“OBTUSE WOMEN”: VENEREAL DISEASE CONTROL POLICIES AND MAINTAINING A “FIT” NATION, 1920-1945

Evelyn Ashley Sorrell
University of Kentucky, ashley.sorrell@uky.edu

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ABSTRACT OF THESIS

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Public health officials and social reformers grew concerned over the prevalence of gonorrhea and syphilis following World War I. The initiatives put in place by authorities to control the spread of venereal disease lacked any concern for women’s health and sought to control their newly found independence and mobility. This thesis examines public health policies related to venereal disease control from 1920-1945 and how these regulations affected women in the United States. Laws and social reform measures such as pre-marital blood tests, the Sheppard-Towner Maternity and Infancy Act, and the use of quarantining prostitutes during World War I and World War II were passed by government officials to ensure the future of America as a fit fighting force of men, placing women’s health concerns last in its race for domination. Women essentially were marked as the diseased dangers to America’s health.

KEYWORDS: Venereal Disease, World War I, World War II, Sheppard-Towner, quarantine

Evelyn Ashley Sorrell
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“OBSTUSE WOMEN”: VENEREAL DISEASE CONTROL POLICIES AND MAINTAINING A “FIT” NATION, 1920-1945

By

Evelyn Ashley Sorrell

Kathi Kern, Ph.D
Director of Thesis

David Hamilton, Ph.D
Director of Graduate Studies

May 6, 2011
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THESIS

Evelyn Ashley Sorrell

The Graduate School
University of Kentucky
2011
“OBTUSE WOMEN”; VENEREAL DISEASE CONTROL POLICIES AND MAINTAINING A “FIT” NATION, 1920-1945

THESIS

A thesis submitted in partial fulfillment of the requirements for the degree of Master of History in the College of Arts and Sciences at the University of Kentucky

By

Evelyn Ashley Sorrell

Lexington, Kentucky

Director: Dr. Kathi Kern, Professor of History

Lexington, Kentucky

2011

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Chapter 1: Introduction

When Susan M. Reverby, a women’s studies professor and historian, unveiled her groundbreaking article on the United States Public Health Service’s syphilis experiments in Guatemala, the U.S. government reacted with outrage and President Barack Obama issued an official apology to Guatemala. In “‘Normal Exposure’ and Inoculation Syphilis: A PHS ‘Tuskegee’ Doctor in Guatemala, 1946-1948,” Reverby uncovered that PHS doctors infected Guatemalan prisoners, mental patients, orphans, and soldiers with syphilis and then treated them with penicillin. The purpose of this policy was to determine if penicillin prevented syphilis infections. Reverby focused on how the Guatemalan study differed from the now infamous Tuskegee experiments, which evaluated already infected African-Americans in Alabama and withheld treatment even after the discovery of penicillin.1

Despite the media exposure generated by this story, one aspect was sorely neglected. The test subjects were infected through exposure to prostitutes who were either already infected with syphilis or were exposed to the disease when doctors purposely placed inoculums of syphilis on their cervix.2 Unlike the largely male population of Guatemalan subjects, doctors did not treat the prostitutes with penicillin, but when news agencies began reporting on Reverby’s work, these women fell from view. The focus was on the men who were infected and then treated in the 1940s and the modern-day outrage it caused within the medical community. But what about the women in this story who never received treatment? Why was this not seen as relevant as or more relevant than the male Guatemalans in Reverby’s research? Reverby details the tragedy

2 Ibid., 12.
surrounding the use of both male and female inmates as test subjects, but offers no indication of what happened to the prostitutes who were used as the infecting agents.

In some ways, my work builds on Reverby’s recent discovery by bringing the focus back to women in the United States. My analysis includes both rural and urban regions. Investigating the public health response in the cities and countryside illustrates how reformers viewed rural and urban women in a different manner. Public health workers perceived prostitution as the main threat to venereal disease control in the cities, while poor sanitation and ignorance was to blame for the spread of syphilis and gonorrhea in rural regions. It is easy to see the blatant outrages arising from America’s venereal disease experiments on African-Americans and Guatemalans, but not all ethical violations are as clear. When it came to women in America, the medical community was more nuanced in its policies to control venereal disease. This systematic but subtle approach to controlling syphilis and gonorrhea placed women in the trigger hairs of public health policy that used women as a scapegoat to explain rising rates of sexually transmitted diseases.

