together, these three features defined the way in which the knowledge base and modes of practice for public health nursing were applied in Finland.

One critical boundary event for public health nursing in the inter-war period in Finland was the creation of the State School of Nursing/Graduate School of Public Health Nursing in Helsinki in 1932. The state took over the education of public health nurses from voluntary non-profit associations with the use of this institution. The knowledge base for Finnish public health nursing came to be institutionalized in this setting. The influence of the RF on this central boundary event will be examined in this chapter.

The RF Fellowship Program enabled Finnish and other foreign nurses and doctors to study and practice public health in North America in the inter-war period and after WW II. It was a catalyst and an occupational socialization factor in the spreading of new ideas about public health practice and organization and training of personnel to a larger public around the world. This exchange program was not a major economic investment in comparison to the Foundation's other public health projects, but it was of lasting importance. To describe its effect I present a group of ten Finnish fellowship holders, eight nurses and two doctors, and examine their stays in North America. By studying this activity it is possible to analyze how new educational strategies for Finnish public health nursing were first experienced and tested by the Finns in an American context. It also helps to uncover institutional issues concerning Finnish public health and public health nursing during the inter-war period which the foreign collaborators were confronted with and interested in in their contacts with the Finnish fellowship holders. The exchange program gives a perspective on how the formation of a knowledge base and modes of practice are linked and socially constructed by the different actors involved, both in the national and international public health arenas.

The public health nursing vision is embedded in the broad programs and policies of the RF. Therefore it is not fruitful to analyze the Foundation's nursing or specified public health nursing projects separately and explicit, because this kind of nursing was still in its early formation in the inter-war period, and was very much subordinate to and dependent on more established and powerful professional activities in the system of professional welfare activities. The main objective therefore is to analyze how those who worked as professionalizers of public health nursing built up different alliance strategies to make the position of public health nursing stronger and more stable. Both opening up and closure strategies were used for collective mobility. They were used to mark an alliance with certain knowledge contents, modes of practice and organization models which the professionalizers thought to be valuable in the struggle for a more independent professional status for public health nurses. The core of this occupational activity in Finland was still vague and an intensive boundary-work took place at the borders of this occupational activity.

Before examining the exchange program and analyzing its impact on the formation of Finnish public health, I want to give a broader socio-historical and cultural background to the establishment of contacts between the RF and the Finnish health authorities and educators in public health in the inter-war period. The initial activi-

ties shed light on how international formation of a knowledge base and modes of practice in public health were gradually adapted to the Finnish context, with its confronting attitudes of nationalistic pride and open-minded interest in the outside world. The process was going through many different stages that were influenced and regulated by the broader political situation and by power relations with several conflicting interests in the inter-war period. I start with a brief presentation of the Finnish inter-war political history.

6.2 Background of the First Rockefeller Foundation Reports on Finland in the 1920s

Finland was a Grand Duchy of Russia from 1809 until the First World War. It has been independent since 1917. Geopolitically Finland was situated on the border between eastern and western Europe, which meant both an interplay with Russia, respecting Russian/Soviet security requirements and a retaining of Western economic and cultural ties. Michael Berry (1987), Docent of political history, argues that a reform program in the beginning of the century in Finland promoted a sense of unity among all Finnish-speaking Finns. The best defence against becoming Russian was a united society that identified with Finnish rather than Swedish or Russian cultural values and thus limited relations with the West to economic and cultural ties. Finland became independent in the wake of the February Revolution of 1917 in Russia. In the newly independent Finnish state, there were conflicts about how the state should be organized and political violence increased. A civil war ensued which the White, bourgeois forces won. The Finnish Civil War was fought from January to May 1918, between the "Reds," i.e. the Social Democrats together with Communists, and the "Whites," i.e. forces commanded by the Conservative Senate.

Finland was a hybrid society with the political, economic, and legal institutional arrangements of the Swedish era (integral part of Sweden until the Napoleonic wars) superimposed upon a socioeconomic structure somewhat similar to that of societies in Eastern Europe. However, Finland was never a feudal society. The nation was eventually organized around values and institutional arrangements of the Nordic countries and ideologically and economically Finland is tied to Western Europe, but has had to meet political imperatives associated with the dual peripheral situation as a borderland between two geopolitical/economic-cultural cores (for studies of Finnish political history and the inter-war period see Meinander 1980 and 1983; Berry 1987; Karvonen 1988 and Jussila, Hentilä and Nevakivi 2000).

The bourgeois victors in Finland pursued a policy of national reconciliation after the Civil War. They often denied socialists, and especially communists, equal rights, but Finland's bourgeois policy of land reforms and political democracy differed from other societies along the Soviet border. Finland remained democratic during the crisis in democracy in the 1930s. There was a homegrown fascist movement in Finland which originated as an anticommunist movement (see, for example,

Karvonen 1988) which first obtained some support from Agrarian and Conservative parties. The Finnish Agrarian party, however, turned toward cooperation with the Social Democrats in order to strengthen the political center against the extreme Right and extreme Left. The Finnish Conservative party also turned against fascism and was convinced that a respect of law was essential to the survival of Finnish institutional arrangements. In 1937 the Agrarian and Social Democratic parties formed the backbone of a centrist coalition government.

The wounds of the Civil War had not yet healed but gradually the Finnish society enjoyed a larger degree of consensus, first, on resistance to Soviet territorial demands and, later, on cooperation with Nazi Germany against the Soviet Union. Between 1939 and 1948 Europe was characterized by hostile ideological and military blocs. Finland emerged from the Second World War with its institutions intact. Finland gained unique status as the only Soviet neighbor with a domestic and foreign policy acceptable to both the superpowers. Finland's power has been rooted in its ability to manage domestic outcomes while adapting to external constraints.

The Rockefeller Foundation started its international activities early on. The RF public health strategy of the first half of the twentieth century can be characterized as one based on a broad understanding of public health, in which social medicine that focused on prevention played a central role. The international activities within the RF successively gained a stronger institutional position. The Rockefeller Foundation's International Health Commission (IHC) was established in 1913 and reorganized in 1916 into the International Health Board (IHB). In 1927 a larger reorganization took place in the Foundation and the IHD gained more resources for the expansion of their international agenda. A commission was of a temporary nature, whereas a board entailed the establishment of the activities as a continuous activity. As a division, the activities grew into a large-scale organization.

The IHC and its successors were established to export the new public health theory and its practices around the world. They planned and carried out health and welfare programs together with organizations such as the International Red Cross which aimed at the cure and prevention of disease and health promotion efforts to decrease health related problems on an international arena. They initiated activities in the inter-war period that were later continued by the United Nations and its different organizations such as the World Health Organization (WHO). Against this background, the formation of the public health nurse occupation in Finland was a part of a larger public health campaign that took place both nationally and internationally during the inter-war period.

The IHD was dissolved in 1951 and a Division of Medicine and Public Health was established. The WHO had taken responsibility for many activities that the IHD had been responsible for, but the IHD also now re-directed its activities more towards physiological hygiene or scientific biomedicine, chronic disease, environmental health and mental health.⁴⁷

The first contacts between the RF and Finnish public health activists were documented in detail in reports and field notes of three RF officials between 1925 and 1930. However, Finnish nurses had had contact with public health activities in the United States much earlier. As early as the 1910s, a few Finnish nurses studied at Teachers College at Columbia University and visited the Henry Street Settlement in New York (Sorvettula 1998: 232, 250). Central public health nursing professionalizers in Finland like Venny Snellman and Tyyne Luoma had contact with public health nursing in the United States in the early 1920s, and they continued to pursue these contacts through the RF.

However, public health nursing was not yet in the limelight of the RF's activities in the 1920s. In the report of a conference on nursing education in October 1925, nursing was regarded an "ancillary service" in the RF programs on public health and medical education.⁴⁸ Notable, regarding the Finnish context is however, the recommendation to "help in the creation or strengthening of a government or university school which will serve as an example ('lighthouse') of sound standards of admission, living and education, attract a group of students from whom leaders may be recruited, and exert an influence in improving the quality of nurse training throughout a whole country" (Recommendations of the conference in nursing education, October 1925: 2). Further-more, the conference recommended that the RF would "not enter into arrangements which include other voluntary societies," it should deal "directly and solely with governments or universities" (Ibid: 5). The school or the government which the RF collaborated with could however unconditionally belong to a network consisting of both public and voluntary agencies in order to support joint projects.

Early scouting in Finland was performed by medical doctors who aimed at describing the system of medical and health care in the country. They were also interested in medical education. The first report was written by Doctor Henry O. Eversole in 1925. The report, titled *Medical Education in the Baltic States—Preliminary Report Covering Finland, Esthonia, Latvia, Lithuania*, focused entirely on medical education.⁴⁹

The second report was made by Doctor Charles A. Bailey, who visited Finland twice. During his travels, Bailey wrote his reflections in short diary notes made in 1928 and 1929 that have been made available for this study.⁵⁰ The report titled *Public Health in Finland* was published in April 1928.⁵¹ It is long and detailed (332 pages divided into two volumes, each with rich illustration). The third report, *Survey of Medical Education in Finland*, was produced by Doctor Alan Gregg in April 1930 and focused more on medical education, as did Eversole's report.⁵²

All of the three authors had a medical educational and professional background. Their task was defined as explorative, meaning that they were primarily expected to map the situation in Finland. They based their analysis of the conditions in Finland on observations of the general features of the country and its geography, economy, politics, demography, primary and secondary school system, and university system.

They deepened their reports with detailed descriptions of the Finnish health care system, the medical education and also nursing education and nursing activities. The reports were based on field notes written for official diaries about their experiences during their trips around Finland, and on statistics and survey-data collected both from Finnish and American sources.

Despite the explorative emphasis, all three RF observers also made suggestions on what kind of support the RF could give Finland. The background for their suggestions was the discontent they felt with the situation of the Finnish medical profession.

6.3 Rockefeller Foundation Observations of the Finnish Medical Profession

The early RF observers discussed the situation in Finnish medicine in relation to the political situation of the country and its different potential strategies in relation to other countries, primarily to Germany, Russia and "the West" (the United States). For instance, Alan Gregg's survey in 1930 analyzed the role of medicine in the broader scope of nation-building in Finland. He discussed cultural differences between Western and Eastern politics in the inter-war period. The RF observer believed that an understanding of medical education in any country

... depends on being able to see medical education in its true relationship to the non-medical and non-pedagogic factors which condition it, rather than merely upon the ability to analyse and describe the various technical components of such education. Particularly is this true of such countries as do not share with Western European nations a similar or comparable background of history, geography, social conditions and economic resources." (Alan Gregg's report 1930: 1)

The RF observers regarded Finland in the late 1920s politically, socially and culturally both as a "Baltic" and a "scandinavian" country:

Placed between Sweden which truly belongs to Western Europe, and Carelian Russia against which it has no natural frontier, Finland can be placed accurately in neither Western Europe nor Russia, though its face is set undoubtedly toward Europe (Alan Gregg's report 1930: 2).

The American observers analyzed Finland in relation to Russia, the Nordic countries and to Western and Central Europe. The organization of international co-operation within medicine of the 1920s reflects the broader political tensions in the world and in Finland. One example is Eversole's criticisms of one of the Finnish medical associations for being too pro-German in matters relating to the international co-operation of scholars within medicine.

This Finnish Medical Society seems to be extremely pro-German in its sympathies, or else is going to extremes in its efforts to be fair. The French legation in Helsingfors transmitted to the Society, through the Ministry of Public Instruction, an invitation

to the coming Congress on Leprosy at Strasbourg in July, 1923. Some members saw no reason for the presence of Finland at the Congress, but it was decided to reply that Finland would take no part in it unless invitations were extended to Germany and Austria, as well as to other countries. In 1921 it formulated two other similar protests, one to the Société Internationale de Chirurgie ... against the action of the Society, which excluded all Germans and Austrians from membership, and another to the committee that extended invitations to the International Congress of Ophthalmology in Washington in February, 1921, for not inviting Germans and Austrians and for barring German as an official language at the Congress. (H.O. Eversole's report 1925: 21)

Topics such as the "Language, History and Racial Politics" of Finland are given a great deal of attention in the general introduction of Gregg's report in 1930 (pp. 3–6). The historical background regarding the languages in Finland in 1930 is described as a "peculiar" one, and a "curious three-cornered game" with Swedish, Russian and Finnish elements involved (p. 3). Gregg describes the Swedish minority as possessing a superior tradition to the Finnish peasants in the administration of affairs and the Russian revolution in 1917 and the civil war 1917–1918 in Finland (not directly mentioned by name by Gregg), thus shaping a "confused period in Finland when power was not very clearly in the hands of any element" (p. 3). Gregg argued that the Swedish speaking elements within the educational system and the state government were under suspect by the Finns, although the Swedish element in the training of the professions and in commerce is "almost necessary to the survival of Finland in any form" (p. 4).

Gregg continued by stating that Finland in 1930, in its new-found political independence, put intense emphasis upon "a relatively unknown language (Finnish)," which would strengthen and solidify the national self-confidence of the majority, but "retard development" (Alan Gregg's report 1930: 4). The Finnish language would have "no advantage whatsoever over the better known languages as a means of communication with the rest of the world" (p. 5). Gregg held a hopeful and optimistic view on the role of foreign languages in Finland because a "great activity in Finland to make English the second language" was taking place, but he also wrote that English would remain the third language for a long time, since the country "is really bilingual" (p. 5). In Sweden German was at this time the second language and contrary to what Gregg optimistically states about the position of the English language in his report, German also had a strong position in Finland, especially in secondary and higher education. One evocative feature that appears in the reports is that some of the well educated Finnish physician collaborators, whom the RF officials met during their visits, could only speak Scandinavian languages and German, not English.

The lack of understanding between the Finnish majority and Swedish minority in Finland was obviously a part of Gregg's experiences in Finland. "Like the Irish language Finnish is however borne upon the wings of racial patriotism, and in-

deed more than that since unlike Irish, Finnish is the living natural language of a large number of peasants" (Alan Gregg's report 1930: 5). Under the separate topic of "Racial Politics," Gregg wrote of old Swedish families who in spite of Russian domination continued to live in Finland through the last century [1809–1917] and that from the standpoint of education, per capita wealth, and traditional culture, the Swedish speaking Finns were superior to the Finnish speaking Finns. In Gregg's words, a racial struggle between Finn and Swedish stock was going on, and was caused by the language difference and to a certain degree by conflicting economic interests. "I had the impression that the difference is so great between the Finns and the Swedes in Finland that in most other countries there would be civil war or at least violent political disturbances," but Gregg continued to state that the problem is under control in Finland and would "smoulder in persistent fashion" but not cause violent disputes (p. 6).

Gregg (1930: 5) reports how the negative attitudes among some people towards Swedish traditions in the country and the position of the Swedish language had influenced the development of medicine in Finland: "one hears from Scandinavian professors that in Finland there is strong antipathy to Sweden."

The observers are introduced to the Finnish tradition of social hygiene, which involved the development of school medicine, the emergence of a public health administration and the collection of vital statistics (see, for example, Pesonen 1980). These issues are central in the first reports. The RF officials are very impressed by school hygiene (physical examination, rehabilitation of children with problems relating to development, sight, hearing and nutrition) in Finland and the way it is organized in comparison to with the U.S.:

Very searching regulations are in force as to the treatment of children who have been suffering from infectious diseases, and medical examinations that are still only a dim hope in certain parts of the United States have been a fact in Finland for years. The children who are entering school for the first time are carefully examined. ... The greatest attention is paid to the hygienic character of the school buildings. A book of plans of Scandinavian and Finnish schools shows with what care they are arranged and how well they are built, the smaller ones of wood and the larger ones of brick. Every rural school house contains an attractive apartment for the use of the teacher, in some of the larger schools there are even two apartments (H.O. Eversole's report 1925: 15–16).

The poor public health situation and vital statistics are explained in the light of the events of the civil war in 1917–1918, in a propagandistic way, with pro-Western ideals. Epidemics had been transmitted from the "chaotic" eastern neighbor:

The sanitary conditions of Finland are of special interest to Western Europe because that country constitutes the extreme left wing of the common front against the epidemics emanating from the Russian chaos. The extremely high death-rate of 1918 was caused by the ravages of the Red Revolution, partly through execution and murder and partly on account of epidemics that were brought into the country by

the Russian soldiers. The Russians brought typhus exanthemas, smallpox, scarlet fever and venereal diseases into Finland, and only by most energetic efforts were the Finnish physicians able to suppress the epidemics from the beginning. (H.O. Eversole's report 1925: 17)

The voluntary organizations' efforts to initiate and organize preventive and curative health work are central issues in the first reports. The voluntary organizations were involved in the fight against tuberculosis and in making child health a national concern (Savonen 1937 and 1957). The RF officials in relation to the social and geographic conditions in Finland of the time analyze these efforts. The Finnish National Anti-Tuberculosis Association (founded in 1907) and the Society for Aid to Poor Consumptives, carrying on "active educational, medical and preventive work ... [and] supporting a number of institutions, dispensaries, etc" are seen as important locally established welfare and health services which introduce new knowledge about public health, yet quite heavily subsidized by the state (H.O. Eversole's report 1925: 19). Considering such challenges as fighting tuberculosis and high infant mortality, Eversole states that the organization and building up of basic resources for Finnish health care are of vital importance for the future of the country. Eversole pays attention to a study on the question of "national tuberculosis control from every angle and to make a comprehensive report on the subject," a project initiated by the State Board of Health in 1922 (H.O. Eversole's report 1925: 19).

Even though the observers in general are impressed with the achievements of the voluntary organizations, they think that problems remain which can hardly be solved by private means. Bailey came to this conclusion explicitly:

A large part of the public health activities in Finland are in the hands of private agencies, although they are, practically all, heavily subsidized by the Government ... there is some overlapping and if the State Health Department assumed entire control, economy and greater efficiency would certainly result, while the local health officers would be drawn in closer touch and sympathy with public health work. (C.A. Bailey's report 1928, volume 2: 322–327)

The length of Finnish medical education was considered problematic, even though the observers recognize that there is no Finnish criticism against it (H.O. Eversole's report 1925: 28). Finnish medical education was also perceived as having positive features. Even though Finnish medical education involved a large proportion of theoretical study, Eversole pointed out with satisfaction that more practical studies were placed at the beginning of the medical training "in order to allow theory and practice to illuminate each other" by introducing the students to clinical medicine and the different specialties within medicine and by an examination which determined how capable the student was to enter the field of medicine (p. 30).

Bailey focuses his analysis on the role that physicians play for existing services (C.A. Bailey's diary notes 1927: 5–7).⁵³ Bailey compares the Finnish system with Sweden and concludes that the physician-led national organization of health services in

Finland is similar to the Swedish model, but perhaps more centralized with its central state organization, provincial/district health officers, and municipal and city health officers.

Bailey's criticism of doctors who have public health duties is harsh. The group of provincial health officers is criticized as "elderly men" with "rather limited" duties and Bailey points out that there are "no modernly trained Public Health Officers in the country" (pp. 5–6). A suggestion to arrange a RF fellowship to train a few public health officers in general public health and experts in epidemiology, statistics and bacteriology was "greatly appreciated" by the Finns (p. 6). The view of the spokesperson of the State Board of Health regarding school health services is that the organization of these activities should be in the hands of the State Board of Education. At this time a revision of the methods of public school education was also planned by a committee, and it was suggested that fellowships for people to organize and supervise these activities be founded.

Alan Gregg, who continues Eversole's and Bailey's work in 1930, emphasized medical education again. He viewed the RF's role as central for the establishment of a fellowship program for medical students:

Although the development of a thorough and effective method of training doctors depends upon the ability of the population to support the product of such medical training and upon the wealth and intelligence of the state in the support of higher education, there is evidence that *contact with the outside world is likely to be peculiarly valuable for the future teachers of medicine in this young country* (Alan Gregg's report 1930: 8, emphasis added).

6.4 Nursing in Finnish Public Health

The work which the nurses performed within public health in Finland was recognized early on by the RF observers. Eversole mentions the tuberculosis nurses, a predecessor to public health nurses, who performed home visits and carried out health education in the sparsely populated areas of the country. Eversole cites a Finnish physician, who is most likely Severi Savonen, the director of the Finnish National Anti-Tuberculosis Association during that time. In accordance with Savonen's views, Eversole emphasized the need to invest in the education of this group of nurses and to create acceptable working conditions for them:

According to the opinion of a Finnish physician who has studied the problem [tuberculosis] closely, the ideal method of control for small districts, as practiced first in the northern counties of Sweden and copied in Finland in 1909, is an examination of the entire population of a district, followed by treatment in a dispensary and prevention in the home under direction of a visiting nurse. But this method is impossible where the population is very scattered and ignorant and the physicians are few...this kind of work has been carried out [in Österbotten in Western Finland] under the direction of the National Society for the Control of Tuberculosis, by preliminary visits of

a trained nurse to every home. The nurse on her first visit examined every person that she could reach, and those with any suspicious symptoms whatever were urged by personal calls, by lectures, posters, newspaper articles, etc., to attend the clinics of the visiting physicians. ... In the meantime the nurse pays monthly visits to each home ... most of all to prevent the further infection of small children. The nurses for this work should receive special training and should have a secure and well-paid position; popular education on the subject should be made as widespread as possible. (H.O. Eversole's report 1925: 18–20)

Although Bailey's attention was mostly directed towards medical activities, he was also interested in the broader set up for public health. He pointed out that activity for public health and welfare have a general support in society, which he associated with Finnish nationalism. He also recognized the role of women in Finnish society:

There is an intense nationalistic spirit evident in every section of the country, and everyone—man, woman and child—is doing his utmost for the welfare and progress of the country. Women occupy a very important part in every enterprise of the country. (C.A. Bailey's diary notes 1927: 7)⁵⁴

Bailey's analysis paved way for new solutions to organize public health in Finland; he noted that the municipal physicians who also served as public health officers were only a limited, but in many ways satisfactory, resource for the activity:

The public health officers are part-time. In many countries this would be less desirable than full-time men, but in Finland where the largest proportion of its territory is sparsely populated, with an insufficient per capita number of physicians, and many areas where the health officer is the only physician within many miles, part-time service is inevitable and on the whole is giving satisfactory results ... the public health organization of Finland compares favorably with many European countries and is far superior to some It would seem highly advisable that control measures should be under the jurisdiction of the Central Health Administration rather than private agencies heavily subsidized by Government. (C.A. Bailey's report 1928, volume 2: 322–327)⁵⁵

As this passage demonstrates, Bailey perceived the role of "private agencies" for public health as a problematic one. However, Bailey used a lot of time to learn to know the voluntary organizations within Finnish public health. He met representatives of the voluntary organizations; the tuberculosis organizations, the General Mannerheim League for Child Welfare, the Finnish Red Cross and the Finnish-Swedish Public Health Association (C.A. Bailey's report 1928, volume 2: 249–274).

Bailey observed and reported on Finnish general nursing and the early forms of public health nursing, district nursing (deaconesses and younger trained nurses (1–2 years training) in the municipalities) and health nursing. Bailey gives a detailed presentation of the training and work of health nurses: tuberculosis nursing, child welfare nursing, school nursing and the new form of generalized public health nursing (C.A. Bailey's diary notes in October, 1927: 5 and July, 1928: 13–14;

C.A. Bailey's report 1928, volume 2: 229–244). His report 1928 include many photographs illustrating Finnish nursing. Baroness Sophie Mannerheim, "the Florence Nightingale of Finland," is presented and portrayed in the report (pp. 230–231). Finnish midwifery gets less attention in Bailey's report and it is outlined shortly compared with Bailey's reporting on public health, medical training, nursing training and child welfare (pp. 245–247).

In Finland, the training of public health nurses was in the hands of the voluntary (non-profit) welfare organizations, the General Mannerheim League for Child Welfare (started PHN-training in 1924) and the Finnish-Swedish Public Health Association (started PHN-training in 1926). Bailey discusses the role of the voluntary organizations in the formation of public health nursing activities in his 1928 report:

It was gratifying to find that a small country like Finland had already in the field a group of trained public health nurses and that there was a considerable demand for this type of service, particularly in the rural districts. Although the preparation of public health nurses is under the jurisdiction of a private agency, the General Mannerheim's League for Child Welfare, the service is developing on a sound basis and capable nurses are being prepared for field work. A very careful selection is being made of applicant three year trained bedside nurses for this public health course. *The facilities and funds for training public health nurses are limited and for these reasons it is impossible to prepare a sufficient number of nurses each year to meet the rapidly increasing demand for this service. The course should be developed by increasing its facilities and funds and closer liaison should be made with the Central Health Administration.* (C.A. Bailey's report 1928, volume 2: 328–329, emphasis added)

Bailey discusses the "rather high standard for qualification" for public health nurse training (graduate 3 year general nurse) (C.A. Bailey's diary notes 1928: 13–14). He is well informed about the shortage of public health nurses in Finland of the time and the claims within the higher health authorities to lower the standard of qualification. He also discusses the will of the General Mannerheim League of Child Welfare to maintain high standards for qualification and to decrease the shortage of public health nurses by raising the pay of nurses and by creating more health centers in order to prepare more nurses for public health. The League's multi-disciplinary training program in public health nursing and the practical training given for nurses at the League's health centers impress Bailey. In his opinion, the Finnish child welfare pro-gram had reached high standards and the league's established posts for supervisor of public health nurses and inspectrice of juvenile work help to standardize the child welfare work in Finland of the time.

Philanthropists like Bailey defined public health nurses as "translators" of broader and abstract scientific knowledge about public health for a local lay public. They were supposed to help to improve the living and working conditions for individuals, families and the community. The public health nursing experts involved in the international discussion thought that the knowledge and experience of hospital

nurses was not broad enough to “prepare” nurses for such public health demands. Neither did the social background of the general nurses educated for institutional work at the hospitals meet the images educators and administrators had of the new “health educator” in the local community in the inter-war society. Both the curricula and the recruitment of students for public health work were thus discussed and re-evaluated by the actors involved in the professionalizing of public health nursing.

The emphasis in the proposed measures for future RF aid was in developing the administration of public health by training physicians and funding large, expensive public health laboratory projects. A school of public health nursing is, however, also among the proposed measures. Bailey is the first RF observer to mention public health nursing specifically as a possible focus of RF support. It is obvious that he had in his mind certain people whom he thought fit to be candidates for possible RF fellowships and for certain positions in the Finnish public health organization and for the training institutions of public health nursing after studying abroad.

The strategies that Bailey outlined for the work that the RF was to perform in Finland are (C.A. Bailey’s report 1928: 330–332, emphasis added): (1) to make it possible for higher officials to study public health organizations and activities in foreign countries, (2) to provide fellowships for a few promising health officers for laboratory and general public health field study, (3) to strengthen the vital statistical service of the central health administration, (4) to aid in developing a central bureau of epidemiology in the central health administration and extend a fellowship to a promising young physician and, when he returns to his post, to give financial aid in the development of this service, (5) to aid in organizing a “much needed central bacteriological laboratory” and to extend a fellowship for the training of a director for that laboratory and later to aid support for the construction of a “greatly needed building” for this laboratory, (6) “[t]o aid in strengthening the campaign against Finland’s greatest problem ‘Tuberculosis,’ ” (7) to give material support and advice in the re-organization of the health service, and, last but not least in relation to the aim of this study (8) “[t]o aid in developing a school for Public Health Nursing.”

However, he did not believe in a major investment from the RF; rather, he believed that “moral support” could be effective without a major monetary investment. “Moral support” appears to refer to an ideological ground and values that are shared between the RF and the parties its representatives met in Finland:

There does not seem to be the need of any considerable or costly cooperation on the part of the Rockefeller Foundation, but there are several means whereby our material aid, as well as moral support and advice would be useful and most gratefully appreciated by a very receptive Government, which is proud of what it has achieved, but very eager for constructive guidance and assistance. (C.A. Bailey’s report 1928, volume 2: 330)

The third RF scout in Finland, Alan Gregg, also mentions public health nursing, but only in passing, because his report was mainly on the education of physicians

in Finland. The RF reports on Finnish public health that were written by the three doctors in the 1920s mainly discuss nursing and public health nursing in sections describing "assisting activities and infrastructure" that facilitate the work of the physicians. They also discuss such topics as building bacteriological and serological laboratories. Yet, already in the early stages of the cooperation between the RF and Finnish public health authorities, there were knowledge and plans regarding Finnish general nursing and public health nursing, which reached fruition, for fellowships for nurses. These fellowships were designed to promote generalized public health nursing.

Nursing professionalizers had for a long time campaigned in Finland for lengthening nursing education in accordance with international models (Henriksson 1998; Sorvettula 1998). This goal was achieved in 1929 when basic nurse education was lengthened by law to three years. The RF's role in achieving this goal may have been great, and it is at least reasonable to assume that it played an important part in the nationalization of the special training of public health nurses in 1931. The first groups of state public health nurses were trained at the State School of Nursing/ Graduate School of Public Health Nursing in Helsinki.

At this point, the RF fellowship program clearly served the interests of developing public health nurse education. A central person to travel to the United States at that time was Venny Snellman, whose scholarship in 1929 was for twenty months. The well-educated and internationally connected nurse administrator had a tailor-made program. She returned to Finland to the position of "female supervisor of nurse education," which was put on the State Board of Health. She was the first person to hold this position and played a central part in the establishment of the State School of Nursing in Helsinki, which was founded in 1932. This school took over public health nurse education from voluntary organizations, and it provided a six month long postgraduate course in public health nursing. The RF exchange program's influence was visible in the curriculum.

Another important person among the early nurse RF fellowship holders was Tyyne Luoma, who studied public health nursing and worked within this field in North America during the 1920s and 1930s. She was the director of the State School of Nursing from 1933 until 1943. Doctor Severi Savonen, leader of the activities of the voluntary tuberculosis organizations in Finland, became director of the Board of the school, and also held a RF fellowship in 1938. This influential public health activist also took part in RF exchanges from early on and became a powerful ally for nursing professionalizers.

The founding of the school is a central boundary event, but it was not a solitary policy goal. Legislation to make public health nurses municipal employees was also drafted. RF allies in Finland, including public health activists working in voluntary organizations, such as the General Mannerheim League for Child Welfare and the tuberculosis organizations, were central for rallying the law proposal. However, the

legislation met with political opposition and an even greater obstacle was in their way; the association which represented the municipalities preempted the legislation, and tried to shift its emphasis from public health to medical care. At this point the public health activists dropped the legislation in the suggested form (Siivola 1984; Wrede 2003).

6.5 Finnish Rockefeller Foundation Fellowship Holders in the 1930s

Between the years 1929–40 the Rockefeller Foundation and its IHD made it possible for eight Finnish nurses, working in the fields of general nursing, public health nursing, medical social work and nurse training, to spend six months to one year in North America (RF: Roster of fellows and scholars, pp. 370–371 (“Finland”).⁵⁶ Two doctors, who were Finnish specialists in public health issues and the treatment of communicable diseases such as tuberculosis, also received RF fellowships. It was planned that these people would broaden their comprehension of public health work with ideas developed in North America. The nurses studied education and administration for local generalized public health nursing purposes, both in theory and practice. The doctors broadened their knowledge about preventive medicine and public health administration at both local and governmental levels.

In addition to this pioneering group of ten, about thirty other nurses and doctors from the field of public health followed their footsteps after World War II in the 1940s and 1950s.⁵⁷ They were educated for the so-called Uusimaa district/provincial health center project, but the analysis of the activities of this group of stipendiaries and the Uusimaa project fall outside the focus of this dissertation.

Furthermore, 30 fellowship holders in other medical fields and in the fields of natural and social sciences as well as the humanities were able to study and work in North America in the inter-war period and after World War II. In the following part of this section I will describe in some more detail the first group of eight nurses and two doctors and their stays in North America in the 1930s.

The educational background of the eight nurse fellowship holders in the 1930s was heterogeneous. This reflects the state of the training of nurses for public health purposes in Finland in the 1920s (Siivola 1984; Yrjälä 1999). During their stay in the U.S. and Canada, the nurses wanted to deepen and broaden their views about the generalized model of public health nursing and social casework as a method. Community-centered and family-oriented approaches were central in this model (see Chapter Five). The previous educational and occupational background of the nurses at the time of their application for RF Fellowships as well as during their RF Fellowships shows that there was a strategy behind the RF’s fellowship program to promote public health nursing work at different administrative levels, including

both training and public health service (see Appendix 2). Some of the RF fellowship holders had previous international training in nursing from the Red Cross-supported Bedford College in London (cf. Sorvettula 1998).

The Rockefeller Foundation stated that the fellowship holders should have a plan, including possible future work in Finland after returning home. The nurses were encouraged to apply for positions within local public health work and in nursing schools and even central positions at higher administrative levels, such as on the State Board of Health, when they returned to Finland (see Appendix 3). The documents concerning discussions between Finnish public health nursing professionalizers and RF officials during the 1930s clearly show that the Finns expressed a wish to integrate suitable American ideas of public health work and training into the Finnish context.⁵⁸ RF administrators investigated what studies in North America in particular would best prepare the stipendiaries, with their different nursing backgrounds, for the tasks facing them back in Finland. This plan was made up as a co-operation between the fellowship holders, the representatives of the IHD of the RF and the officials at the Finnish State Board of Health (cf. Sorvettula 1998).

Half of the Finnish group of fellowship holders with a nursing background were between 33 and 35 years old, and the rest were between 39 and 41 years old when they went to North America, so they had all in all a great deal of working experience before they were sent to North America. The marital status was "single" for all of these women when they were granted the fellowship. The RF followed their educational and occupational developments after their stay in America. Their private lives were mentioned in the cards. For instance, it is documented in the cards that two of these female fellowship holders later married. Even though marriage appears to have been expected as a factor which would end these women's involvement in professional life, this does not seem to have been the case. One of these women married shortly after her stay abroad and remained married only a short time, because her husband died. She had a short break from professional life and went back to nursing after her husband's death. The other fellowship holder, who married in 1942, had two children and continued her occupational career on a full time basis.

The individual plans included both theoretical and practical studies (see Appendix 2). Finnish fellowship holders studied at leading programs in public health nursing and medical social work at American and Canadian universities, such as: Yale School of Nursing, Vanderbilt University School of Nursing and Program in Social Work, the School of Nursing at the University of Toronto, Western Reserve University School of Nursing, the Department of Nursing Education at the University of Chicago, the University of Minnesota, the New York Hospital School of Nursing, the School of Social Work at Simmons College in Boston and the Teachers College at Columbia University in New York. The fellowship holders studied subjects such as "public health," "public health nursing in theory integrated into undergraduate

nursing studies and as post-graduate studies," "public health nursing practical field training," and "social work and the casework method."⁵⁹

The stipendiaries also visited and worked at different health service departments for short periods, such as: the Philadelphia General Hospital, the Toronto Health Department, the Wisconsin State Board of Health, the New York State Department of Health and Johns Hopkins Hospital. All the stipendiaries in the group got to know the East Harlem Nursing and Health Service and the Henry Street Settlement in New York (see Chapter Five) very well when they studied and worked there during the 1920s and 1930s together with other foreign nurses. What impressed the Finnish nurses was the opportunity to become familiar with innovative local visiting nurse services that combined home visits, health demonstrations and social services for families.

The two physician stipendiaries mentioned were both trained in Finland; Severi Savonen completed his M.D. in 1913 and Erkki Leppo finished his M.D. in 1936. Savonen was Secretary General of the National Anti-Tuberculosis Association in Finland; he was also in charge of anti-tuberculosis work in Finland. He also acted as chairman of the Directing Committee of the State Graduate School of Public Health Nursing in Helsinki. His RF Fellowship lasted for 3 months in 1938. His program was tailor-made to allow him to observe public health administration and tuberculosis work in the U.S. and to visit state and local health departments and schools of nursing and hygiene in Baltimore (Maryland), Nashville (Tenn.), New York City and Boston. Savonen wanted to get a comprehensive view of the full-time public health service model at the local and state levels in the U.S. He also wanted to get to know how preventive medicine was taught to undergraduates and public health to graduates. He was also interested in the role of public health nursing in the U.S., the rural health center model and how nurses were trained for this purpose. Before returning to Finland, Savonen visited the London School of Hygiene and Tropical Medicine and met the RF representative in Europe, Doctor Warren, at the RF office in Paris.

The younger doctor, Erkki Leppo, had worked as an assistant physician at the Hospital for Communicable Diseases for the City of Helsinki. Leppo got his RF Fellowship for one year, 1938–39. At this point the decision had already been made to initiate the experiment in the Municipality of Helsinki in Finland to allow practical implementation of public health ideas following the RF model for rural local health centers.⁶⁰ Professor Eino Saari at the University of Helsinki describes Leppo's U.S. training in a letter in May 1940 as follows: "L's U.S. training was for his directorship of the 1st full-time rural health dep't in Finland, the "Helsinki County Health Dep't at Malmi [the project in the Municipality of Helsinki]."⁶¹

Leppo took several courses during his fellowship year at Johns Hopkins School of Hygiene and Public Health in Baltimore (Maryland), the school that acted as a model for the Flexner report about medical training in the U.S. and got a master's degree

in Public Health. His studies and grades are reported in detail in the Recorder File of the RF. Comments on his progress and where he might work in the future were also written in the file, such as: "L.J. Reed considers L. an excellent student and is willing to push him along as much as possible, espec. as HM explains to him that L's training may be very important in the development of future work in Finland."⁶² After he completed his studies, he visited several health departments, such as the departments in Lansing (Mich.), Nashville (Tenn.), Montgomery (Ala.), and Albany (N.Y.). Leppo visited many health centers, schools and associations active in the field of public health, such as: the East Harlem Nursing and Health Service, the National Tuberculosis Association, the National Public Health Association and the Maternity Center in New York City, the Henry Phipps Institute in Philadelphia and the U.S.P.H.S. in Washington D.C.

Savonen and Leppo were seen as the innovators of a generalized public health service and its administration in Finland at a local (rural) level and as a governmental public health policy. RF administrators described Severi Savonen as follows: "Although S. is not the Director of Public Health Service in Finland, he is probably the most influential individual in the field of p.h. in that country."⁶³ Savonen continued his anti-tuberculosis work in Finland and in 1944 he was called to be director of the newly established Public Health Division of the State Board of Health in Finland.

The number of fellowship holders during the 1930s was not large, but the choice of who received a fellowship and how they spent their time in the United States show how well the intensified exchange between public health activists and the RF was integrated in policy implementation in Finland, especially in the late 1930s. At this point, the institutionalization of American ideas of public health nursing also started at the practice level of nursing.

6.6 Summary

The focus of this chapter has been on the dissemination of the RF agenda for generalized public health nursing in the context of the 1920s' contacts created between the RF scouts and Finnish actors and in the context of the fellowship program that the RF provided for foreign nurses and doctors within public health.

The Foundation's attitude towards possible RF-funded public health projects in Finland remained a "wait-and-see" policy during several years after Eversole, Bailey and Gregg finished their reports in the later part of the 1920s. However, the RF analysis of the Finnish situation became gradually broader and more nuanced. The reports were not just informative and descriptive in their expression, but also included arguments and statements about the formation of Finnish inter-war public health and public health nursing, which were a result of detailed discussions between the RF scouts and several Finnish public health actors. Personal contacts

between RF officials and Finnish health administrators and educators who had both medical and nursing interests were established at this stage. This contact continued for several years through correspondence, even as new officials entered the offices, which happened within the RF particularly.⁶⁴

The fellowship program represented the cautious strategy that the RF applied on Finland. The hand picked fellowship holders got firsthand experience of the U.S. model, a circumstance that increased the RF's trust concerning the way RF resources would be used in possible Finnish projects. The fellowship program also made it possible to maintain, renew and establish personal contacts between the RF and the Finnish partners.

The conditions for the collaboration between the RF and Finnish actors were clearly stated and critically motivated on both sides. General nursing education in Finland had reached a rather standardized stage when the collaboration with the RF was initiated in the mid-1920s. By the early 1930s both general nurse and public health nurse training had been nationalized. The voluntary welfare organizations had prepared a stable ground regarding early health nursing in Finland and for implementation and institutionalization of the generalized model for public health nursing at local health centers in the community.

In a meeting with Elisabeth Crowell, nursing officer at the RF's Paris office, on November 2, 1931, Miss Tracy and Miss Hubbard discussed their detailed experiences of a recent visit to Scandinavia. They stated that "Finland was the only country where they saw any P.H. nursing worth mentioning" and that they were impressed with "what Miss Snellman has done in the way of raising the standard of nursing schools and organizing the preliminary training centers" (Elisabeth Crowell's diaries 1930-1931: November 2, 1931).⁶⁵ They continued to argue that the hospitals in the Scandinavian countries had a very high standard but that the training schools in general were "still more or less in the dark ages as far as educational organization is concerned."⁶⁶

Generalized Public Health Nursing in Practice—the Model Training Field in the Municipality of Helsinki

In Finland, the one country that has paid her war debt, we find a pattern in process of weaving that gives great promise of the desired plan and program of nursing education and nursing practice for a given unit of population. ... [S]he has been foremost in seeking knowledge from other countries to forward progress in her own. (Dean Annie Goodrich of Yale University School of Nursing, quoted in Beard 1936, “Fundamental Changes in Nursing Education”: 4)⁶⁷

7.1 Introduction

In this chapter I examine what kind of recognition the professionalizers of public health nursing within the Rockefeller Foundation (RF) and amongst Finnish actors sought for regarding rural public health nursing, in North America and in the Finnish context. A particular focus is on how jurisdictional claims concerning the generalized public health nursing model were presented in the negotiations between the RF representatives and the Finns. The central actors here are: the RF-actors and Finnish officials at the State Board of Health in the planning and implementation process of the health center project in the Municipality of Helsinki; RF-supported American, and Finnish public health activists promoting rural public health; the representatives of the rural Municipality of Helsinki; and educators representing the State School of Nursing/Graduate School of Public Health Nursing in Helsinki.

I contextualize the claims-making process by first looking at the RF inter-war vision of hygiene, rural public health organization and administration, and the training of medical and nursing personnel for the county health centers in the U.S.

The local health center organization, with its full-time health officers (physicians) and public health nurses and midwives who provided a broad range of health services for the local community, is an example of a mode of practice that in the Finnish case became very influential for the formation of local municipal health centers on national bases in Finland. My focus is on the institutionalizing educational processes regarding the health center model that supported the professionalization of the public health nurse occupation. The local health center model including the

RF-supported training fields for public health nursing reflect educational strategies carried out by the RF and negotiated with Finnish health administrators and Finnish educators of personnel for public health purposes. These ideas had been applied to many administrative and educating institutions which supported the shaping of county health centers in the U.S., but with a limited effect. They were however further disseminated in the RF's public health policy and program which was spread abroad.