I analyze venereal disease control policies in the United States from 1920 to 1948 and how gender, class, and region influenced policymakers. Initiatives to stop the spread of gonorrhea and syphilis focused on maintaining a healthy population of men “fit to fight” and children fit to ensure the future economic and military health of the United States. Despite a national rhetoric of “maternalism,” women’s health and liberty were sacrificed for the collective health of the nation. Medical professionals and social reformers were not concerned about the health of women who also suffered from these ailments, but rather they focused obsessively on what female infection rates meant to the
future of the nation. My work attempts to present a gendered cultural history of venereal disease in mid-century America. Using a thematic approach in my organization, I situate women’s health as a window on larger issues of sexuality, class, and race.

Chapter one uses Kentucky as a case study to illustrate how the health of infants became social reformers’ priority in promoting venereal disease control policies. Kentuckian Linda Neville drew on her Progressive Era roots to highlight the suffering of infants born with gonorrheal eye infections and congenital syphilis. Her work with venereal disease spanned from the 1920s to the 1940s, well beyond what historians have deemed the Progressive Era. Material culture, sexuality, family and community work, and popular culture are just a few of the lenses in which historians analyze women in the Progressive Era.3 I use the maternalist paradigm of the Progressive Era, which focuses on women’s work in the family and community. Maternalism was a political culture that built upon women’s traditional responsibilities within the family and community to create government programs that focused on women and children. This paradigm helps highlight how Progressive reformers entered the debate on venereal disease and motherhood in the 1920s. My analysis of Neville is influenced by Estelle Freedman’s “Separatism as Strategy: Female Institution Building and American Feminism, 1870-1930” (1979) and Robyn Muncy’s Creating a Female Dominion in American Reform (1991). Freedman focuses on the importance of building a separate space in which women could express their autonomy in reform efforts during the Progressive Era.4 Neville demonstrates this use of space in her individualistic approach to helping children

stricken with gonorrheal eye infections and her carving out a space in the male-dominated field of medicine in which she held considerable authority.

Historical periodization presents dangers to historians and can significantly narrow their analysis and understanding of change over time. I attempt to step back from the process of periodization to highlight how Neville’s Progressive Era mindset and activities did not end when history suggests it should, but that she continued driving reform into the 1930s and 1940s. Muncy argues that the New Deal in the 1930s represented a culmination of women’s Progressive Era efforts at creating professional organizations that placed women in leadership roles, but Neville demonstrates that women’s maternalist reform movements did not stop with the New Deal, but continued into the 1940s.

Neville, along with the U.S. Children’s Bureau, reflect the focus on maternalism that arose in the 1920s. Women were able to create a professional status in society by limiting their focus to women and children. I explore how maternalism influenced and promoted venereal disease control policies in chapter two. Central to my analysis is how class operated within maternalism to create biased views of both black and white impoverished women. Here I draw upon the work of Molly Ladd-Taylor who examines the maternalist movement in *Mother-Work: Women, Child Welfare, and the State, 1890-1930* (1994). She argues that white, middle-class culture shaped maternalists' understanding of motherhood. Women reformers expressed this understanding in national health policies, such as the Sheppard-Towner Act and the transformation toward
“scientific” housekeeping and home economics. Women reformers attempted to "professionalize" motherhood, which led to a policy of mother-blaming in the twentieth century. Ladd-Taylor and Lauri Umansky argue that the exacerbation of mother-blaming occurred because of the "dominance of childrearing experts, the growth of state power, and the flux in gender roles." The maternalist movement, while having a stated purpose of professionalizing motherhood, invoked politics of blame to describe deficiencies found in child-birthing and child-rearing methods.