The following sections examine the specific implementation of these general ideas in the context of Finnish public health, in the planning and realization of the Malmi health center project in the Municipality of Helsinki.⁶⁸ I examine the alliance strategies used by the RF officials and Finnish public health actors to develop the public health organization and public health nursing within that organization in Finland. A key aim was to institutionalize generalized public health nursing as a part of the public health work in Finland. In Chapter Five I demonstrated how the education of public health nurses went in this direction. I also discussed the first attempts to introduce legislation on public health nursing. This chapter examines how a model health center was created in order to support practical training for public health nurses and to show the symbolic meaning of the creation of a more independent and visible position for public health and public health nursing in the local community. The different features of this demonstration field are examined in order to better understand the rural local health center model as it was applied in the model. Furthermore, two coincident critical boundary events in the Finnish context are shortly considered. First, there was the report of the Rural Health Committee issued in 1939, which included a proposal for an act on public health nurses. Second, an Act on Municipal Public Health Nurses and Midwives and Municipal Child Health and Maternity Centers was enacted in the Finnish Parliament in 1944. These events mark the legislative boundaries of the formation process of Finnish public health nursing. The knowledge base and the modes of practice these boundary events related to were similar to those that Finnish activists together with the RF developed for Finland during the 1930s and the early 1940s.

7.2 The Rural Local Health Center Model and the Public Health Nurse

The RF's model for generalized public health nursing with the key elements forming the knowledge base, described in Chapter Five, and the type of public health nursing work using social casework as one method in addition to more traditional nursing practice methods are all present in the RF's model for rural local health center organization.

To understand the Foundation's motives behind such a model, it is necessary to examine the principles and policies stated in the early formative process of the RF. Already in 1911 Jerome D. Greene, at that time general manager for the Rockefeller

Institute, had presented to the trustees “a memorandum on principles and policies” that was to have a significant influence on the later development of the RF policies (Fosdick [1952] 1989: 22–23). The Foundation was to invest in large-scale projects that aimed at changing social conditions, not merely at alleviating social problems. These principles and policies very much reflect the purpose of the RF public health projects in Europe, even such small projects as the health center project in the Municipality of Helsinki in Finland. The principles and policies include the following statements (Fosdick [1952] 1989: 22–23, emphasis added):

- (1) Individual charity and relief are excluded.
- (2) Institutions or enterprises that are purely local are similarly excluded, “except as aid may be given to their *establishment as models to other localities*.”
- (3) When an institution goes into a community with the intention of making a contribution to its welfare, “no gift of money however large, and no outside agency however wise or good, can render a service of permanent value except insofar as the gift or the agency offers the *means* or the *need* to be met, *its own will to meet that need*, and *its own resources*, both material and spiritual, *wherewith to meet it*.”
- (4) “In general, it is unwise for an institution like the Rockefeller Foundation to assume permanently or indefinitely a share of the current expenses of an institution which it does not control. Such a continuing relation inevitable carries with it a continuing responsibility for the conduct of institution that is aided ... and the implied continuing approval of management tends to make the receiver subservient to the giver, thus detracting from the receiver’s independence and self-respect *When giving to the support of institutions or movements for which the community, whether general or local, ought to make itself responsible*, the Foundation will, as a rule, assume *less than half* of the cost of current expenditure.”
- (5) The Foundation must carefully avoid the dangers incident to gifts in perpetuity. It should not hamper the trustees of other institutions by gifts in perpetuity narrowly limited to particular uses.
- (6) “As between objects which are of an immediately remedial or alleviatory nature, such as asylums for the orphans, blind or cripples, and those which *go to the root* of individual or social ill-being and misery, the latter objects are preferred—not that the former are unworthy, but because the latter are *more far-reaching in their effects*.”

To illustrate the RF’s visions of the role of public health nursing within rural, local public health services, and educational and administrative strategies concerning the theoretical and field training of the new occupation, I have examined John A. Ferrell’s four articles on the rural public health service, its work and personnel.

The articles also draw attention to North American negotiations in the 1920s and 1930s about the division of labor between federal (national), state, and local health departments and agencies. It is important to identify actors and ideas in such negotiations in order to understand the adaptation of the idea of a generalized local health center model in rural communities in the Finnish context and the RF's influence in that process.

John A. Ferrell worked as Associate Director of the IHD of the Rockefeller Foundation for several years and he was also President of the American Public Health Association.⁶⁹ Ferrell retired in 1944. These articles are part of the RF's archival collections on policy and program documents and RF statements within North American public health reform. The articles were written in the years 1926, 1927, 1933 and 1940 for different audiences and purposes and are statements in the debate of the time, focusing on the organization of public health in rural areas of the U.S. and Canada. They also reflect the ongoing discussion about the general acceptance and public support of public health and the role of public health nursing in the rural communities. The economic depression in the beginning of the 1930s limited the economic resources and sharpened the discussion of what strategies should be prioritized in public health. The division of labor between public and private/voluntary organizations and between national (federal), state and local authorities promoting public health reform is discussed in the articles.

In June 1926, Ferrell wrote an article for the journal *Public Health Nurse*.⁷⁰ It is titled *The Public Health Nurse and County Health Service*. The second article is based on a speech which Ferrell held at the proceedings of the *Fourth Annual Conference of State Directors in Charge of Local Administration of Maternity and Infancy Act* in Washington D.C., January 11–13, 1927. It was titled *The County Health Organization in Relation to Maternity and Infancy Work and Its Permanency* and published as a Children's Bureau publication.⁷¹ A few years later on October 9, 1933, Ferrell delivered a Presidential Address before the American Public Health Association's sixty-second annual meeting in Indianapolis. The title for his talk was *America's Contribution and Problems in Public Health*.⁷² The fourth collected Ferrell article, is an article titled *State and Provincial Health Organizations* in *Nelson Loose Leaf Medicine*, which was published in 1940.⁷³

Ferrell (1933: 1119) identifies the rapid growth of broadly defined activities in public health nursing in the beginning of the twentieth century as essentially an American movement. In his 1926 article directed toward the public health nurses, Ferrell gives a broad description of the county health service in its pioneering phase in the U.S. and describes in a rather functionalistic and harmonizing way the role of public health nurses within this local health organization. Ferrell reflects on the origin, growth, function, character, cost and value of county health service, and the role and attitude of the public health nurse within such health service.

Furthermore, in the 1926 article Ferrell assigns the central role in public health to the public health leaders who, according to him, originated the local public health organization in their effort to conduct adequate health services within the homes and in the schools of villages and rural communities. In convincing terms, Ferrell discusses the institutionalization of public health in the local context. He recognizes that the public health organization for the county was a recent development and identifies that the county health movement gained headway first in southern states due to the large incidence of communicable diseases in the 1910s.

In the 1926 article, and also in the 1927 speech directed toward administrative actors of maternity and child health services, Ferrell (1926: 339 and 1927: 58) presents figures that document a considerable growth in the number of county health organizations: When up to the end of 1916 there were 12 county health organizations, by the end of 1926 there were already 331. He emphasizes the role of the Rockefeller Foundation: 226 of these county health organizations had received contributions from the RF in the establishing process of this service. The objectives were comparable with those of an efficient city health department, but the rural program had a broader scope. Even though Ferrell can report a successful trend, he recognizes that the idea of having county health organizations did not quickly gain general acceptance and public support. The new organization had to find itself, take shape and spring into action. This process required time and some experimentation with programs and personnel. Ferrell emphasizes the role of the existing competent and strong leadership within public health nursing. In his view, university courses in public health nursing, their own organization and journal, and the section of public health nursing within the American Public Health Association, show how the public health nurses had gained a visible position in the public health reform work (Ferrell 1933: 1119).⁷⁴

In both voluntary and official public health agencies, the public health nurses had far outnumbered other categories of health personnel (Ferrell 1933: 1119). The use of public health nurses was seen as more cost effective than the use of expensive services of medical county health officers (Ferrell 1926: 342–345). The size of the population group that one public health nurse would have in her district had been an issue widely discussed. The proposed numbers in the mid-1920s varied from one public health nurse for every 2,000 inhabitants to one public health nurse for 20,000 inhabitants (Ferrell 1926: 344). Ferrell thought that the economic conditions and public sentiment would have to change before there could be a decrease of the size of the territorial units that one public health nurse would be responsible for, especially in the rural communities.

In his 1920s' articles, Ferrell criticizes too much federal and state control of local county health policies. He emphasizes the tradition of a desire for, and pride in local self-government. The establishment of an "efficient, quick and thorough" local public health service is essential, "an unwieldy centralized health organization is not generally efficient or popular" (Ferrell 1926: 337, 339 and 1927: 55). On the

other hand, Ferrell becomes more conscious in the later articles about the federal and state health officials' role of bringing leadership, financial aid and guidance to the local development of public health services. In his view, the county health movement with its local organization could be a common ground for all interested agencies, state and local, public and private, for combining resources to establish and maintain adequate full-time service with qualified workers. In Ferrell's 1940 article, he presents statistics from the 1932 Public Health Bulletin No. 184, about the different divisions of public health activities within the state and provincial (Canada) health organizations. The organizations were far from uniform in the beginning of the 1930s. In this formative stage, there were several divisions of public health related activities. The trend seemed to be that in many U.S. states the public health nursing divisions had started to collaborate actively with the divisions for maternity and child health care ("Maternal and Child Hygiene") as a result of governmental social security funds administrated through the federal Children's Bureau (Ferrell 1940: 291–292). In Canada, all provincial health departments had combined public health nursing and child welfare activities in a single division.

A relationship with federal and outside health agencies was recommended for the county health organizations. Ferrell argues that the federal Sheppard-Towner fund for maternity and infancy welfare work in the 1920s had a stimulating effect on the growth of county health services. The Children's Bureau of the Department of Labor is viewed in the articles as an important actor supporting maternity and infancy welfare work in collaboration with other federal actors, and state, local and private actors.

Ferrell (1927) observes that the merits of "specialized" versus "generalized" activities for the local public health organization or for the members of its staff had been recently lively discussed. He points out that when the service for small towns and rural communities with few workers available to cover vast areas was planned, only limited specialization was feasible. In 1927, before the state directors in charge of maternity and child health services, Ferrell makes a sharp distinction between the traditional "medical profession" as private practitioner and the new "health workers" in collaboration with and supported by the health departments. Furthermore, he discusses the possible applications of clinical medicine on one hand and preventive medicine, hygiene and public health on the other, in local public health activities (Ferrell 1927: 58). This sharp drawing of boundaries perhaps reflects a view that the traditional specialties based on hospital services had to be altered with new kinds of specialties and new divisions of private and public labor in the field of community-based public health, which would fit the conditions in the local communities. In the county health model, Ferrell (1927: 58) supports a dominant position for the medical profession, i.e. a foundation based on medical knowledge and medical practices, but requests the physicians to cooperate as much as possible with other groups of the county health staff. Furthermore, he supports an idea that "the health worker, whether physician, nurse, or sanitary officer, will find it necessary, as a rule,

to function much after the fashion of a general practitioner of medicine" serving all kinds of population groups in the territorial public health units (Ferrell 1927: 56). Ferrell draws new boundaries of future public health work which will promote and expand the medical dominion in community-based public health by stating that "[t]he practice of medicine should be entirely the province of the practicing physician, and he should consider it a part of his duties to practice preventive medicine among his own clientele" (Ferrell 1927: 59). Furthermore, he argues that "[i]f I were a health worker in a county unit I should not undertake any activity that could be considered to belong to the field of clinical medicine" (Ferrell 1927: 67).

Doctor Monger, director of health in Ohio and delegate at the conference, commented on this statement of Ferrell by adding that "[w]e must remember that in this sort of work we can not go faster than the medical profession can or will go with us" (Ferrell 1927: 67). Monger defines public health administration as a "distinct specialty" and as "application of the principles of preventive medicine" led by a medical doctor, "who must be a scientific statesman" (Ferrell 1927: 67). The role of the other health workers is to cooperate and assist the physicians, "[i]n cooperating with them [physicians] and in attending to general public-health duties which can not be expected of the practitioners of medicine, the health worker will be fully occupied" (Ferrell 1927: 59).

Ferrell suggests that the state administration could employ a small group of experts in order to "give leadership, counsel, and aid to the local workers" (Ferrell 1927: 55). By 1940, there was still uncertainty and different opinion in administrative circles about how public health nurses could be included as experts in the state and provincial health departments for supervision of local public health nurses. It was widely recognized, however, that "public health nurses are absolutely essential to health services, that they should be well educated academically, socially, and professionally, and that they should enjoy a responsible status as to both rating and compensation" (Ferrell 1940: 294).

Ferrell (1926 and 1927) emphasizes the importance of competent personnel. He argues that the broad scale of health problems on the community level required a full-time health service (Ferrell 1926: 337 and 1927: 55). Results that are more lasting could be reached with trained health workers that would continuously work with health education among the local population. In Ferrell's (1926: 343) view, the character of the personnel employed, the measurable results obtained in the public health field, and the impression made on public opinion would ultimately determine how favorable and cost effective the rural county health service would be.

A modern health service required good training for the health workers and adaptation of new methods and scientifically based knowledge to deal with the health problems more effectively. Ferrell declares that the three main professional groups in the new county health organization model were the physicians, nurses and sanitary officers, assisted by a secretary. However, this group of public health personnel

lacked qualifications for this pioneering work. Ferrell (1926: 338) states that the practicing physician, as a part-time health officer, had to be educated with respect to the duties of the full-time health officer. The occupation of a sanitary officer had to be introduced and people had to be trained to work within this position. This called for theoretical training in preventive medicine, hygiene and public health but also "a few months of practical field training under efficient direction" (Ferrell 1926: 341). "The right kind of practical field training" would stimulate "a spirit of team-play" among the staff members and make for "harmony, contentment and efficiency" (Ferrell 1926: 341). Practically all government boards of health, which were in the process of developing county organizations, insisted upon both theoretical and practical training for their main health workers.

More registered nurses, who were engaged in the care of the sick, had to be educated to serve as public health nurses, i.e. to be engaged in keeping people well. Ferrell (1926: 341–342) stresses that the generalized public health nursing model fits well with the broad scope of rural public health activities. The gaining of such a broad knowledge base would be possible only with university-based public health courses in combination with the support of a competent and experienced health officer and supervising nurse in the field. The broad public health nursing activities could consist of public health education, control and following-up on cases of communicable disease, pre-natal and natal health care, infant and pre-school health care and measures to combat special diseases, such as tuberculosis and venereal diseases. The arenas for health education were the home, the school, the classroom (health education for small groups) and the clinic (health check-ups). Public health nurses conducted well-baby clinics (preventive child health care) and classes for pregnant mothers.

The topic of Ferrell's speech at the Conference for State Directors in Charge of Local Administration of Maternity and Infancy Act 1927 stressed the question about the permanency of maternity and child health work. There were different opinions about which professionals should be in charge of this field of public health work which Ferrell (1927: 57) characterized as "highly specialized work" within the generalized public health program. He presents three administrative models that had recently been adopted in the rural communities to improve maternity and child health care (Ferrell 1927: 60). The first model was based on the state health departments' "special workers" (he does not define the occupational and educational backgrounds of these workers) taking care of maternity and child health work in wide areas and a commitment among these special workers to develop this special field of public health work. The second model was based on the activities of voluntary public health nursing organizations providing maternity and child health services in one county, or sometimes covering a few counties. The third widely used model was based on the county health departments' use of federal Sheppard-Towner funding for arranging at least a minimum maternity and child health services in the

local communities. The Sheppard-Towner fund had enabled a faster establishment of county-based maternity and child health units.

Hence, there were several diverse methods to deal with especially the problem of the high maternal mortality rate in the U.S., which the delegates at the conference had expressed their worries about. Some thought that the maternity and child health field of work belonged to clinical medicine (obstetricians and pediatricians) and others thought that the new specialists in preventive medicine and public health would be in charge and carry out these health care activities.

The midwives were seen to play a minor role in the new county health model based on health workers such as physicians, public health nurses and sanitary officers. They needed to be educated along the lines of the new scientific medical knowledge in the public health field. One expressed goal in the generalized county health model that was adopted was to “instruct and supervise” and “inform” midwives about new knowledge in the fields of preventive medicine, hygiene and public health (Ferrell 1940: 292). The midwives in the U.S. and in Canada were not seen as central autonomous actors in the generalized public health model. In the southern states of the U.S., black midwives had taken care of most of the deliveries. Ferrell (1940: 292) states that “the instruction and supervision of midwives is a real problem but the number of midwives is being diminished yearly and to an increasing degree physicians attend women in confinement.” Midwives were not very commonly used in maternity health services in Canada either although some provinces, e.g. New Brunswick, reported 15 percent midwife attended births.

The public health activities were conducted from a community point of view. The community and not the individual became the employer. The prevention of disease, rather than its cure, became the chief goal. Ferrell argues that this change in the orientation of work demanded a new attitude of the professionals, something that needed to be achieved in practice and not only in theory. To engage the attention of the county health personnel when no epidemics required special attention was one task, which could promote the public health nurses’ intimate contact with the school and the home. The public health nurse served as an essential part of the local health organization in this county health model (Ferrell (1926: 346–347). Doctor Monger (quoted in Ferrell 1927: 68), delegate at the 1927 conference for state directors in charge of maternity and child health activities, describes the nurses’ role as the bond of contact between the health staff and the population by their visiting nursing methods within maternity and child health care. He argues, “after all the tap of the public-health nurse on the taxpayer’s door is foremost in the whole picture of public-health accomplishments” (Ferrell 1927: 68).

7.3 A Critical Moment in Finnish Public Health Nursing

Many negotiations and contacts between Finns and Americans preceded the decision to experiment on institutional generalized public health nursing within a local health center organization at the end of the 1930s. This local health center offered community health service on a broader basis than earlier practices, and it served a double purpose. First, it was a model "demonstration field" for public health administrators adapting the concept of full-time primary care services. Second, it was a model "training field/area" for the State School of Nursing/Graduate School of Public Health Nursing in Helsinki and other public health personnel, where new educational philosophies and the method of social casework in individual and family health teaching, described in Chapter Four, could be experimented. The Finns argued that the experiment could show how generalized public health nursing could be practiced "for the benefit of the rest of the country" (letter by the Acting Director of the Finnish State Board of Health, Herman Lavonius, to George T. Strode, representative at the Paris office of the Rockefeller Foundation, December 20, 1937).⁷⁵

Frederick F. Russel, who was the director of the International Health Division (IHD) of the RF in the late 1920s, and George K. Strode, the director of the Paris office of the IHD who was later to become Russel's successor, were particularly impressed by C.A. Bailey's report (1928), which was compiled on public health in Finland (see Chapter Six).⁷⁶ The correspondence of these high officials from the years 1928–1929 includes statements that the Finns "are progressive" and that public health work in Finland was at a high standard when compared with many other countries.⁷⁷

However, Strode in particular was cautious at the end of the 1920s. In his opinion, the support that the RF could give Finland at that time should not extend beyond fellowships for personnel. Russel adopted this vigilant line, and together the two officials persuaded other representatives of the International Health Board (IHB, predecessor of the IHD) that larger Finnish-American public health projects were not to be supported for the time being. Nonetheless, in a letter dated June 18, 1928 Strode comments on a planned trip to Finland in July, but he cautiously states that he hopes that this visit would not raise unrealistic expectations among the Finns. He states that the aim of his trip would be purely to make "contacts and ... [to familiarize] myself with the local conditions."⁷⁸

In August 28, 1928, the "Finnish case" proceeded to the Executive Committee of the RF in New York. At this point C. A. Bailey had added some new ideas about possible public health projects in Finland to the list (see Section 6.4), which he had presented in his report on public health in Finland, finished in 1928. This new idea was that a public health demonstration in line with the American model of rural health centers of the 1920s could be one option for a RF project in Finland.⁷⁹

One question which the RF officials discussed was the extent of state and municipal responsibility for health care in Finland in the late 1920s. At that time, the health care system in Finland was largely based on the work of private practitioners and the activities of voluntary organizations (see Section 4.6). The RF wanted to support publicly funded activities. The RF held the activities of voluntary organizations in Finnish public health in high regard, but the officials considered it unlikely that the RF would support voluntary organizations in Finland, if only because they supported public activities in other countries.

The experience of the RF on public health activities internationally was that voluntary organizations did not have the capacity to take on large-scale activities, which was the RF's goal. Nevertheless, the ability to focus adequately these activities presupposed that voluntary organizations were listened to during the planning of the activities, yet they were not official parts in the negotiations between the Finns and the RF. A letter dated September 13, 1928, proposes that the planned extension of activities in Finland was to be postponed.⁸⁰ The expressed reason for the delay was that all the divisions in the Rockefeller Foundation were going through a stage of restructuring and there was going to be a new division of labor between the different divisions of the Foundation. Within a few years' time, the IHD would have more economic resources and more field personnel to engage in different international public health projects.

A concrete and positive effect of Bailey's report was that his lobbying for an increase in collaboration with Finland resulted in a fellowship to Miss Venny Snellman, who was to become the first supervisor of nursing education in Finland, and who would be a part of the State Board of Health.⁸¹ Snellman visited the U.S. from May to November in 1929; according to a RF official, "at the psychological moment when the State took over the control and support of nursing education and her with it" (Elisabeth Crowell's diaries 1932–34: 155–156).⁸² The RF collected detailed notes on all fellowship holders. The following extract is from Venny Snellman's folder:⁸³

Snellman, Miss Venny Certificate, International Course in Public Health Nursing, Bedford College Univ. of London, 1921–22. . . . General Supervisor of Nursing Services, State Board of Health of Finland. . . . Will re-organize & provide for unification of nurse training throughout country, both bedside & p.h. [public health], & to supervise these services (RF, Fellowship Recorder Cards/Venny Snellman, IHB/Finland)⁸⁴.

This was an important first step for the fellowship program, which the RF implemented for Finland during the 1930s to train key officials for Finnish public health. This visit was also important in other ways. Snellman, who herself held a formal qualification as a public health nurse, was a key actor for the development of nursing and public health nursing education. She was also to play a central part in the implementation of generalized public health nursing into practice. Snellman's comment about her visit to the U.S. in 1933 when a RF nursing official asked what she

got out of her trip to the U.S. reveals that she was looking for concrete ideas for the solidification of generalized public health nursing:

Practically nothing, she replied, as regards public health nursing that they were not already doing or planning to do in Finland—but when it came to the organization of nursing education, a whole new world opened up before her ... the problems that she is facing now are over production, the lack of supervision for the public health field work and the need of a generalized training field for public health nursing students ... she has already an embryo plan for attaching a nursing supervisor to each one of the 52 district health offices (Elisabeth Crowell's diaries 1932–34: 155–156).⁸⁵

7.4 The Rockefeller Foundation's Strategy for Collaboration with Finland in the 1930s

In the early 1930s, three RF officials, two nurses and one doctor visited Finland. The two nurses were F. Elisabeth Crowell ("F.E.C." as abbreviation in letters and diaries) and Mary Beard ("M.B." as abbreviation in letters and diaries).

Elisabeth Crowell (1880–1950) was a trained nurse with a diploma in social work as well. She had experience from the COS (Charity Organization Society) and the Hull House in Chicago. Crowell was responsible for several nursing projects in Europe and led, among others, a home nursing project in France. She also made reports on European nursing for the RF/IHB headquarters in New York City in the mid-1920s.⁸⁶ Crowell directed the Bureau of Public Health Visiting in Paris and developed a general European program in nursing education for the RF.⁸⁷ Together with other nursing leaders Crowell guided the strengthening of modern schools of nursing and of nursing techniques in 14 European countries. Crowell retired from the Paris office staff on June 1, 1940.

Mary Beard (1876–1946) was a trained nurse with experience from the District Nursing Association and the Community Health Association in Boston in the early 1920s. She was the director of the National Association for Public Health Nurses before she joined the RF in 1924. Mary Beard was associate director of the IHD from 1931 to 1938. In 1924 Beard made a survey on European nursing and a study of maternal care in England for the RF.⁸⁸ Before attaining the post as associate director of the IHD, she had held influential positions in the divisions for medical education and medical science, and had taken part in different studies commissioned by the RF. Beard also took an active part in developing preventive health care in China and India during the 1920s and 1930s. Beard left the RF on September 9, 1938 and became director of nursing for the American Red Cross.

The RF generally employed prominent medical men as its officials. Crowell and Beard were exceptions to this. Both were trained nurses who had worked in both public agencies and voluntary organizations on matters that dealt directly with the education and work of nurses, public health nurses, social workers and midwives.

The two other central staff members active in the field of nursing were, Esther Mary Hirst (connected to the RF 1944–1957) and Mary Elizabeth Tennant (connected to the RF 1932–1954). The work of these female innovators is very sparsely documented in the RF's archives on its personnel. In contrast, the life and work of their male colleagues are covered in great detail, for instance in interviews performed in different stages of their career. The thoughts of Beard and Crowell are best documented through the official diaries that they kept during their time serving the RF.⁸⁹

The diaries tell us that the two nurses had intensive contact with public health innovators, schools of nursing, universities, voluntary organizations and public health officials. An important task for them was to meet RF fellowship holders and plan the programs for their stays in North America. Both of them took an active part in different conferences and meetings that dealt with public health and the education and practice of public health nurses and midwives in North America, Europe and other parts of the world.

The third RF official to visit Finland at this time is Doctor Andrew J. Warren ("A. J.W." as abbreviation in letters and diaries)(1891–1981), who had his first contacts with the RF in 1920. Warren was associate director for the IHD from 1936 to 1951 and director for the Division of medicine and public health from 1951 to 1955.⁹⁰ When Wilbur Sawyer, director of the IHD (1935–1944), was away Warren served as acting director for the IHD. He had a M.D. degree (1914) and a master's degree in public health from Johns Hopkins School of Hygiene and Public Health (1930). Warren had experience from the fields of preventive medicine and pediatrics and worked as county health officer and state health officer of rural health work in the late 1910s and the 1920s. Warren was regional director for Europe, Africa and Near East, with headquarters in Paris, 1938–1939. Like his female colleagues, Warren had extensive experience with international public health activities. He had a researcher's background as well, but his main tasks within the RF were to develop practices for fighting epidemic diseases and to develop local health center models in different parts of the world. In an interview conducted in 1963, Warren describes the RF's mission in Europe during the inter-war years: "The program in Europe, begun after World War I, was designed to aid new small nations as well as some old ones to develop public health programs and train health officers" (Interview with A.J. Warren July 31, 1963: 4).⁹¹ In this interview Warren also reflects on the IHD policy regarding the field staff,

[y]ou do not mention The Rockefeller Foundation ... [t]his was a firm policy; [w]e were instructed to fit into the local situation and give all credit to state health departments. We were to stay out of politics and take orders from state health officers. That policy was adhered to rigidly the world around.⁹²

One reason for RF officials to be interested in Finland was the program of early forms of public health nursing developed in the 1920s. Crowell notes in her diary, on November 2, 1931, that she considers Finland an interesting Nordic country when

nursing education is considered (Elisabeth Crowell's diaries 1930–31: 158).⁹³ In the early 1930s, Finland was the only Nordic country to have public health nursing according to RF's definition of that term. The RF officials were particularly impressed with the basic training of nurses in Finland and with the level of hospitals in the country. The biggest investments in hospital care of that time were made in the care of tuberculosis and in the care of mental patients. Now general hospitals were a growing issue in hospital policy.

Elisabeth Crowell visited Finland several times. One of these visits occurred at the end of year 1933, when she came to Helsinki and Turku (Elisabeth Crowell's diaries 1932–34: 147–156). Crowell had an intensive program during her eight-day visit. Her hostess for the visit was Venny Snellman, who worked as the supervisor for nursing education at the State Board of Health and had recently been to the U.S. on a RF fellowship. The documents indicate that Crowell and Snellman knew each other well and that Snellman had good English. Crowell visited both hospitals and municipalities to familiarize herself with Finnish health care. Among these visits was one to the rural Municipality of Helsinki that was later to become the focus for a major RF project. She also visited different nursing schools, among them the State School of Nursing in Helsinki.

In her diary she describes in detail the different locations she visited; she reports on hospital activities and infrastructure, nursing school curricula, pupil housing and the health care agencies of different voluntary health associations. She also discusses people she met during her visit. She notes that the economic depression affected the nursing and public health nursing education. The number of state schools of nursing had been cut from seven to four.

The first state-run courses in public health nursing were held at the State School of Nursing/Graduate School of Public Health Nursing in Helsinki. The leader of this was Tyyne Luoma, a RF fellowship holder. Crowell discussed in detail the program for the first Finnish state courses in public health nursing. It was built in line with the American model, including, among other things, extensive training in health education for both adults and children. It also included training in the method of social casework. The practical training included two months of fieldwork in a rural municipality. After the RF-supported health center experiment in the Municipality of Helsinki the state school in Helsinki had reached a very standardized curriculum where the knowledge base and modes of practice of generalized public health nursing were part of the school organization. The curricula reflected the nursing education strategies that had been promoted by the RF. Elizabeth W. Brackett's report for the IHD in 1948 on nursing programs in Europe, supports further RF aid for the school:

This post-graduate school is by far the most comprehensive of its kind in Europe and it is hoped [to] influence the development of post-graduate schools in other countries where post-graduate nursing education is a very live issue to-day.⁹⁴

Several former and recent RF fellowship holders were proposed for the leading positions in the administration of the school, for example Aino Durchman and Märta Boman who are among the 1930s' Finnish RF fellowship holders presented in this study.⁹⁵

During her visit to Finland in November 1933, Crowell also visits both the Finnish and Finnish-Swedish nursing associations in the country. When describing the latter, she points out the signs of a nursing tradition in Finland:

An impressive group of cultured, well poised women with an excellent professional background and years of experience—several of them had been over to the U.S., others to England. It was a decided contrast to the group of eager young things FEC had expected to meet—but if youth and inexperience were lacking, enthusiasm certainly was not. They were an unusual group—that's why nursing has gone so far in Finland! Two younger nurses played and sang old Finnish songs delightfully. (Elisabeth Crowell's diaries 1932–34 (November 30, 1933): 149).

During her visit to the Municipality of Helsinki, Miss Crowell was able to witness a health education class that a public health nurse, Hedvig Sucksdorff, who had been trained at Skogsborg Sanatorium School of Nursing in 1920 (and were to be RF fellowship holder 1937–1938), held in an elementary school. She also discovered that public health education was already put into practice in Finland:

At the school we looked on while Miss S. [Sucksdorff] gave one of the most effective health talks FEC [Crowell] has ever listened to and then observed her cleanliness inspection. The entire class had had ten at the last inspection and they got it again this time—they certainly deserved it. We had lunch with the children, a hot sweetened milk and flour porridge which they can have in unlimited quantity (Elisabeth Crowell's diaries 1932–34 (December 1, 1933)).

Crowell also visited the three voluntary organizations that played a central role in Finnish public health at the time, the General Mannerheim League for Child Welfare, the Finnish Red Cross and the national Society for the Control of Tuberculosis in Finland. Crowell met General C.G.E. Mannerheim, who was the chairman of the Finnish Red Cross at that time. She learned the Finnish Red Cross's primary goal, which was to organize health care in the sparsely populated rural areas in Finland and in the poor regions along the eastern border with Russia. The Red Cross received state aid, with which it had built small cottage hospitals along the border. This service relied heavily on the work of public health nurses who were based at cottage hospitals, but it also provided home nursing and health education for people near the hospital. The cottage hospitals had beds for a few patients, but the aim was to increase home nursing and improve preventive health care activities.

The General Mannerheim League for Child Welfare reports to Crowell on its work for children's health care. During this visit, public health nurses became a center of attention when the role of the Mannerheim League as a trainer of public health nurses was discussed. Since 1924, the Mannerheim League had trained 215 of the

total 305 public health nurses in the country (the rest were trained at the state school in Helsinki).

Severi Savonen, the influential public health activist presented in Sections 4.5 and 6.5 of this volume, hosted the visit to the Finnish National Anti-Tuberculosis Association. At the time he lectured as part of the public health nursing courses held at the State School of Nursing in Helsinki, for which he was also a board member. Crowell and Savonen discussed generalized public health nursing. Savonen was not yet a supporter of this way of organizing public health nursing because he was afraid that patients with tuberculosis would not get adequate attention in such a system (Elisabeth Crowell's diaries 1932-34 (December 3, 1933): 152).

When concluding her notes on her first visit to Finland on December 6, 1933, which are cited below, Crowell mentions an idea that Venny Snellman had introduced to her as a tentative plan which she and the other central public health nurse activist, Tyyne Luoma, were developing. Crowell was eager to support the idea, and she made plans in her diary on how to facilitate the project. A noteworthy detail was that Snellman arranged for creating expertise in social work among public health nurses:

Finally both she and Miss Luoma have been playing with the idea of a special city district with a generalized public health nursing service to serve as a training field for the students of the Public Health Nursing Institute [State School of Nursing/ Postgraduate School of Public Health Nursing in Helsinki] ... a trip to Warsaw, Budapest and Lyon would be helpful for both of them. It would permit them to study the organization of the teaching districts Miss S. made only one direct request—the possibility of a fellowship to train a nurse in Social Work One thing seems certain. We can count on a hundred per cent return for any time or money invested in nursing development in Finland and it will not end here. Both Sweden and Denmark are sending nurses here to study public health nursing and methods of teaching! (Elisabeth Crowell's diaries 1932-34 (December 6, 1933): 155–156)

During the years 1936–1938, Märta Boman, who had graduated as public health nurse in 1932, studied Medical Social Work in hospitals with a RF fellowship (Härkälä 1992 and Sorvettula 1998: 428).⁹⁶

7.5 The Rural Health Committee and the Launching of the Project in the Municipality of Helsinki

Even though the fellowship program continued to be used to support the activities of Finnish public health activists after Crowell's visit in 1933 (see Section 6.5), it took until the year 1938 for the RF to be prepared to engage in a concrete public health project in Finland. At this point, the situation for Finnish public health activists had changed. A new elected government introduced a "red-green" coalition in Finnish politics in the mid-1930s, which resulted in new political initiatives. In its first year, 1937, the government consisting of Agrarians and Social Democrats set up a par-

liamentary committee for public health. The Rural Health Committee—established by the Ministry of Interior and initiated by several voluntary organizations—was given the task of examining how public health conditions in the countryside could be developed (Wrede 2001: 130).

At the time when the Committee was working actively, two high-ranking RF officials, Beard and Warren, visited Finland again (for Beard's visit in June 1937 and Warren's visit in May 1938—see Mary Beard's diary 1937 and Andrew J. Warren's diaries 1938–1939). Beard, who was at that time stationed in New York City and was responsible for a large number of projects in different parts of the world, was less familiar with the Finnish situation regarding public health than were Crowell and Warren, who were stationed in Europe. However, at a time when concrete decisions about launching a joint project were to be made, an official of her rank was needed. Beard was very familiar with the training of nurses, public health nurses and midwives in North America, Europe and other parts of the world, and this gave her solid ground for discussing the organization of public health activities, the training of public health nurses and the organization of a model district in Finland (Mary Beard's diaries 1935–38: June 8–19, 1937).

Beard visited the Municipality of Helsinki, and the formal decision was made at this point to start a joint project. In December 1937, the representatives of the Finnish committee who were to plan the project in the Municipality of Helsinki were chosen. They were: Severi Savonen, who at that time acted as the secretary of the newly founded Rural Health Committee; Venny Snellman, the Supervisor of Nursing Education from the State Board of Health; Professor Arvo Ylppö from the University of Helsinki (presented in Section 4.6), who was a major figure in the Finnish medical profession and active in the General Mannerheim League for Child Welfare; and, finally, Tyyne Luoma, the director of the State School of Nursing in Helsinki and a leading public health nurse pioneer and professionalizer.

When Doctor Warren visited Finland in May 1938, he met with the planning committee and with the representatives of the State Board of Health. The latter was represented by its general director Oskari Reinikainen and by the Supervisor of Nursing Education Venny Snellman, who was also a member of the Rural Health Committee (Andrew J. Warren's diaries 1938–1939 (May 15–19, 1938): 3). Based on these negotiations, the model district in the Municipality of Helsinki intended to start its activities in January 1940. The RF was to support its activities during the years 1940–1944, and this support would successively diminish while support from the state and municipality increased. During the first year of this project, the support from the Foundation would be 60% of costs; in the final year of the project, this would dwindle to 10%. The planned support from the RF for the activities in the Malmi district during the five year project was 628,000 Finnish Marks (currency value November 6, 1939). For the construction of a main health center building in the district of Malmi in the Municipality of Helsinki 300,000 Finnish Marks was set aside.⁹⁷

In November 1938, Crowell visited Finland again and renewed her observations of the health care in Helsinki and Turku (Elisabeth Crowell's diaries 1937-40: November 29, 1938). Crowell once again had an extensive program of visits to schools of nursing and midwifery, maternity hospitals, child health care facilities, public schools et cetera. Crowell notes that the economic situation in the country had improved since her last visit. There was a great shortage of health care personnel, but there were resources to train them. Compared to her last trip, there were fewer visits to different locations, giving her time to discuss issues intensively with people and renew her contact with those activists whom Crowell had met on her previous trip. Her most intensive contact was with public health nurses, the majority of whom were senior nurse professionalizers.

The group that Crowell met with consisted of Venny Snellman, Tyyne Luoma, Hedvig Sucksdorff, Märta Boman, Aino Durchman, Maj-Lis Juslin (former Edgren). All of them had held Rockefeller fellowships during the 1930s, most of which transpired after Crowell's last visit. These stays were not, however, their only studies abroad. At least Snellman and Juslin had studied at Bedford College in London, Durchman had a Bachelor of Science degree from Teachers College at Columbia University in New York and Luoma had worked at Henry Street Settlement at two separate points in time. At the time of Crowell's visit, Snellman (born 1893) continued her work as a supervisor for nursing education at the State Board of Health, and Luoma (born 1893) led the education of public health nurses. Durchman (born 1892) was the director of the City School of Nursing in Helsinki (1936-58), and Juslin (born 1899) was director of the recently established Turku School of Nursing (Sorvettula 1998: 431, 437). These two younger nurses were to have key roles in the planned demonstration district in the Municipality of Helsinki. Märta Boman (born 1902) was to become the leader of the social work activities at the health center and Hedvig Sucksdorff (born 1896) would supervise the practical training of public health nurse students. These two nurses were to have key roles in the planned demonstration district in the Municipality of Helsinki. The only person who was not a public health nurse with whom Crowell had intense contact was doctor Severi Savonen, the "born-again" public health activist who, since his stay in the U.S., began to support the generalized public health nursing model.

The discussions dealt with the plans for RF-supported educational projects in Finland. The activists were unanimous about the need of a training field for public health nursing students. They wanted to develop this training field into a model district that would be used in the general development of health care in Finland, not only for public health nursing. In the center of the model, the district will be the health center. At this point, plans to establish such a model district in the Municipality of Helsinki outside Helsinki was already taking shape, as Mary Beard's earlier visit had also prepared ground for this project.

Another topic for these discussions was the general organization of public health nursing education in Finland. The Finns had many ideas and alternative plans

which they wanted to discuss with Crowell. With her international experience, she could rely on knowledge/information about how similar projects have been carried out in other countries. She also represented the potential funding of development projects. Crowell recommended that Snellman and Luoma visit different European locations, and she promised to lobby for economic support for such trips from the RF. The central point of interest for these trips was the integration of social work in the training and work of public health nurses. Such plans existed in several European countries, including France, Belgium, Poland, Czechoslovakia, Hungary and Romania. Innovative projects were also carried out in Prague and Zagreb at this time with RF support.

In their discussions with Crowell, the Finnish nurses explained why they preferred the RF model and not the international course in public health nursing which was taught at Bedford College in London under the auspices of the International Red Cross (see Sorvettula 1998). The course of the International Red Cross was perceived as too elementary and insufficient for Finnish needs. No Finnish nurses had been trained in Bedford for many years. Instead, Finnish nurses sought the education offered by the RF, which included a large social science component, medical social work and modern psychiatric nursing, as well as training in the method of social casework used in the field. Finnish nurse professionalizers consider this knowledge base to be something that not only social workers needed, but public health nurses and doctors could benefit from as well. In an agenda for a meeting of the Scientific Directors of the RF, June 27, 1938, the plans for developing the program in public health nursing in England were presented. It was planned that Mary Beard would visit England and discuss temporary aid to the University of London or its School of Tropical Medicine and Hygiene, in establishing a "Chair of Nursing for the better organization of public health nursing and other nursing education."⁹⁸

Crowell also visited the Municipality of Helsinki. In 1938, the municipality had 28,000 inhabitants and was undergoing a process of industrialization. Small factories from Helsinki were moving into the municipality, and with them industrial workers settled down in the former rural area. A housing shortage was the result of the rapid change in the structure of the municipality's economy. Crowell discussed the municipality's social problems and its need for social work with the representatives of the social board of the municipality. She was informed that the social board spent 40% of the tax revenue of the municipality, whereas the health board controlled 25 %.

At the same time as the RF developed its action plan for the project in the Municipality of Helsinki, Finnish public health activists were drafting a comprehensive plan for a municipal public health system (Wrede 2001: 130–134). The Report of the Rural Health Committee assigned the public health nurses a central role in these planned services. Among the activists engaged in the work of the Rural Health Committee, most notable is Severi Savonen, who was its secretary. Crowell noted in her diary in 1938 that Savonen stated that he had changed his position concern-

ing the organization of public health nursing. When in 1933 he still supported the specialization of public health nurses into specific sectors of public health, he was now a strong supporter of generalized public health nursing: "He says he has been born again and is quite convinced as to the advantages of a generalized service" (Elisabeth Crowell's diaries 1937–1940: November 26, 1938).

When the model district in the Municipality of Helsinki was established in 1940, a committee consisting of six members was in charge of its activities. The RF required that three of its representatives were to represent the Municipality of Helsinki and three the Finnish state. The state representatives were Severi Savonen, Venny Snellman and Tyyne Luoma. As Savonen at this point had a position in the State Board of Health, this implied that the Board had two representatives in the committee. The third state member, Luoma, represented the State School of Nursing in Helsinki. The municipality was represented by two politicians and the municipality's health officer.

At the time when the model district was founded, the Municipality of Helsinki had 30,000 inhabitants, including a growing population of industrial workers employed either in the Municipality of Helsinki or in the City of Helsinki. The district in the Municipality of Helsinki was to be a model for the other municipalities in the country. The argument was that it was cheaper for the society to prevent disease than to care for a great number of chronically ill patients. The early plan was that the model district would be used as a training field for both public health nursing students and medical students. These plans changed, however, because of the Winter War, which began in November 1939. There was also a lack of resources, and the resulting situation was that only public health nurse students from the State School of Nursing were trained in the Municipality of Helsinki.

The plan was for the activity of the model district to continue after 1944 and for state funding to be permanent by then. The model district was also to continue to be a training field for public health nurses. The chief public health physician would lead the project and its health care activities. This person was supposed to be trained in the U.S., and as we saw in Chapter Six, Doctor Erkki Leppo had been chosen for this task well in advance. His position in the Municipality of Helsinki was to be a full-time post, which was a clear improvement. His duties were also to include lecturing at the State School of Nursing in Helsinki. In addition to six municipal public health nurses, one supervising public health nurse was to be employed. One new teacher position was to be created for the State Graduate School of Public Health Nursing in Helsinki to coordinate the teaching and supervision of the public health nursing students in the Municipality of Helsinki. One full-time sanitary inspector was also to be attached to the activities. His duty would be to take care of public health inspections in the municipality. The final agreement on the experiment was signed in July 1940.⁹⁹

7.6 The Implementation of the Model Training Field in the Municipality of Helsinki

The Municipality of Helsinki had a long tradition of public health activity, but voluntary organizations also played an important role in pioneering health care work as initiators. The origins of local public health work in the Municipality of Helsinki can be traced to the severe epidemics of scarlet fever and diphtheria, which raged in the Municipality of Helsinki during the years 1916 and 1917. At the time, the district physician demanded that the municipality start effectively preventing the spread of vermin. At that point, the municipality was divided in four districts and a nurse was employed for each, who were to work under the supervision of the district physician (Tahvanainen 1996: 28). Following the legislation on health care for primary schools, a doctor and a nurse were employed for schools in 1928. In the same year, the General Mannerheim League for Child Welfare founded a center for child health care in the municipality.

State support was also given for the prevention of tuberculosis, and in 1931, the Municipality of Helsinki acquired two public health nurses who were to work to this end. As a second public health nurse had been employed for the school health care in 1929, the total number of public health nurses working in the municipality in the early 1930s was four, but they were not yet following a generalized model at this point. The municipality decided not to pay for vaccinations carried out by other health workers (sanitary inspectors), as the number of public health nurses was adequate to handle this task (Tahvanainen 1996: 28).

During the 1930s, the General Mannerheim League for Child Welfare as I have mentioned earlier, actively promoted child health care. In the Municipality of Helsinki, three centers for child health care were founded in 1937.¹⁰⁰ The founding of these centers prepared the ground for the model district, which were partly funded by the May Day Fund and supported by the municipality. A pediatrician carried out medical controls at these childcare centers. In the spring of 1937, the General Mannerheim League for Child Welfare founded one more center for child health care, making the total number of such centers four (the first founded center had been discontinued in 1932). These centers provided health education to mothers and health check-ups for children by pediatricians and nurses. Two more public health nurses were employed in 1938, raising the number of public health nurses to six. This was exceptional, as the national legislation, which made the employment of municipal public health nurses mandatory, was enacted much later, in 1944.

The resources for public health increased in the Municipality of Helsinki. Prior to the model district there were already activities directed at infants and small children, as the personnel employed for school health care also took up this duty. School nurses did home visits to families with small children and gave advice on the care of children and the household. The founding of the model district increased the

number of public health nurses to eight, making it possible to develop the health care of pre-school children. The practice of public health nurses in the Municipality of Helsinki grew rapidly during the 1930s, so that at the end of the 1930s it included health care for all groups of children, the treatment of tuberculosis, home nursing and general preventive health care (Tahvanainen 1996: 29).

In 1944 Severi Savonen wrote a detailed description of how the new type of municipal health center building (Fin. *kunnallinen terveystalo*, Swe. *kommunal hälsogård*) should look like, what symbolic meanings these health centers could have in the local community and how the work should be organized (Savonen 1944). The municipal health center could raise the question about the value of public health in the local community and could signify changed attitudes of the inhabitants' toward public health. The more new centers for health education and health services there would be, the better the foundation would be for a nation of healthy and productive people (Ibid: 1). Savonen called the health centers "lighthouses" of health education and saw them as important as the hospitals, a visible testimony to the new official character of public health (Ibid: 1–2). The health centers would house permanent exhibitions with concrete information about healthy living habits and the health education would be intensified by personal guidance and courses for people in different life stages and with specific needs. He described in detail how the building should be used to serve the needs of the different professionals working there and the needs of different people visiting the health center.

The infrastructure of the new health center building in the Municipality of Helsinki was to enable the practical organization of activities. For instance, there were rooms for isolating children with infectious diseases. Rationality was emphasized everywhere: in the middle of the reception area there was a room with glass windows in the walls. From this room public health nurses were able to follow all of the health center's activities. Visitors to the center could easily seek guidance from public health nurses, as it was always possible to find them in this room. If, for example, a visitor had questions after a visit to the doctor, he or she would be able to refer to the public health nurses in their "open office." The health center building was built in two floors. On the ground floor were consultation rooms for pregnant women and the infants. These activities were a part of the experiment. They were later institutionalized by the aforementioned legislation of 1944. The ground floor also had rooms for doctors' consultations and a laboratory. The first floor held rooms for the public health nursing supervisors, who instructed personnel and nurse students, the health officer (physician in charge), the dentist and the secretary of the health center. These offices were used for administration and social work.

Erkki Leppo who had been trained to be the health officer was called to war duty several times during 1940–1944. The health officer was the administrative leader of the model district, but he also had practical duties in school health care. While Leppo was in the war service as a military physician, Johan Wickström took care of the health officer's duties. The chief public health nurse, Hedvig Sucksdorff,

supervised the work of public health nurses and students. The project relied on the work of students; without their work, efforts to reach the objectives of the Finnish-American project in the Municipality of Helsinki would have been limited. However the students got regular and planned instruction and were guided into the independent role of a professional community health worker. This program was in contrast with the hospitals, where nurse students very often were used mainly as a workforce in wards, without regular work instruction.

In the organization of the model district, social work was closely associated with health care and medical social workers were placed in the same facilities. One of the medical social workers, Märta Boman, was a trained public health nurse and had been trained in the U.S. as a RF fellowship holder 1936–1937.

At first, the planned number of public health nurses was eight; this turned out to be inadequate. The RF gave more monetary support, making it possible to hire two more public health nurses. The ten public health nurses all had their own districts in which they carried out generalized public health nursing (see Figure 7.1 on next page).

The population of a district varied from 2,000 to 4,500 inhabitants. It has been estimated that of the children born in the Municipality of Helsinki in 1943 approximately 90% were registered at the health center—the proportion had risen rapidly during the years when the model district had been in action (1940–1944).¹⁰¹

The reformers later noted that before the model district began, the problems families had with raising their children largely went unnoticed by the authorities. The health condition of children had increased. Mothers' comprehension of and interest in childcare improved substantially.¹⁰² Child health demonstrations were a central activity of the model district in the Municipality of Helsinki and an outreach strategy was implemented. In addition to the large health center located in the district of Malmi, public health nurses also held health consultations in 18 other smaller locations in the Municipality of Helsinki.

The maternity care activities of the model district differed from the American model. There was a maternity center at the health center, and a second center was later founded at another location. The three midwives of the municipality played the central role in maternity care. However, in the 1944 report it was recommended that new midwives who were employed should also have public health nurse training.¹⁰³ The number of mothers who attended prenatal care grew rapidly; in 1943, more than 60 % of the pregnant women were registered for prenatal care. Home visits were essential in both child health care and maternity care. They fitted well the ambulatory practice style of the public health nurses, who also provided home nursing services.¹⁰⁴

The activities of the model district were also influenced by the Act on Venereal Disease, which was enacted in 1943. A physician who specialized in venereal dis-

The Model District of Malmi

- maternity care (carried out in cooperation with midwives, both midwife and public health nurse training recommended for new personnel)
- infant health care and health care for small children
- health care for schoolchildren
- psychiatric care (on a limited scale)
- the care of epidemics
- home nursing (visiting nursing)
- tuberculosis care
- the care of epidemics
- care of venereal diseases
- psychiatric care (on a limited scale)
- medical social work (certain tasks assigned by the Social Board)
- housekeeping
- dental care
- health inspection (sanitary inspection)
- supervision of public health nursing students and arranging of further training for the personnel

Figure 7.1 The model district of Malmi

eases took care of the reporting and correspondence on this health matter. The health care of these patients took place at a hospital clinic in the city of Helsinki, so the role of the model center was only to screen the population for venereal disease. Every pregnant woman was tested for syphilis. According to plans, the responsibility for medical care in the Municipality of Helsinki was to remain in the hands of the local organization: the health officer, the public health nurses, the midwives, the health/sanitary inspector (Fin. *terveysstarkastaja*, Swe. *hälsoinspektör*), nutritionists and other specialized health care professionals visiting the health center. Midwives were to continue their practice within the field of childbirth as before. The abortion issue should get more attention and it was recommended that more physicians' offices would be held. More home visits were recommended as well. The Health Officer and public health nurses were to take over public health activities and focus on preventive and promotive activities and were to follow-up on the health status of the population. The plan was that these follow-ups would be based on the screening of different population groups for different health problems.¹⁰⁵

The activities of public health nurses were a part of a comprehensive health system according to how it was planned by the Rural Health Committee in its report published in 1939 (see Wrede 2001: 130–134). For instance, a health/sanitary inspector were to play an important part in the sanitary inspections of shops, factories and housing facilities.

Along with their practical activities, the Health Officer and the Public Health Nursing Supervisor held regular lectures for the personnel and arranged Saturday group discussions for the students on different central public health topics. A small reference library was established for the model district. Excursions to the different districts and to social and "public hygiene" institutions were organized.¹⁰⁶

These activities constituted a new element in the organization of health care in Finland. The need for constant education and the coherent planning of activities had been formerly associated with hospital medicine. What in modern terms is defined as primary care was then seen as a field that presupposed expertise, not only of doctors but of public health nurses and midwives as well.

7.7 The Institutionalization of Public Health Nursing

When reporting on the activities of the model health center between 1940 and 1944, Acting Health Officer (pediatrician) Johan Wickström and Chief Public Health Nurse Hedvig Sucksdorff were convinced that it was at the forefront of public health work in Finland and many other countries as well. At the core of the success was the public health nurse:

In no other municipality in Finland, not even in the world, is generalized public health work organized in such a broad way as in the Municipality of Helsinki, where ten different forms of health care and social work are taken care of by the public health nurses. This model has great advantages. Instead of different specialized officials, who without any connection to each other would wear out the home with frequent visits and often give conflicting advice and cause confusion, only one person—the public health nurse—handles all health problems. This means that she has a more all-round understanding of the problems and that she is able to remedy the difficulties in a more objective way. This also means a considerable saving of time, as only one person visits the home and can perform all tasks in one visit. The generalized work sets huge demands on the competence of public health nurses. They have to be well acquainted with all branches of their field of work.¹⁰⁷ (author's free translation from Swedish)

There were also problems in implementing the generalized public health nursing model. The workload was so large that an eight-hour day was difficult to attain "without the risk of working superficially," as Wickström and Sucksdorff stated. The workload would have presupposed 12-hour days for the public health nurses. To avoid overloading them, student nurses were assigned many tasks, which they performed without supervision. Home visits were a typical activity for which students were used. Wickström and Sucksdorff considered this to be a problematic situation, and called for more funding for the model district to allow the employment of more public health nurses. The size of the districts per public health nurse should be decreased. Adequate resources were needed so that the important needs of the population could be adequately taken into consideration in the planning and

carrying out of the activities. Wickström and Sucksdorff estimated an increase in different public health tasks in the municipality and suggested that there should be a new division of labor between the different public health and welfare workers and cooperation with the voluntary organizations in the field.¹⁰⁸

The administrators of the model district had regular contacts with representatives of the RF. Their letters deal with the problems for which they seek solutions in collaboration with the Americans. When the Finnish collaborator wanted new resources, the highest level of authority was linked to the exchange. In a letter dated October 22, 1940, the director of the State Board of Health, Oskar Reinikainen, wrote to Doctor Warren at the IHD office in Paris.¹⁰⁹ His letter is polite and detailed. In it, he argues for the need for a greater investment in mental care in the model district and suggests that a psychologist be employed. He also raises other issues: personnel should get pay raises, a nutritionist is needed, et cetera. All these needs presupposed greater support from the RF. Reinikainen describes in his letter how the Winter War (fought during the winter of 1939–1940) had made it more difficult to carry out these planned activities.

By June 1941, the RF had paid 300,000 Finnish Marks for the health center building and 265,072.80 Finnish Marks for the operation of the model health center.¹¹⁰ Thereafter, the Continuation War between Finland and the Soviet Union, which began after the Winter War, caused further payments to stop, meaning that the bulk of the intended funding never came to the Municipality of Helsinki. The money was later directed to the training fields of the Schools of Nursing at Pori and Oulu.¹¹¹

Nevertheless, activities in the Helsing model district in the Municipality of Helsinki continued. Health Officer Erkki Leppo's activities were disrupted by the war. The RF did not train his substitute and it can be assumed that the medical activities of the model district would have been more extensive and perhaps more focused if Leppo could have remained at the same position. Despite the war, public health nurses' activities continued as planned. An important observation is, that the field of public health nursing got even more power to act independently in the municipality than was intended. Furthermore, the broadening scope of the training of public health nurse students in the model training field 1940–1944, had made it necessary to consider a more independent status for the municipality as an educator in public health and public health nursing.¹¹² The cooperation with the state nursing school in Helsinki had at times been problematic because of limited resources and lack of time for the experiment in the Municipality of Helsinki. It was however hoped that this cooperation would develop in a positive way in order to provide both theoretical and practical training of high quality for the public health nursing students¹¹³

The model district was restructured in 1946, when big parts of the Municipality of Helsinki were incorporated into the city of Helsinki. Nevertheless, public health authorities of the state and the municipality and the representatives of nursing schools were convinced that generalized public health nursing was to continue. The

next collaboration with the RF was again about a model health care district. This time the extent of the project was much larger, when a province, Uusimaa, rather than a municipality in southern Finland was in focus. This model district would become a training field for public health nursing students in the same way as the model district in the Municipality of Helsinki had been (Siivola 1984: 126–134) and Sorvettula 1998). This was not the only collaboration between the RF and Finnish partners, nor was it the only one to center around public health nursing. When it again became possible for the RF to fund projects in Finland after the wars, a decision was made to redirect the resources that had been intended for the Municipality of Helsinki but that had been stopped. Two new model training fields for health care were now founded in Pori and Oulu. These were founded in 1947, and they trained public health nurses according to the same model that was applied in the Municipality of Helsinki. The districts got 467,200 Finnish Marks each.¹¹⁴

At this point, the model district served a national system of municipally organized public health nursing. In 1944, the Act on Municipal Public Health Nurses was enacted. It was a part of a legislation that also included the Act on Municipal Midwives and the Act on Municipal Maternity and Child Health Centers. At the same time, a public health division was founded at the State Board of Health. Severi Savonen, the untiring public health activist, became its director (Pesonen 1980 and Wrede 2001). These critical boundary events marked the institutionalization of generalized public health nursing in the Finnish health care system. All municipalities were to employ public health nurses and the state paid $\frac{3}{4}$ of the costs. The number of public health nurses in the municipality was regulated according to the number of its inhabitants.

7.8 Summary and Discussion

The local health center organization, with its full-time health officers (physicians) and public health nurses and midwives who provided a broad range of health services for the local community, is an example of a mode of practice that in the Finnish case became very influential for the formation of local municipal health centers on national bases in Finland. I have focused more on the institutionalizing educational processes regarding the health center model that supported the professionalization of the public health nurse occupation than on the political negotiations shaping a new municipal public health policy and administration in the inter-war period. The local health center model including the RF-supported training fields for public health nursing reflect educational strategies carried out by the RF and which were negotiated with Finnish health administrators and Finnish educators of personnel for public health purposes.

The goal of the project in the Municipality of Helsinki was to establish a model district for primary care, a so called “demonstration field.” This was intended to offer a frame for the development of preventive and promotive health care in Finland.

It was also a so-called “training field” aimed at both the theoretical and practical training of public health nurse students. Even though public health nurses were central in the model district, other professionals, primarily doctors and midwives, also took part in its activities. In the early plans, the model district was viewed as a potential training field for medical students as well, but because of the war it was not possible to train doctors there. The model health center was however also a training field for midwives as a subject of developing collaboration with the public health nurses in the community. The specific situation, with the responsible RF-educated doctor on war duty and no medical students in the district during the project might be seen as an extended opportunity and mandate for the nurses to develop their own autonomous model for generalized public health nursing.

For the development of the knowledge base and the modes of practice for public health nursing, the training field was of the utmost importance. Putting generalized public health nursing into practice required the development of an expertise for the all-round health care expert who coordinated, supervised and surveyed health care activities. The public health nurse was seen as the link between the homes and the health center and the “translator” of abstract new academic knowledge about preventive medicine, hygiene and public health to the public.

The examination of the practical formation of generalized public health nursing presented in this chapter demonstrates that the practice of public health nurses became closely linked to the municipal administration and to the local organization of public health activities. The public health nurses were to be the backbone of local health care. As municipal physicians continued to be primarily medical practitioners, the public health nurses were the linchpin of the emerging public health system.

My examination of the initial Finnish-American exchange (see also Chapter Six) which led to the project in the Municipality of Helsinki described in this chapter also demonstrates that key professionalizers of public health nursing were active partners in drafting both the knowledge base and modes of practice to be linked with generalized public health nursing. The experiment in the Municipality of Helsinki was a result of intertwined negotiations between professionalizers of public health nursing, public health activists within voluntary organizations and public agencies and public and voluntary implementers of public health service and educational programs. This fits well with the description which Elisabeth Crowell gave of the public health nurses in her diary on her visit to Finland in the early 1930s:

They have gone a long way in this little country with very simple means and great intelligence inspired by an emotional urge to use their recently gained, unexpected independence to climb to new heights which is comparable to driving impulse that one feels behind nursing effort in the “new” countries of Central and South Eastern Europe. Unlike these countries however they had a past of high nursing ideals to build upon, a past still young enough to be supple and capable of assimilating new ideas easily. And they had contacts abroad. The Finns are great travelers. It was a constant source of surprise to meet repeatedly nurses who had been in the U.S., in

England, in Sweden. They have done their own thinking and have made their own adaptation of what they have observed in other countries. The State has offered scholarships yearly to aid nurses especially for study in foreign countries. Formerly this appropriation amounted to 80 000 mks [Finnish Marks] annually now it has been reduced to 5000 because of the financial crisis. (Elisabeth Crowell's diaries 1932-34 (December 6, 1933): 155-156)

The past ideals that Finnish nursing activists and public health nursing professionalizers built upon had direct links with the Nightingale tradition of nursing that had been brought to Finland by Sophie Mannerheim, sister to General C. G. E. Mannerheim, who qualified as a nurse in England. Finnish nursing was also directly influenced by the German tradition of deaconess nursing which Florence Nightingale had studied (Henriksson 1998: 73-85). Both before and after Finland gained its independence, Finnish nurses actively took part in international nursing networks. Many trained at Bedford College, where the International Red Cross organized courses for nurses in public health (Punto 1991 and Sorvettula 1998) and the collaboration between the Nordic nurse activists was intensive within the Nordic network, SSN. Influences from other countries were reflected in the struggles of the nursing professionalizers to improve both nursing education and the social position of nurses (Henriksson 1998). On the other hand, Crowell notes that the Finns had "made their own adaptation" of what they observed in other countries. In the 1930s and in the frame of the project in the Municipality of Helsinki they continued to do so, at which time they relied on the models and resources offered by the RF.

In the frame of the RF activities in Finland, there was room for an alliance for public health nursing to appear. Key figures for the alliance were Elisabeth Crowell and Mary Beard, who in their work for the RF had a keen interest in public health nursing. Their involvement in the exchange made room for the Finnish public health nursing professionalizers. Particularly important was the direct contact between Elisabeth Crowell, Venny Snellman and Tyyne Luoma. It is fair to say that these women shared a professional project, common visions about what kind of public health nursing they wanted to see and how it was to be achieved. At a time when that project was failing in the United States, after the Sheppard-Towner Act was discontinued at the end of the 1920s, it found a fertile basis in Finnish society.



PART IV

Alliance Strategies
in the Inter-War
Formation of Finnish
Public Health Nursing

Conclusions

8.1 Negotiated Alliances of Social, Cognitive and Legitimizing Strategies

The early formation of Finnish public health nursing that I have examined in this study was a complex process of professionalization and institutionalization in which national and international social actors were involved as negotiators in a formative boundary-work setting. This study has been an attempt to see how the international and national vanguard of early "professionalizers" of Finnish public health nursing—the leaders, initiators, educators, and pioneers of an occupational group—deployed their resources and assets in their struggle for collective social mobility for the occupational group. This early leading group of professionalizers of Finnish public health nursing was faced with other actors within the voluntary and public, educational and administrative fields of medicine, social welfare and education, all of whom had different positions and interests. I call these other social actors "public health-activists" (PH-activists) and "implementers of public health programs." Some of these PH-activists and implementers of public health programs became convinced supporters of professional public health nursing during the inter-war period. Therefore, this study also sheds light on how proposed jurisdictional claims were negotiated amongst different social actors and what the consequences were for the professional project within nursing in the Finnish context.

Core claims used by nurse professionalizers promoted the professional project and the occupational social mobility of nurses in general in Finland. However, the examined alliance strategies in the inter-war period clearly supported the formation of a separate professional jurisdiction for Finnish public health nursing. My study shows that some of the structuring resources produced by boundary-work were more closely related to the concrete activities of the occupational group and other resources were an outcome of external, larger and more general processes of social change going on in society. The boundary-work in this study is characterized by an extension of the nursing field, monopolization of central elements in the knowledge base and the modes of practice of public health nursing and the protection of

a new autonomous field of work in local public health. The identified structuring conditions and institutional features surrounding the professional project of public health nursing either supported or limited the social mobility of this occupational group. Furthermore, these processes created, maintained or broke down boundaries between knowledge units such as scientific philanthropy, public health, traditional nursing, and public 'health nursing'. Thus, the struggle for a more independent professional field of nursing which differed from hospital nursing and sick nursing in homes was a turf battle between many different social actors.

More concretely, I have contextualized this complex and rather scattered professionalization process by viewing international and national philanthropic reform cultures and by exploring how the boundaries of Finnish public health nursing took shape during the inter-war period through the collaboration between the Rockefeller Foundation, a central international health organization of the time, and Finnish actors within public health. The creation of groundwork of both public health nurse education and administration of public health nursing in the community is contextualized in the planning and implementation of the local health center project in the Municipality of Helsinki.

To borrow Andrew Abbott's (1988: 315) three general "levels of forces" which influence the historical formation of occupations, the professional project of Finnish public health nursing in the inter-war period was shaped through (1) larger social forces (national and international), (2) movements in the system of inter-war welfare and health occupations, and (3) differentiation within the heterogeneous occupational group labeled "nursing."

This study also shows what kind of social strategies the professionalizers of public health nursing used to defend and promote their professional project, when they interacted with and confronted actors with different interests. Furthermore, the collective social values which the professionalizers presented in the formative negotiations regarding jurisdictional claims for the group of new public health nurses, has been examined. The basic assumption that has been guiding this research is that the public health movement in Finland and the related formation of a jurisdiction for public health nursing were embedded in the broader social and cultural transformations of Finnish society in the 1920s and the 1930s. These critical social processes contributed to the formation of public health nursing by shaping the division of labor in Finnish health care which prepared a place for a women's occupation in public health. The cultural and ideological/moral ideas of national and international PH-activists influenced the shaping of health policy and educational strategies for health occupations and guided the allocation of resources during this period of nation-building in Finland.

However, in empirical research, these struggles can only be examined through the study of how they were shaped and became visible in the processes closely related to the occupation of public health nursing. In such processes which the actors involved

in professionalizing public health nursing took part of directly, the making of jurisdictional claims on the new type of professional status was to be endowed on public health nursing. I view the “core” formation of early Finnish public health nursing, by using the term intersectionality. This means that the complex and heterogeneous social and cultural formation of early public health nursing was a result of alliance strategies carried out in the intersectional relations of the identified three social actors with different positions and interests. The collective professional jurisdiction of public health nursing was created in the intersections of social ordering in the inter-war period characterized by power relations based on scholarly and practical knowledge, gender relations and class compositions of the time.

In the beginning of the time period in focus in this study the core of this occupational activity in Finland was still vague and therefore intensive boundary-work took place at the borders of this occupational activity. A particular process that I focus on is the alliance between the actions of philanthropic and voluntary organizations and the formation of a knowledge base and modes of practice for public (governmental) ‘health nursing.’ The linkage of the formation of a knowledge base and modes of practice uncovers the different ways that the three identified social actors used in their educational and administrative strategies. The kind of power the three social actors used becomes visible in the links between knowledge and health programs, in social and cultural spaces shaped by gender and class relations, at different times, and on different social levels. By having this focus I hope to contribute to earlier research on women’s welfare occupations in the inter-war period where groups such as general nurses, midwives, primary school teachers and social workers have been in focus. This study also provides a more comprehensive understanding of how international social and cultural processes regarding nursing and the formation of public health have influenced the shaping of public health nursing in Finland in the inter-war period.

Both opening up and closure strategies were used as temporary alliance strategies for collective mobility of public health nursing in Finland. The aim of the professionalizers was to define and control public tasks in nursing in the local community/outside the hospital and in a broader way than individual sick nursing in the homes, through negotiations with PH-activists and implementers of public health programs. The professionalizers struggling for a more independent professional status for public health nursing used these strategies to mark an alliance with certain knowledge contents, modes of practice and organizational models supported by the PH-activists and the implementers. However, these alliance strategies were not easy to build. Conflicting ideas, values and objectives were negotiated in a field of tension but also with a spirit of innovative and pioneering thinking and a general will to “build a better world” through nation-building. The professionalizers, the PH-activists, and the implementers of public health programs saw a better, more organized public health system as a civilizing mission. The professionalizing of public health nursing was thus connected to the development of national health

and welfare policies and this study shows that investments in legitimating strategies in the early formation of an occupation supports the position of the occupational group and its social mobility. Support for independent educational strategies and the creation of appropriate workplaces were important legitimating strategies in the early formation of Finnish public health nursing. This study shows that the creation of concrete public arenas for new occupations, such as the local health centers (Fin. *terveyystalo*, Swe. *hälsogård*) were for public health nursing, had important symbolic value and that they increased the public's recognition of the new welfare occupations and public health.

Elzinga (1990: 162) states that when members of welfare occupations articulate a conception of their role in society, which is important in outlining social, cognitive and legitimating strategies, members and supporters of such occupations usually invoke three important premises: (1) they ideally provide help or services in face-to-face situations with their welfare recipients (different social groups in the local community, families and individuals); (2) their services are regarded as essential, not only by welfare recipients, but also for the well-being of society as a whole; (3) ideally, welfare occupations are founded on humanitarian and non-commercial values.

The social ethos of hygiene and public health reform was part of broader cultures of international reform work discussed in this dissertation. The Progressive era in the U.S. (ca. 1890–1918), which promoted science and learning, the case finding activities developed by the Charity Organization Societies (COS) in England and the U.S., the visiting nursing activities at the nurses' settlements, and the rise and fall of the governmental Sheppard-Towner program for maternity and child health care in the U.S. in the 1920s, all embody reform cultures which influenced the internationally disseminated definitions of the knowledge base and modes of practice that the Rockefeller Foundation promoted for public health nursing. The reciprocal understandings of an occupational entity which included certain characteristic elements of the knowledge base and modes of practice for public health nursing, were however implemented in different ways in different national contexts.

In Table 8.1, I summarize the central results of my study. I discuss these results in more detail in the following sections, in relation to my research questions, and with regards to the theoretical frameworks and methodological tools I have chosen for this study.

Table 8.1 Summary of the central results of the study.

<i>The principal research question and its four themes</i>	<i>Conclusions</i>
What kind of boundary-work did professionalizers of public health nursing within the Rockefeller Foundation and amongst Finnish actors engage in during the inter-war period?	<p>Negotiated occupational formation as an alliance strategy (concerning abstract & practical knowledge; social organization/social mobility of the occupational group) is identified in four social settings:</p> <p>(1) philanthropy, (2) small and large voluntary non-profit organizations, (3) professions/occupations, and (4) public/governmental agencies.</p> <p>Aim of the professionalizers: to define and control public tasks in nursing in the local community/outside the hospital through negotiating with PH-activists and implementers of PHNing.</p>
(a) Through what kind of processes did the <u>knowledge base</u> of public health nursing take shape in the American context and how was it adapted in the Finnish context?	<p>(1) US: Scientific philanthropy: scientific medicine, preventive medicine, “to promote the wellbeing of mankind.”</p> <p>FIN: Social ethos of public health: hygiene, public health surveillance and health education as a nation-building project.</p> <p>(2) US: Basics in visiting nursing and social casework at nurses’ settlements, a multi-disciplinary approach to health and illness.</p> <p>FIN: A shift <i>from</i> sectionalized knowledge developed by voluntary organizations which trained earlier nurses for special tasks, such as early district nursing, TBC work, child welfare work and school health work—<i>toward</i> a multi-disciplinary public health approach to health and illness that formed the foundation of a new broader and more standardized PHNing knowledge base.</p> <p>(3) US: PHNing as special university-based training for educated nurses. Close collaboration between the RF and universities which promoted the shaping of courses for PHNing.</p> <p>FIN: A shift <i>from</i> the idea of the nurse’s separate task as welfare worker <i>toward</i> the emergence of a new type of nurse, the public health nurse, whose competence is based on the multi-disciplinary curriculum established at the independent state Graduate School of PHNing in Helsinki in 1932, which consisted of studies in medicine, social science, psychology and education, a “centralized” concept of PHN:ing (Fin. <i>keskitetty terveyssisäryö</i>, Swe. <i>centraliserat hälsosysterarbete</i>).</p>

	<p>(4) US: Rise and fall of Sheppard-Towner Act, The federal Children's Bureau, Innovative PH-projects and PHNing in New York City.</p> <p>FIN: National governmental health and population policies supported the idea of "preparing the nurse for public health." In 1931: the nationalization of PHNing education. Positions of Inspector of Nursing at the State Board of Health (1929) and Inspector of PHNing (1945) and positions of provincial public health nurses (1945).</p>
<p>(b) What kind of <u>modes of practice</u> did the Rockefeller Foundation promote for public health nursing and how were they adapted to Finland?</p>	<p>(1) RF: social and health conditions charted, classified, recorded and reported by a PHN. The PHN as health educator: translator, mediator, and executer of new scholarly knowledge in public health, preventive medicine, social welfare and education to different population groups.</p> <p>FIN: The work of the predecessors of the early public health nurses, trained by the voluntary PH-organizations, was publicly recognized in the 1910s.</p> <p>(2) RF: The Henry Street Visiting Nurse Service in New York City as a socialization arena for foreign RF stipendiaries.</p> <p>FIN: Voluntary PH-organizations supported an extended jurisdiction for PHNing practice (1920s and 1930s). A network of local agencies of voluntary PH-organizations (TBC, child & maternity health, school health) and "friendly visiting"/ambulatory nursing/early district nursing prepared the ground for governmental PHNing practice. From 1937 positions for leading public health nurses (General Mannerheim League for Child Health Care) for supervision and inspection of PHNing work and education.</p> <p>(3) RF: The generalized public health nurse at a public local health center, <i>training fields</i> and <i>demonstration fields</i> where theory and practice could co-exist.</p> <p>FIN: "Centralized" and family-centered PHNing in collaboration with experts: the "health center" (Fin. <i>terveysalo</i>, Swe. <i>hälsögård</i>) as a site of modern publicly recognized public health activities, the training fields (Fin. <i>opetuskenttä</i>, Swe. <i>praktisk undervisning</i>) and demonstration fields [Fin. <i>mallipiiri</i>, Swe. <i>mönsterdistrikt</i>] as a model for PHNing organization.</p> <p>(4) RF: export of the idea of public-based PHNing and local health centers where PHNs can develop autonomous PHN-practices.</p> <p>FIN: The Municipality of Helsinki as a governmental model local health center and model training field: a fertile basis (an innovative, governmentally supported and independent PHNing "room") for the extended institutionalization of modes of practice within PHNing.</p>

(c) What kind of <u>social strategies</u> did the professionalizers of public health nursing use to defend and promote their professional project?	<p>Building of national and international networks in an educational and administrative boundary-work setting. Utilizing critical boundary events in order to make jurisdictional claims for public health nursing.</p> <p>Alliances along class lines rather than gender lines: the professionalizers of PHNing found allies among male professionals of their own social class higher in the work hierarchy but practised exclusionary strategies towards lower-level nursing groups and other health professionals which were discussed as a potential workforce for public health nursing (i.e. dual closure strategies).</p> <p>Drawing-up of boundaries toward educational and administrative strategies in hospital medicine, hospital nursing, general nursing in the homes, midwifery and early social work.</p>
(d) What were the <u>collective social values</u> that the professionalizers of public health nursing promoted for the <u>women's occupation</u> of public health nursing?	<p>Preparing ground for:</p> <ul style="list-style-type: none"> – female professionalization of voluntary effort outside the domestic field and outside the hospital – skilled female expertise within public health. – female professionalization of interventionist philosophies in public health – caring “in/with/for” the community – close bond of contact with the population <p>→ empowerment through such a legacy</p> <p>”Proper” class and educational backgrounds for the PHNs: middle-class or upper-lower class civilized women with secondary school education.</p>

The four empirically identified social settings in this study are: (1) philanthropy, (2) small and large voluntary non-profit organizations, (3) professions/occupations, and (4) public/ governmental agencies. Furthermore, the turf battles and negotiations at the boundaries of public health nursing took place on three different jurisdictional arenas (Abbott 1988) within these four large social settings: in the arena of public opinion, within the legal arena or the governmental apparatus (educational and public health policies, public health legislation), and in the workplace arena. Hence the formation of inter-war public health nursing described and analyzed in this dissertation was not a linear evolution which “emerged” by itself.

The collaboration between the actors of the Rockefeller Foundation promoting scientific philanthropy and new educational and administrative models and the Finnish actors, is identified in this dissertation as a range of social patterns, varying from a few scattered options for the forerunners of the public health nurses to the widescale, generalized practice of public health nursing in the setting of a local health center.

8.2 Professionalization of Voluntary Effort and Interventionist Philosophies

The model for public health nursing that the philanthropic organization the Rockefeller Foundation promoted worldwide was a generalized one. Three critical boundary events concerning the adoption of this model in the Finnish context are identified.

First, the establishment of public health collaboration between the Finns and the Rockefeller Foundation formed an important groundwork for later individual professional relationships and larger governmental activities. During this period individual Finnish public health nursing pioneers were active in international occupational organizations within nursing and many of them studied at international educational institutions abroad. This prepared them for international contact, a resource that was noted by several Rockefeller scouts. The first official contact that the Rockefeller Foundation officials established when they surveyed the Finnish educational and health care system ended up in concrete plans for the future collaboration.

A second critical boundary event was the activities of the Finnish Rockefeller Foundation fellowship holders (stipendiaries)—namely, the nurses, doctors and administrators who studied new ideas about public health in North America in the 1930s. They formed a network of second-generation professionalizers who, together with Rockefeller Foundation officials, continued to institutionalize public health nursing in the local workplace arena, within the educational institutions, in the public arena, eventually even in the legal arena. The State School of Nursing/Graduate School of Public Health Nursing in Helsinki, established in 1932, became a core agency for collaboration. It implemented the Rockefeller Foundation's ideas of generalized public health nursing.

Even though the fellowship program in the 1930s expanded the network of agents engaged in the boundary-work for Finnish public health nursing, core positions in the field were held by central public health nursing pioneers. Tyyne Luoma, who had studied new ideas of health nursing in North America in the 1920s and 1930s, was the director of the State School of Nursing/Graduate School of Public Health Nursing in Helsinki from 1933 to 1943. Luoma collaborated closely with Doctor Severi Savonen, the central state official in public health, who was the chairman of the School Board. Such networking further improved the integration of public health nursing professionalizers to general public health administration. Reflecting my empirically constructed abstract actors' categories, the study shows that some of the professionalizers of public health nursing also became implementers. Another central agent during this period was Venny Snellman, whose strategic positions, first at the Mannerheim League for Child Welfare and later on the State Board of Health made her an important coordinator of the Rockefeller Foundation exchange.

She had studied at Bedford College, making her familiar with the International Red Cross's activities concerning nursing, and she had also visited the United States on a Rockefeller Foundation fellowship. The tailor-made program she attended during her visit gave her unique insights on how the Rockefeller Foundation's ideas worked in practice and what could be implemented in Finland.

The third critical boundary event was the planning of the generalized public health nursing training field in the Municipality of Helsinki as part of the experimenting of a local health center model. This project was the first large public health project supported and partly funded by the Rockefeller Foundation in Finland. A necessary condition for and important outcome of the project in the Municipality of Helsinki was the intensified collaboration with the State School of Nursing/Graduate School of Public Health Nursing in Helsinki which continued after the war. In the early 1950s, a broader generalized public health nursing project was experimented in collaboration with the Rockefeller Foundation. This project took place in the province of Uusimaa in southern Finland, and two smaller generalized training fields were established in connection with the schools of nursing in the city of Pori in western Finland and in the northern city of Oulu.

After returning home to Finland, the Rockefeller Foundation fellowship holders got central positions within institutions that influenced the development of public health nursing in Finnish society, and they took part in critical decision-making on issues of public health. Such critical decisions made were: the establishment of national governmental control of public health nursing training in 1931; the establishment of the State School of Nursing/Graduate School of Public Health Nursing in 1932; and the law-making process before the 1944 Act on municipal public health nurses and the decree on public health nursing in 1945.

8.3 Modes of Interventionist Practice—The Public Health Nurse as a Relational Generalist in the Local Community

The reciprocal understanding of the generalized model in public health nursing, which the Rockefeller Foundation fellowship holders wanted to develop in a Finnish context, was put into practice and tested in the public health experiment in the Municipality of Helsinki. The local health center model in the Municipality of Helsinki, with its generalized public health nursing training field, was the result of many years of determined struggle by different professionalizers and implementers.

The planning and establishment of the model public health nursing training field at the health center in the Municipality of Helsinki in 1940–1944 resulted from a series of negotiations at multiple levels of public administration in Finland, involving in different stages both state and non-state actors as well as Rockefeller Foundation officials. This process exemplifies the impact of the institutional and interactional

context for the dissemination of scholarly knowledge into practice. Practical knowledge about health nursing in relation to sick nursing and the generalized concept of public health nursing in local carework strengthened the position of nurses as community workers or civil servants. The public health nurses' integral connection with the community, their expertise in health promotion and the prevention of disease, and the practical skills they held with regards to general nursing, child health care, maternity care, school health and the care of contagious and venereal disease provided the potential for autonomous practice and decision making for public health nurses. This was carried out at the model health center under the supervision and leadership of the doctors. This means that, in the generalized public health nursing model, certain public tasks in nursing in the local community had been clearly defined and controlled by the professionalizers and implementers of public health nursing.

The war politicized, militarized and strengthened hierarchical strategies within women's carework, but from the viewpoint of the civil public health nurses in the municipalities, their position became stronger and more noticeable. National patriotic interests motivated their work (Henriksson 2002). They represented an elite of women careworkers. The public health nurses had the role of being "guards of the home front," when most of the men (including many doctors) were engaged in war duties, away from their home communities. In line with the patriotic and civilizing nation-building project that many voluntary organizations were engaged in, the public health nurses were central actors in a "patriotic public health project." They carried out medical-hygienic interventions in the homes and at the new health centers and taught healthy living habits to a wide audience of citizens in order to support the national popular enlightenment project going on in Finland in spite of the war. The public health nurses' role as health educator was to be translators, mediators, and executors of new scholarly knowledge in preventive medicine, hygiene and public health to different population groups, particularly lower-class groups.

Because of the war the original plans for the model public health nursing training field and the health center in the Municipality of Helsinki could not be carried out. The project that was carried out was narrower in focus and had somewhat different emphasis. However, the central ideas and the spirit of the generalized model for public health nursing were actively experimented on in the Finnish context in the Municipality of Helsinki and the project was considered by its implementers to be true to the spirit of the new expertise. The experiences of the project in the Municipality of Helsinki formed a valuable and strong foundation for future developments in municipal public health nursing. The collaboration and negotiations between the professionalizers and implementers of Finnish public health nursing in Finland and within the Rockefeller Foundation had enabled a process of drawing new boundaries for Finnish public health nursing. This was done in order to shape, strengthen and maintain an occupational jurisdiction for Finnish public health nurses, an independent professional field of nursing outside hospital nursing.

8.4 A Patriotic Professional Project for Women in Public Health

This study has also identified different social roles and social values in the inter-war formation of public health nursing. By locating the professionalization and implementation of public health nursing within a certain historical period and in reference to formative external processes that influenced the leading professionalizers and implementers, I have demonstrated that middle-class women with patriotic values and an interest in socially defined preventive health care carried out the early professional project of public health nursing. They believed, as did the other middle-class activists promoting public health in that era, in the need to target women as mothers and as wives (Davies 1988; Henriksson 1998 and Wrede 2001). The shift from traditional charity toward a more secular and bureaucratic form of scientific philanthropy opened up new jurisdictions for the professional project of middle-class female public health workers. The vacant jurisdiction for women in public health was defined by the professionalizers of public health nursing as an occupation that would bridge the gap between the new multi-disciplinary scholarly knowledge about public health, and the population. Families, women and children were central target groups for the health education. The strategy of acting through women to influence the conduct of men was a result of ideologies of domesticity and motherhood, and this attitude was also adopted in the medical-hygienic interventionist strategy present in the social casework concept.

The early hospital nurses were a group of health workers controlled by physicians in the hospital. In the beginning of the twentieth century the hospital setting was a hierarchical, male-dominated organization when the training of nurses took place at hospitals and was controlled by physicians. Hospital nurses were unable to expand their occupational jurisdiction in the hierarchical hospital setting that was dominated by doctors. One reason for this was that the knowledge base and modes of practice of hospital nurses were shaped in relation to a dominant medical knowledge base ruled by medical men (Rothman 1978; Reverby 1987; Witz 1990 and Davies 1995). Wrede (forthcoming) has studied the law-drafting process before the 1944 Act on Municipal Public Health Nurses, and she identifies what she calls “the hierarchical sisterhood of public health” in the context of home nursing. Home nursing became a work field that can be characterized as “dirty work” (Hughes 1958). This field of work is an example of a boundary issue, which was actively negotiated, when the boundaries of generalized public health nursing were drawn up. It was seen as similar to hospital nursing and as a service that could be carried out by lower-level nursing groups.

By contrast, the professionalizers of public health nursing engaged in a new kind of health nursing. The new kind of nurse was confronted with knowledge and practice fields that differed from hospital nursing which had been dominated by doctors' exclusionary and demarcationary strategies. This study shows that public health

nursing offered a gateway for women to occupy independent paths in the occupational field and to initiate and establish professional careers of their own. The female professionalization of public health nursing also extended these women's social and personal identities. As female caregivers paid by the public in the local communities with expanded social rights, these women had an opportunity to gain recognition and legal and economic rights unlike anything possible in the traditional domestic field. These kinds of opportunities were first available for women with upper- and middle-class backgrounds, but they were later gradually extended to all social classes, as a consequence of democratization and social reforms in society. Pioneering female social workers, primary school teachers and kindergarten teachers went through similar social patterns in their movements toward professionalization of voluntary effort within welfare work (Seip 1981; Satka 1995; Sjöberg & Vammen 1995 and Hatje 1999). The leaders, initiators and educators of public health nursing had dedicated most of their lives to some central ideas and movements in their fields and to professionalization of different caregiving and teaching practices.

8.5 Reflections on the Results and Chosen Analytical and Methodological Tools

Research on the role of welfare policy for women's occupations in the Nordic welfare states (see, for example, Kjølørød 1993; Milton 2001; Wrede 2001; Evertsson 2002 and Kjølørød & Thornquist 2004), health visitors' and midwives' specific professional projects in Britain (Davies 1988), and midwives' struggles for an independent position in the Netherlands (van Teijlingen 2003) show that the institutional context for the formation and developments of occupational groups can be quite different. Such research has highlighted the relevance of studying health care and social welfare occupations from a broader social perspective, not just from the viewpoint of major disciplinary backgrounds with dominant and ideological knowledge positions or of powerful and concrete actions of professional associations, as in, for example the role of medicine/medical knowledge and the influence of medical associations in controlling other groups in the field.

Different developments within medicine have played an important and crucial role for the shaping of different "nursing." However, various social movements such as different social reform cultures during different historical periods have also shaped new kinds of expertise. The conceptual approaches which I have used in my interpretations have helped me to set forth multiple and shifting meanings of different critical boundary events in the complex formative boundary-work of early public health nursing. I have here investigated both scholarly definitions and definitions of practice in the context of public health nursing. I hope to have proved that it is both exciting and important to examine how philanthropy and public health nursing have been intertwined both as a larger social process and in the lives of individual actors. Thus, my study is an attempt to move from detailed specialized concerns

to broader synthetic work on occupational formation that uncovers both local and more general developments. A disadvantage of such an actor-oriented approach is that it focuses on processes rather than on an entity. This makes it difficult to produce in-depth interpretations. Some actors might get an overemphasized position in the phenomenon studied. My dissertation examines the action/interaction of the social elite and the leaders of occupational formation. There will be room for future studies on, for example, experiences of occupational formation related to the themes in this dissertation within rank and file public health nursing. On the other hand, an actor-oriented approach is fruitful when it is applied on a research topic or research field which has been largely uninvestigated.

The actor-oriented approach has made it possible for me to look at occupational formation from a joint perspective of different national and international actors. However, these different social actors have all practiced reflective orientation into the knowledge base, modes of practices and social structures of public health nursing.

The value of studying action/interaction in changing social relations and practices—not in deterministic and self-evident institutions ruled by written doctrines and discourses—uncovers sequences of often conflicting or unexpected processes. Public health nursing has been constructed both *by* and *in* relations and structures.

I believe that historically guided context-specific interpretation of the present time provide resources for understanding contemporary developments in public health. I hope that my study will encourage future interdisciplinary research where collective research will transcend the origins of different welfare state occupations and open up dichotomies such as medical/social, control/agency, reproduction/transformation, men's work/women's work, and theoretical knowledge/practical knowledge.

The application of neo-institutional theory about how ideas are disseminated within and between different organizational cultures (see, for example, Powell & DiMaggio 1991; Hatch 1997; Erlingsdóttir 1999 and Sahlin-Andersson & Engwall 2002) might be a fruitful analytic tool in order to get deeper focus and understanding of some aspects of how new educational and administrative strategies have been institutionalized, not only in recent times, but during earlier historical periods as well. I studied such neo-institutional theoretical models in an earlier stage of my research project and decided to limit my perspective to some theoretical models developed in the sociology of professional groups. They are grounded in classical sociology and have helped me to grasp and understand the specific early formation of the women's occupation of public health nursing in the context of Finnish-American boundary-work rather well.

In my study, the Finnish organizational context within welfare work and public health had a rather multifunctional character with both voluntary and public institutional frameworks in the inter-war period. It was a historical period characterized by experimenting of new ideas in order to find more standardized models for

public health and public health nursing. This standardization prepared ground for legislative processes in the early formative period of the Nordic welfare state and created broader institutional support for early welfare occupations.

8.6 The Contribution of the Study and Its Relevance to the Analysis of Trends in Contemporary Finnish Public Health Nursing

The early formative phase of the so-called Nordic model for public health developed through interrelated national and international processes. In Finland today the public health nurse is a professional who primarily exists within the frame of the public sector. Private occupational health services represent one exception to this pattern, but they usually require that public health nurses gain additional specific training. Thus, the jurisdiction in public health is essentially based on the mandate provided by welfare policy, and more precisely on the health policy aimed at health promotion and the prevention of disease. The act of practicing as a generalist professional who is responsible for primary care for a designated population group has been viewed as constituting the core of the professional identity of public health nurses (Sorvettula 1998; Simoila 1994; for a description of the traditional professional identity, see also Siivola 1984).

Currently the position of promotive and preventive public health in Finnish health policy is changing. In the 1980s, Finnish health policymakers emphasized primary care as a gatekeeper to specialized services. The mode of practice emphasized in the so-called Population Responsibility program (Fin. *väestövastuu*, Swe. *befolkningsansvar*) that was adopted in the early 1990s was based on a generalist service design (Simoila 1994; Wrede 2001). This policy program was developed in the spirit of the international policy program *Health for All by the Year 2000*. *Health for All* was launched in Finland as a national health program in 1986 (Ministry of Social Affairs and Health, 1986). The implementation of the health policy through the Population Responsibility program (National Board of Health 1990) gave public health nurses a central position. Together with the primary care doctors, public health nurses were to form the core of primary care teams at local health centers (National Agency for Welfare and Health 1991 and 1992).

However, in the early 1990s the central steering system of the Finnish health system was dismantled and health policymaking was decentralized. After this, the *Health for All* program started to lose its central position as a national health program, even though the Ministry of Social Affairs and Health tried to redefine the program for the changed situation (Ministry of Social Affairs and Health 1993, 1996). The program was reduced to being recommendation-based. The organization of services changed more slowly than the rhetoric of policy. The implementation of the Population Responsibility program in the municipalities supported the generalist mode of practice in health centers during the period of the 1990s. Not surprisingly,

both the medical profession and the public health nurses' association supported the new service design (Wrede 2001). However, gradually new policies reflecting the changed institutional context emerged and challenged the Population Responsibility program as an overriding principle to organize primary care.

The public health nurses' association viewed the Population Responsibility program as a return to their "traditional" mode of practice and saw the health policy as an opportunity to employ their knowledge base more broadly than was the case in the sector-based organization of the health center that had been introduced by the Public Health Act of 1972 (see Simoila 1994). The generalist mode of practice was originally established as a health policy by the Act on Municipal Public Health Nurses in 1944 which has been examined within this dissertation.

The decentralization of health policy that occurred in the 1990s has fragmented national health policy programs and reduced their status to mere guidelines. Even the Public Health Act of 1972, though still in force, is losing its status when the position of the public sector as a producer of primary care services is increasingly challenged. In current health policy, the position of public health nurses as primary care providers is not emphasized. Municipalities are again choosing sector-based solutions to organize primary care. Medical care is treated as the core content of primary care and the resources used to address health promotion and disease prevention have decreased. The emphasis in current policy debates is best described by the policy program that has introduced the so-called *care guaranty* (Fin. *hoitotakuu*, Swe. *vårdgaranti*), by which all are secured access to medical care.

From the point of view of public health nursing, the central development in health policy implementation is the reviving of specialization as the mode of practice for public health nurses. Specialization is called for by many different actors in the health system and endorsed by the public health nurses' professional associations. Not surprisingly, sector organization in local health care is returning. It has been suggested that in areas like home care for the elderly, the practice of public health nurses is more reminiscent of the work of general nurses than of traditional 'health nursing' of this occupational group (Wrede and Henriksson 2004). Practice in specialized school nursing, diabetes counselling et cetera is replacing the traditional holistic view of public health nursing in the local community.

From the perspective of public health nursing as a professional occupation, the tendency towards specialization, together with the ongoing medicalization of primary care threatens to fragment the knowledge base for public health nursing in its practical settings. If the shared mode of practice loses its institutional support, the occupation itself may face deskilling and transformative change.

A comparison between the outcomes of the studied period of the formation of Finnish public health nursing and today's trends concerning public health nursing uncovers some interesting issues. In my view, the professional project of early public health nursing presented in this study was a kind of joint venture project.

There were clear role divisions concerning primary care and the political will to promote public health developments in the local community. The group of public health nurses had a clearly stated mandate and license to carry out their specific role in promoting health and preventing disease. This mandate and license was clearly stated in the national health policy. These developments were an outcome of networking among voluntary organizations, public administrators, volunteer and public educators working on the collective joint venture public health project. In today's welfare mix (public sector, private sector and third sector), the mandate for promotive and preventive social welfare and public health work is indistinguishable in public welfare policies and programs. It is not a central national political issue in the public sector's rather short-range decisions, which are ruled by a new public management which adopts ideas from organizations that are considered successful by the private sector's standards. Sirpa Wrede (2001) who has argued that midwives' loss of a position in primary care is due to this dissolution of a health policy mandate identified a similar development in health policy concerning maternity care.

From the viewpoint of today's situation in public health nursing, the trend is toward supporting the specialization instead of supporting the traditional generalist community health model and toward emphasizing curative and clinical medical health care with a focus on fighting acute and chronic medical problems from a rather narrow, biomedical perspective. One might ask if there is an illusion that health promotion and disease prevention is not needed in the Finnish welfare state of today. Is it an issue for the third sector alone, or is there a crisis in primary care today in which there is an opportunity for different social actors of the welfare state to create a new long-range model? A generalist and negotiated view on health and disease and on social problems could serve as a central resource and foundation for sustaining welfare and increasing social equality among citizens today and in the future.

The claim for "opportunistic" public health nursing, expressed in the quote of Mary Beard (1937) in the beginning of this volume, describes the process of creating temporary alliances in opportune moments to reach more stable positions in the world of work. Today, Finnish public health nursing has traditions to fall back on. Fruitful educational and administrative strategies that support the generalist public health nursing model for health promotion and disease prevention have been developed over the years. Therefore, the occupation of public health nursing might today benefit from a focus on keeping the broad institutional support that the occupation gained in the Finnish society already in the early formative years, instead of being "too opportunistic."

Notes

Chapter One Introduction

- 1 Mary Beard, September 29, 1937, "Nursing Needs," Rockefeller Archive Center (North Tarrytown, New York), Rockefeller Foundation Archives, (hereafter RAC, RF), Record Group (hereafter RG) 3, box 15, folder 165, pp. 13–15.
- 2 John B. Grant, "Public Health Policy, Europe – 1951. Background for Future Policy," June 6, 1951, 11 pages, RAC, RF, RG 1.2, series 700 (Europe), box 19, folder 161.
- 3 RAC, RF, RG Hist-1, series 900/Source Material History, Vol. 8, "II Early program in nursing education in the United States (1914–1927)," pp. 2076–2115.
- 4 Professional titles referring to similar occupations in other countries: Health Visitor (UK), District Nurse (UK), Visiting Nurse (U.S.), Distriktssköterska (SE), Skolsköterska (SE), Företagssköterska (SE), Helsesøster (N), Sundhedsplejerske (DK).

Chapter Three Tracing Boundary-Work

- 5 Today an extensive description of the collections is also available on the home pages of the Rockefeller Archive Center (<http://archive.rockefeller.edu/collections>).
- 6 The Municipality of Helsinki had a Swedish speaking majority until the beginning of the 1930s, and the Swedish name of the rural municipality, Helsing, is still commonly used. By 1940 there was a big Finnish speaking majority in the municipality due to work-motivated influx of Finnish speaking people. The relative numbers of Finnish speaking versus Swedish speaking inhabitants were as follows: In 1920 4,916/7,217; in 1930 5,188/6,299 and in 1940 12,779/5,822. Source: 1920, 1930 and 1940 Population Census, volume 1, Official Statistics of Finland series VI C 102. Central Statistical Office of Finland. Helsinki 1956.

Chapter Four Scientific Philanthropy As a Catalyst for Early Public Health Nursing

- 7 Barry D. Karl and Stanley N. Katz, "Donors, trustees, staffs: an historical view, 1890–1930," a paper published in 1979 relating to a RAC conference: "The Art of Giving, Four Views on American Philanthropy: Proceedings of the Third Rockefeller Archive Center Conference, October 14, 1977."
- 8 Between 1889 and 1907, thirty-four organizations, institutes and associations had secured incorporation and government control by the American Congress (Fosdick [1952] 1989: 16).

- 9 (1) Letter “No. 29,” E.W. Brackett to M.E. Tennant, January 19, 1951 and Tennant’s handwritten note enclosed to it; (2) Letter, V. Snellman to M.E. Tennant, January 16, 1951; (3) Tyyne Luoma, December 30, 1950: “Description of development in Public Health Nursing in Finland in which the Rockefeller Foundation has played a part in 1930–1950”; (4) Venny Snellman, December 28, 1950: “The part of the Rockefeller Foundation in developments in nursing in Finland since 1929,” RAC, RF, RG 2 – 1951, series 787 C (Finland), box 547, folder 3651.
- 10 RAC, RF, RG Hist-1, series 900/Source Material History, Vol. 9, “III European nursing program (1920–1931),” pp. 2200–2220.
- 11 Elisabeth Crowell, April 14, 1922, “Notes on Study of English Sick Nursing and Health Visiting,” RAC, RF, RG 1.1, series 401, box 33, folder 425, 13 pages.
- 12 Mary Beard, September 29, 1937, “Nursing Needs,” RAC, RF, RG 3, series 908, box 15, folder 165, pp. 3–4.
- 13 Mary Beard, September 29, 1937, “Nursing Needs,” RAC, RF, RG 3, series 908, box 15, folder 165.
- 14 Mary Beard, September 29, 1937, “Nursing Needs,” RAC, RF, RG 3, series 908, box 15, folder 165.
- 15 There was Red Cross activities in Finland during the autonomy period, beginning in 1877 (Rosén 1977).
- 16 Public health doctor Leo A. Kaprio was himself a Rockefeller Foundation fellowship holder after WW II and leading actor in the provincial so-called Uusimaa project 1948–56. This project was supported by the RF and many of the nurses and doctors involved in the project were RF fellowship holders in the 1940s and 1950s. See also Sorvettula 1998, on post-war cooperation with the RF.

Chapter Five The Rockefeller Foundation Agenda for Public Health Nursing

- 17 Mary Elizabeth Tennant, “What is Public Health Nursing?”, November 1935, p.1 (36 pages), RAC, RF, RG 1.1, box 38, folder 342.
- 18 Report on “Conference on the training of nurses. Called by officers of the Rockefeller Foundation,” held in February 28, 1920, at Hotel Commodore, New York, 38 pages, RAC, RF, RG 3, series 906, box 2, folder 16.
- 19 Josephine Goldmark 1923, “Study of Nursing and Nursing Education in the United States. Report of the Committee for the Study of Nursing,” RAC, RF, RG 3, series 908, box 15, folder 166.
- 20 “Their Health is Your Health,” a fund raising booklet for Henry Street Nurses’ Settlement, New York 1934. RAC, Laura Spelman Rockefeller Memorial Archives (1918–1930)–1949, Series 3.1: Public Health, box 2, folder 14: Henry Street Settlement, 1919–1944.

- 21 C.E.A. Winslow, "The New Profession of Public Health Nursing and its Educational Needs," speech 1917, Winslow Collection, Yale University Library, New Haven, folder 119: 128 (quoted in Buhler-Wilkerson 1985).
- 22 Gertrude Hodgman in *The Henry Street Nurse*, Vol. II, No. 6–7, June–July 1921, the New York Academy of Medicine/Library, pp.1–4.
- 23 M. Curran in *The Henry Street Nurse*, Vol. II, No.5, 1921, the New York Academy of Medicine/Library, p. 11.
- 24 Gertrude Hodgman in *The Henry Street Nurse*, Vol. II, No. 6–7, June–July 1921, the New York Academy of Medicine/Library, pp. 1–4.
- 25 Florence J. Kelly in *The Henry Street Nurse*, Vol. II, No. 1, January 1921, the New York Academy of Medicine/Library, p. 2.
- 26 "J.R." in *The Henry Street Nurse*, Vol. II, No. 4, April 1921, the New York Academy of Medicine/Library, p.5.
- 27 Ibid., pp. 1–5.
- 28 Miss Leverich in *The Henry Street Nurse*, Vol. II, No. 1, January 1921, the New York Academy of Medicine/Library, p. 5.
- 29 Dorothy Deming in *The Henry Street Nurse*, Vol III, No. 11–12, Nov.–Dec. 1922, the New York Academy of Medicine/Library, p. 1.
- 30 Naomi Deutsch in a presentation of the Morris Avenue Health Center in *The Henry Street Nurse*, Vol. II, No. 1, January 1921, the New York Academy of Medicine/Library, pp. 5–6.
- 31 J.R. in *The Henry Street Nurse*, Vol. II, No. 4, April 1921, the New York Academy of Medicine/Library, pp. 1–5.
- 32 Ibid., pp. 1–2.
- 33 Ibid., pp. 1–5.
- 34 For the theme "close bond of contact" see, for example, RAC, RF, Annual Report 1921, p. 208; Mary Elizabeth Tennant, "What is Public Health Nursing?," November 1935, pp.6–7 ("Objectives"), RAC, RF, RG 1.1, box 38, folder 342; Lavinia L. Dock (R.N. and Secretary of the International Council of Nurses), "The history of public health nursing," 1921, RAC, RF, RG 3, series 908, box7E, folder 86.54, published in *A half Century of Public Health*, APHA, New York, pp. 439–452.
- 35 RAC, RF, RG Hist-1, series 900/Source Material History, Vol. 8, "II Early program in nursing education in the United States (1914–1927)," pp. 2076–2115 and Vol. 9, "III European nursing program (1920–1931)," pp. 2200–2220.
- 36 Mary Elizabeth Tennant, "What is Public Health Nursing?," November 1935, pp. 28–34, RAC, RF, RG 1.1, box 38, folder 342.
- 37 TBA to Rockefeller 3d, July 9, 1946, "The Rockefeller Foundation in Europe—a brief survey of work done in Europe from 1913–1946," RAC, RF, RG 1.2, series 700, box 9, folder 81.

- 38 Dorothy Deming registered nurse from New Haven is known for several career books about the various opportunities in nursing. For example her nine popular old-time girls' series books, about the career and private life of the public health nurse Penny Marsh in the 1930s and 1940s, are widely known. The stories tell about Penny Marsh working in public health nursing both in a rural area and in a big city. During World War II, Penny worked on the homefront, helping to recruit new nurses. The image of the nurse in fiction for young girls was a potent symbol of both femininity and patriotism. In U.S. in the 1930s and 1940s, middle-class women were stereotypically considered homemakers. Women who got into a nursing career, at least for a short time, started to alter and extend this kind of femininity. (<http://www.netwx1.com/CherryAmes/pennymarsh.html> fetched 07/02/2005, <http://www.elliemik.com/warnurses.html> fetched 07/02/2005)
- 39 Dorothy Deming in *The Henry Street Nurse*, Vol III, No. 11–12, Nov.–Dec. 1922, pp. 1–2.
- 40 For example “Resumé of Rockefeller Foundation Public Health Nursing and Nursing Education Activities,” RAC, RF, RG 3, series 906, box 2, folder 15 (“Nursing Education, 1950”); and “Public Health Nursing. International Health Division Objectives and Methods Employed for their Achievement,” presented by Mary Elizabeth Tennant at a staff meeting on May 19, 1948, RAC, RF, RG 3, series 906, box 2, folder 15 (“Nursing Education, 1950”).
- 41 “Resumé of Rockefeller Foundation Public Health Nursing and Nursing Education Activities”, July 6, 1950, RAC, RF, RG 3, series 906, box 2, folder 15.
- 42 “PH Analysis” of rural health, and “Some Questions About the Rockefeller Foundation’s Decision to Support County Health Departments,” RAC, RF, RG 3, series 908, box 7E, folder 86.69.
- 43 Mary Elizabeth Tennant, “What is Public Health Nursing?”, November 1935, RAC, RF, RG 1.1, box 38, folder 342.
- 44 Tennant to MER, July 6, 1950, “Resume of Rockefeller Foundation public health nursing and nursing education activities,” RAC, RF, RG 3, series 906, box 2, folder 15.
- 45 The Finnish RF fellowship holders studied public health nursing at several university-based nursing schools and got to know progressive public health nursing practices in many parts of the U.S. and Canada.

Chapter Six The Dissemination of Generalized Public Health Nursing

- 46 “Whole” person and “total” life—in modern terms a “holistic view” that focuses on the entire “life-cycle.”
- 47 John B. Grant, “Public Health Policy, Europe—1951. Background for Future Policy, June 6, 1951,” RAC, RF, RG 1.2, series 700, box 19, folder 161, pp. 1–11.
- 48 “Recommendations of the conference on nursing education,” New York, October 5–20, 1925, RAC, RF, RG 3.1, series 906, box 2, folder 16, Pro-Nurs-2, p. 2.

- 49 H.O. Eversole, 1925, *Medical Education in the Baltic States—Preliminary Report Covering Finland, Esthonia, Latvia, Lithuania*, RAC, RF, RG 1.1, series 787 (Finland), box 1, folder 5.
- 50 C.A. Bailey, "Scandinavia – Public Health, Observations re on visits to Norway, Denmark, and Finland: Oct., 1927; Feb., July, Nov., 1928; March, Aug.,," RAC, RF, RG 1.1, series 716(Scandinavia), box 1, folder 1, pp. 4–7, pp. 11–14, and pp. 19–25; and "Diary of Dr. Charles A. Bailey, Trip to Scandinavia," March 12, 1929. RAC, RF, RG 1.1, series 716(Scandinavia), box 1, folder 1, pp. 1–15.
- 51 Charles A. Bailey, 1928, *Public Health in Finland*, RAC, RF, RG 1.1, series 787(Finland), box 2, folders 23 and 24, 332 pages.
- 52 Alan Gregg, 1930, *Survey of Medical Education in Finland*, RAC, RF, RG 1.1, series 787(Finland), box 1, folder 5, 31 pages.
- 53 C.A. Bailey, "Scandinavia – Public Health, Observations re on visits to Norway, Denmark, and Finland: Oct., 1927; Feb., July, Nov., 1928; March, Aug.,," RAC, RF, RG 1.1, series 716(Scandinavia), box 1, folder 1, pp. 4–7.
- 54 *Ibid.* p. 7.
- 55 RAC, RF, RG 1.1, series 787(Finland), box 2, folder 23, p.
- 56 "Roster of fellows and scholars, pp. 370–371 ('Finland')," RAC, RF, RG 10.
- 57 *Ibid.*
- 58 Elisabeth Crowell's and Mary Beard's diaries. RAC, RF, RG 12.1.
- 59 Fellowship Recorder Cards on: Märta Boman, Aino Durchman, Maj-Lis Edgren (later Juslin), Birgit Kansanen (later Nieminen), Tyyne Luoma, Helga Sjöholm, Venny Snellman and Hedvig Sucksdorff, RAC, all RF/IHB/D fellowship files are in RG 10 (Fellowship Recorder Cards), either the grant-making institution (IHB/D or RF) or the discipline (nursing, medical sciences, etc) is viewed as the topic of the documents, as well as the country and the grant recipient's name. The cards for the physicians Savonen and Leppo are also filed in RG 10.
- 60 E. Crowell Diaries 1930–31, 1932–34 and M. Beard Diaries 1935–38, RAC, RF, RG 12.1.
- 61 Letter Eino Saari to RBF, May 30, 1940, RAC, RF, RG 10, Fellowship Recorder Cards/IHD/Leppo.
- 62 Fellowship Recorder Cards/Leppo, RAC, RF, RG 10.
- 63 Fellowship Recorder Cards/Savonen, RAC, RF, RG 10
- 64 RAC, RF, RG Hist-1, series 900/Source Material History, Vol. 8, Vol. 9, "(6) Program and Policy," pp. 2477–2513.
- 65 F. Elisabeth Crowell's diaries, 1930-1931, November 2, 1931, RAC, RF, RG 12.1.
- 66 *Ibid.*

Chapter Seven Generalized Public Health Nursing in Practice

- 67 Mary Beard, "Fundamental Changes in Nursing Education," June 12, 1936, 20 pages, Rockefeller Archive Center (North Tarrytown, New York), Rockefeller Foundation Archives, (hereafter RAC, RF), Record Group (hereafter RG) 1.1, series 100 C, box 37, folder 302. The paper was written for a meeting of the Canadian Nurses Association, Vancouver, B.C., July 3, 1936. In 1923, Annie Goodrich became 1st Dean of the new Yale University School of Nursing, a school funded by the Rockefeller Foundation.
- 68 The health center project carried out as collaboration between the RF and Finnish health authorities 1940–1944 had its central administration (Fin. *Helsingin maalais-kunnan terveydenhuoltotoimisto*, Swe. *Helsinge kommuns hälsovårdsbyrå*) in Malmi, a rural district within the Municipality of Helsinki. The new health center building in Malmi (Fin. *Malmin terveystalo*, Swe. *Malms hälsogård*), was partly financed by the RF. Several smaller units in the municipality for maternity and child health care delivery belonged to the same health center administration.
- 69 By 1933, the American Public Health Association included the U.S. (1872) and other countries, such as Canada (1884), Mexico (1891) and Cuba (1902), Ferrell 1933: 1115.
- 70 John A. Ferrell, 1926, *The Public Health Nurse and County Health Service*, RAC, RF, RG 3, series 908, box 7 E, folder 86.54. Also published in *The Public Health Nurse*, June 1926, pp. 337–350.
- 71 John A. Ferrell, 1927, *The County Health Organization in Relation to Maternity and Infancy Work and Its Permanency*, RAC, RF, RG 3, series 908, box 7E, folder 86.54. U.S. Dept. of Labor, Children's Bureau Publication No. 181, pp. 55–68.
- 72 John A. Ferrell, 1933, *America's Contributions and Problems in Public Health*, RAC, RF, RG 3, series 908, box 7E, folder 86.54. Also published in *American Journal of Public Health*, Vol. XXIII, No. 11, November 1933, pp. 1115–1123.
- 73 John A. Ferrell, 1940, *State and Provincial Health Organizations*, RAC, RF, RG 3, series 908, box 7E, Folder 86.54. Also published in *Nelson Loose Leaf Medicine*, New York: Thomas Nelson and Sons, pp. 283–299.
- 74 Courses and teaching organized entirely from the public health point of view had been established in e.g.: School of Public Health of Harvard-Technology (1914), Johns Hopkins University School of Hygiene and Public Health (1918), Harvard School of Public Health (1922), and University of Toronto School of Hygiene (1927), Ferrell 1933: 1118.
- 75 Letter Lavonius to Strode, December 20, 1937, RAC, RF, RG 6.1, series 1.1, box 23, folder 255.
- 76 C.A. Bailey, 1928, *Public Health in Finland*, RAC, RF, RG 1.1, series 787(Finland), box 2, folders 23 and 24, 332 pages.
- 77 Letters, Russel to Strode and Strode to Russel 1928–1929, RAC, RF, RG 787, series 1.1, box 1, folder 1.

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- 83 RAC, all RF/IHB/D fellowships files are in RG 10 (Fellowship Recorder Cards), either the grant-making institution (IHD or RF) or the discipline (nursing, medical sciences, etc) is viewed as the topic of the documents, as well as the country and the grant recipient's name. The cards for the physicians Savonen and Leppo are also filed in RG 10.
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- 89 F. Elisabeth Crowell's, Mary Beard's, Esther Mary Hirst's and Mary Elizabeth Tennant's Diaries, RAC, RF, RG 12.1.
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- 95 Ibid., appendix sheet on planned administrative organization of the state nursing school in Helsinki.
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- 98 “Program in Public Health Nursing,” Agenda for the Meeting of the Scientific Directors, June 27, 1938, RAC, RF, RG 3, series 908, box 15, folder 163 (“Program and Policy—Nursing, Public Health 1922–1940”), p. 1.
- 99 Agreement signed in Helsinki on July 5, 1940, by the representants of the State Board of Health and the Municipality of Helsinki, Vantaa City Archives.
- 100 Letter “210,” Health Officer Erkki Leppo’s report to the RF, year?, p. 2, RAC, RF, RG 787, series 1.1, box 2, folder 22.
- 101 See Leppänen, Lauri (1980), Tahvanainen, Aarno (1996) and the report of October 26, 1944, titled “*Synpunkter rörande hälsovårdsarbetets utveckling i Helsingē under åren 1940–1944*” [Viewpoints according the development of public health work in the Municipality of Helsinki 1940–1944] and signed by acting Health Officer (pediatrician) Johan Wickström and Chief Public Health Nurse, Hedvig Sucksdorff, 31 pages.
- 102 Ibid, p. 5
- 103 “*Synpunkter rörande hälsovårdsarbetets utveckling i Helsingē under åren 1940–1944*” [Viewpoints according the development of public health work in the Municipality of Helsinki 1940–1944] and signed by acting Health Officer (pediatrician) Johan Wickström and Chief Public Health Nurse, Hedvig Sucksdorff, p. 5.
- 104 Ibid.
- 105 Ibid.
- 106 Report of October 26, 1944, titled “*Synpunkter rörande hälsovårdsarbetets utveckling i Helsingē under åren 1940–1944*” [Viewpoints according the development of public health work in the Municipality of Helsinki 1940–1944], and signed by acting Health Officer (pediatrician) Johan Wickström and Chief Public Health Nurse, Hedvig Sucksdorff, Appendix 1 in the report.
- 107 Swedish original text: I ingen annan kommun i Finland, ja knappast någonstans i hela världen, utföres ett i så grad centraliserat arbete som i Helsingē, där 10 olika former av hälsovårdarbete och socialverksamhet ankomma på hälsosystrarna. Fördelarna härav äro stora. I stället för att olika specialfunktionärer oberoende av varandra trötta hemmet med täta besök och ofta giva mot varandra stridande instruktioner och därigenom åstadkomma förvirring, handhavas alla hälsovårdspöblem av en enda person, hälsosystemen. Detta innebär att hon kommer att få en allsidigare uppfattning om problemen och att hon därigenom på ett mera objektivt sätt kan avhjälpa svårigheterna. Det innebär också en mycket avsevärd tidsbesparing att endast en person besöker hemmet och därvid utför samtliga arbetsuppgifter. Det centraliserade arbetet ställer dock mycket stora fordringar på hälsosystrarnas kompetens. De måste vara väl inkomna i alla arbetsgrenar[.] (Report of October 26, 1944, titled *Synpunkter rörande hälsovårdsarbetets utveckling i Helsingē under åren 1940–1944* [Viewpoints according the development of

public health work in the Municipality of Helsinki 1940–1944], and signed by acting Health Officer (pediatrician) Johan Wickström and Chief Public Health Nurse, Hedvig Sucksdorff, pp. 15–16.)

- 108 “Synpunkter rörande hälsovårdsarbetets utveckling i Helsing under åren 1940–1944” [Viewpoints according the development of public health work in the Municipality of Helsinki 1940–1944] and signed by acting Health Officer (pediatrician) Johan Wickström and Chief Public Health Nurse, Hedvig Sucksdorff, pp. 15–17.
- 109 Letter, Reinikainen to Warren, October 22, 1940, RAC, RF, RG 787, series 1.1, box 2, folder 22.
- 110 Budget document, “Finland—Health Center (Helsing—Payment of designation”, September 27, 1946, RAC, RF, RG 1.1, series 787, box 2, folder 22.
- 111 Correspondence about the Oulu and Pori Schools of Nursing/Training fields: (1) letter Luoma to Bracket, July 30, 1946; (2) letter Leppo to Leach, July 31, 1946; and (3) letter Leach to Reinikainen, November 30, 1946, RAC, RF, RG 6.1, series 2.1, box 11, folder 81.
- 112 “Synpunkter rörande hälsovårdsarbetets utveckling i Helsing under åren 1940–1944” [Viewpoints according the development of public health work in the Municipality of Helsinki 1940–1944] and signed by acting Health Officer (pediatrician) Johan Wickström and Chief Public Health Nurse, Hedvig Sucksdorff, p. 19.
- 113 Ibid, pp. 18–19.
- 114 Letter “No.287,” Leach to Strode, May 23, 1947, RAC, RF, RG 787, series 1.1, box 2, folder 22.

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Appendices

Appendix 1 Location and General Description of Materials Collected for the Study at the Rockefeller Archive Center

1. Rockefeller Foundation Archives (nineteen record groups)

Project materials (1912–2000) are situated in **Record Group 1** (RG 1), and constitute the largest portion of the RF archives. These records typically include correspondence related to projects, institutional minutes, internal RF reports, publications, RF officer diary excerpts, and Foundation grant actions. They are arranged by geographic area and alphabetically by subject. Finland's country code is "787" and the code for Scandinavia is "716." Reports on nursing education and public health nursing, in the U.S. and abroad, written by nurse activists of the RF; reports on local visiting nursing services in New York City; and documents related specifically to Finnish nursing and public health, can be found in Record Groups 1.1 and 1.2.

General Correspondence (1927–1989) materials are situated in **Record Group 2** (RG 2 1927–1989). Files relating to public health (supplementing files of the International Health Board/Division), and correspondence documenting the Foundation's cooperation with the United Nations and U.S. government agencies, are found in RG 2. The materials include interoffice memoranda; correspondence with field officers and the home office; forms and other material relating to fellowships, casual requests for information, employment, or aid; printed matter, and crank mail. Correspondence material with the topic "Finland—Nursing" can be found in Series 787 C of this record group.

Record Group 3 includes materials on Administration, Program and Policy (1910, 1913–1989). RG 3 is arranged in twenty-eight series by administrative function or area of program activity. The files include correspondence, memoranda, minutes, and reports that reflect decision making and agendas established by the RF officials, as well as day-to-day detailed materials of the activities of the RF. Especially initial interests of the RF in a field and the developing of a strategy for supporting it, can be observed in these materials. A 21-volume history of the Foundation's programs (1909–1939) are included in RG 3. Conference reports on nursing education and recommendations for nursing policies of the RF in the inter-war period can be found in Record Group 3.1.

Record Group 5 includes International Health Board/Division (1910, (1913–1927)–1951) materials. Correspondence, reports, and financial records of the Board’s work in the investigation and control of specific diseases, and records of public health education, experimentation and demonstrations in the U.S. and abroad, are located in Record Group 5. Materials related to Finland can be find in Record Group 5.3.

Records of the activities administrated by the Field Offices in different parts of the world are situated in **Record Group 6**. Projects and activities in Europe were administrated by the Paris office (Series 6.1—Paris, 1917–1959). The Paris office was opened in 1917 by the International Health Board, and was the headquarters of the work of the Commission for the Prevention of Tuberculosis in France. From 1922 onwards the Paris office was shared by many division of the Foundation with projects relating to issues of medical education, medical science, nursing, social sciences and natural sciences. The Paris office administered payments of appropriations made by the Foundation to projects in Europe, or made by the discretion of the Paris officers and acted as fiscal agent for other U.S. organizations. The office was closed in 1959. Most of the records on public health related projects in Finland, such as the project in the Municipality of Helsinki are located in this record group, in Record Groups 6.1.1 and 6.1.2. There are two subseries of Record Group 6: (1.) Prewar, 1922–1941 and (2.) Postwar, 1945–1959.

All RF/IHB/D fellowship files (Fellowship Recorder Cards) are found in **Record Group 10** (RG 10).

The Officer’s Diaries are situated in **Record Group 12.1**: Miss Mary Beard, 1925–1938 (6 volumes), Miss F. Elisabeth Crowell, 1926–1940 (7 volumes), and Dr. Andrew J. Warren, 1930–1955. (9 volumes).

Minutes and Annual Reports are located in **Record Group 16**.

2. Laura Spellman Rockefeller Memorial Archives, (1918–1930)–1949

The Laura Spelman Rockefeller Memorial was incorporated in 1918 for general philanthropic purposes. The LSRM merged with the RF in 1929. Records on the local visiting nursing services and nurses’ settlements in New York City, such as the Henry Street Settlement and Visiting Nurse Service and East Harlem Health Center-Nursing Demonstration, in the inter-war period can be found in “Series 3.1 – Public Health” of these archives.

3. Rockefeller Family Archives

Documents about the Henry Street Settlement and Visiting Nurse Service can also be found in Record Group 2 of the Messrs. Rockefeller (OMR) General Files, 1858–(1879–1961), in the OMR Series Welfare-General Files, 1894–1961, Subseries 10/Settlements: box 57. This series documents the Rockefeller family's involvement with mainstream charitable and philanthropic organizations such as support for urban reform, manifested by involvement with the settlement house movement in New York City and Cleveland.

Appendix 2 Finnish Nurses as Rockefeller Foundation Fellowship Holders in North America in the 1930s

The nurses' central educational and occupational backgrounds at the time of applying for a RF fellowship. Time and length of their stays in North America. The information follows the contents and structure of the RF's own registration of foreign applicants and fellowship receivers. (Source: RAC, RF, RG 12.1 (Fellowship Recorder Cards))

Venny Snellman Diploma in Nursing, Helsinki General Hospital 1917. International Course in Public Health Nursing at Bedford College, University of London 1921–1922. General Supervisor of Nursing Services at the State Board of Health in Finland. RF fellowship 1926: 6 months.

Tyynne Luoma Diploma in Nursing, Helsinki General Hospital 1917. Studies and work in North America in the 1920s [twice] within the fields of Public Health and Social Work (e.g. Columbia University Teachers College and Henry Street Settlement in NY). Director of Visiting Nurse Services & Professional Registry for Nurses of the National League of Trained Nurses of Finland. RF fellowship 1932: 10 months [third stay].

Aino Durchman Diploma in Nursing, Helsinki General Hospital 1918. Diploma in Education 1924. Bachelor of Science at Teachers College Columbia University, USA 1927. (Major: Teaching in Schools of Nursing). Superintendent of Nurses and Director of Postgraduate course in Nursing Education at the University Hospital in Helsinki. RF fellowship 1933–1934: 6 months.

Maj-Lis Edgren (later Juslin) Diploma in Nursing, Helsinki General Hospital 1920. Course in Child Health Care, the General Mannerheim League 1923. International Course in Public Health Nursing at Bedford College, University of London 1925–1926. Superintendent at the State School of Nursing in Turku. RF fellowship 1934–1935: 6 months.

Helga Sjöholm Public Health Nurse, Samfundet Folkhälsan [Society for Improving Public Health in Swedish Finland]. Nurse Director of the new Health Demonstration Field in Turku. RF fellowship 1935–1936: 1 year.

Märta Boman Diploma in Nursing, Helsinki General Hospital 1925. Public Health Nurse 1932. Milk Booth work in Helsinki 1928–1935. Medical Social Worker at University Hospital Clinics in Helsinki 1935 and 1938–1939. RF fellowship 1936–1937: 1 year 10 months.

Hedvig Sucksdorff Diploma in Nursing, Skogsborg Sanatorium School of Nursing 1920. Assistant Director of State School of Public Health Nursing in Helsinki. RF fellowship 1937–1938: 1 year.

Birgit Kansanen (later Nieminen) Diploma in Nursing, Maria Hospital Nursing School in Helsinki 1929. Public Health Nurse 1930. International Course in Public Health Nursing at Bedford College, University of London 1933–1934. Supervisor of Public Health Nursing in the Province of Oulu. RF fellowship 1939–1940: 11 months.

Appendix 3 Possible future positions in Finland for the Rockefeller Foundation nurse fellowship holders in the 1930s.

Source: RAC, RF, RG 12.1 (Fellowship Recorder Cards)

The State Board of Health (*Venny Snellman*: Director of Nursing).

The State School of Nursing/Graduate School of Public Health Nursing in Helsinki (*Työne Luoma*: Director; *Hedvig Sucksdorff*: Assistant Director and Instructor).

The State Board of Health's planned teaching center in the City of Helsinki (*Työne Luoma*: planning).

The Postgraduate Course in Nursing Education for administrators and nursing instructors, State School of Nursing in Helsinki (*Aino Durchman*: Director (postgraduate courses, State School of Nursing, Helsinki, and School of Nursing, City of Helsinki); *Maj-Lis Edgren*: Assistant).

The University Clinics in Helsinki (*Märta Boman*: Social Service for wards and outpatients)

The State School of Nursing in Turku (*Maj-Lis Edgren*: Superintendent)

The National Nurses' Association in Finland (*Maj-Lis Juslin* (former Edgren): Planning of textbooks for schools of nursing).

Province of Oulu (*Birgit Kansanen*: Supervisor of Public Health Nursing)

Appendix 4 The dress and the badge of the inter-war public health nurse



“The dress of the public health nurse should be practical, hygienic, easy to wash and in such a price range that one can have many enough. Furthermore, it has to be dignified and inspire confidence. The State School of Nursing has approved a blue cotton dress. ... In my view this dress is very fitting for the nurse social worker. The white loose collar and the black tie make a nice impression. The audience who we serve watches and judges us. This blue and white dress generally evokes admiration. It also evokes trust, because one expects a certain skill and knowledge from its wearer.”

Source: *Suomen Sairaanhoitajatarlehti* [Occupational magazine of the Finnish nurses] 1936 3: 70–71, author’s free translation.



The badge was designed in 1926 by artist Signe Hammarsten-Jansson. It carries the image of Finland and the rising sun in silver and enamel, which symbolize the new public health services that the public health nurses carried out in the local community.

Sources: Finnish Union of Public Health Nurses and Sorvettula, Maija. 1998. *Johdatus suomalaisen hoitotyön historiaan* [Introduction to the history of Finnish nursing]. Helsinki: Suomen Sairaanhoitajaliitto ry. pp. 126–127.

Public Health and Rockefeller Wealth examines how scientifically minded American philanthropists influenced welfare building and public health in Finland in the inter-war period. It demonstrates that the collaboration between Finnish public health authorities, educators and the Rockefeller Foundation had a crucial impact on the early formation of Finnish public health nursing and public health in Finland.

A new occupational activity gains a position through an interactive process in which cultural values, social structures and knowledge are changing. This complex process can be studied by identifying critical boundary events in the early formation of an occupation. Yrjälä shows that those who worked to professionalize public health nursing in Finland used educational and administrative strategies to legitimize and institutionalize public health nursing knowledge and practice. She identifies ways through which the meanings of health nursing as a knowledge base and generalized public health nursing as a mode of practice were internationally negotiated and disseminated.

This study shows that the professionalization of public health nursing in the Finnish context was part of a complex network of diverse social actors who interacted in order to shape new models for welfare and public health service systems. Yrjälä analyzes how Finnish-American exchange enabled Finnish public health nurses to use alliance strategies to promote their professional project. Such alliance strategies supported the formation of a women's place in Finnish inter-war public health.

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