Through the maternalist movement, the medical community turned its focus toward rural areas and viewed venereal disease as running rampant among rural women, both black and white. Instead of looking at the economic situation of these women, they excused high rates of infection on race and class biases. Organizations operated by middle-class white women like the U.S. Children’s Bureau and the Frontier Nursing Service entered rural areas and the Appalachian region to promote a new scientific method of child birthing and motherhood. Influenced by middle-class values and norms, these women viewed Appalachian mothers as dirty and too ignorant to understand venereal disease. Sandra Lee Barney’s study on the transformation of medicine in Appalachia illustrates how medical professionals entered the region to replace what they saw as the dangerous practice of lay mid-wifery with medically trained nurses. In Authorized to Heal: Gender, Class, and the Transformation of Medicine in Appalachia, 1880-1930, she argues that women reformers “carried a message of dependency on and

5 The Sheppard-Towner Maternity and Infancy Protection Act was passed by the U.S. Congress in 1921 and provided federal funding to states for educational and public health initiatives focusing on maternal and infant health.
deference to the professional physician.”7 Barney illustrates that what emerged from rural areas was a combination of traditional and scientific birthing methods. I use arguments from Barney, Ladd-Taylor, and Melanie Beal Goan’s recent study on Mary Breckinridge and the Frontier Nursing Service (Mary Breckinridge: The Frontier Nursing Service and Rural Health in Appalachia 2008), along with records from the U.S. Children’s Bureau to argue that reforms involving pre-natal care were focused more on the health of the child and not the mother. Reformers urged women to seek pre-natal care to prevent their children from being born debilitated with congenital syphilis. After the child is born, the focus turned toward sanitation and sex education in the home.

Children’s Bureau officials often described the living conditions of poor women as dirty and unsanitary. Medical professionals linked unsanitary homes to the spread of gonorrhea infections in young girls, despite knowing that germ theory as it relates to infection disproves the possibility of contracting venereal disease without direct sexual contact. I draw heavily on Lynn Sacco’s seminal work on incest in America to illustrate how doctors and social hygienists pursued a policy of mother-blaming to explain gonorrhea infection in young girls. Unspeakable: Father-Daughter Incest in American History (2009) reveals that “health care professionals and social reformers erased the connection between men, sexual assault, and infection by casting suspicion on ‘dangerous’ objects and infected girls, whom they labeled ‘menaces to society.’”8 The insistence that dirty towels, linens, and mothers spread gonorrhea to their daughters centered blame on the mothers and not potential rapists lurking in the home. This

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example is one poignant way to show how women’s health was really of minor concern to medical professionals seeking to uphold middle-class respectability and male authority. “Scientific” housecleaning became central in the fight against venereal disease and as Nancy Tomes argued in “Spreading the Germ Theory: Sanitary Science and Home Economics, 1880-1930” (1997), women developed feelings of guilt if they were did not spend enough time sanitizing their home against bacterial menaces.

Chapter three analyzes how protecting children against venereal diseases meant ensuring the future of America’s economy and defense. Women were replaceable in society, but their sons were not. After World War I and during World War II, the government enacted venereal disease control policies that showed how a nation concerned with flexing its military might disregarded the lives of women. Marilyn E. Hegarty analyzes the control of female sexuality during World War II in Victory Girls, Khaki-Wackies and Patriotutes: The Regulation of Female Sexuality During World War II (2008). I draw on her study and Ruth Rosen’s seminal text on prostitution in America (The Lost Sisterhood: Prostitution in America, 1900-1918, 1982) to show how venereal disease control policies during war trampled on women’s civil liberties and cast them as evil agents of infection. Most work on the practice of quarantining prostitutes focuses on World War II, but I argue that the policy also was widely practiced after World War I under the Chamberlain-Kahn Act. Quarantining did not just target prostitutes, but all women who engaged in independent lifestyles and who were openly mobile in society. State and medical health officials used quarantine facilities not primarily to treat women for gonorrhea or syphilis infections, but to keep them away from soldiers during war. Medical professionals operated in coordination with the courts to strip women of their
civil liberties and rights under the U.S. Constitution in the name of national defense. Women were the infecting agents and men the innocent victims who seemingly had no way of controlling their “natural” sexual urges. Court records, medical studies of quarantine facilities, and published articles urging the control of prostitution and venereal disease document a failed policy that put men’s health as America’s fighting force over women’s.

Venereal disease policies controlled women’s wombs, women’s homes, and women’s mobility, but did nothing to promote women’s health. Women were synonymous with the disease in which men and children needed protection against. What happened in Guatemala is tragic, but we must not ignore the ambivalence toward the women who medical professionals used as the infecting agents and then not treated by doctors. We also must recognize that, while not deliberately infecting women in America, the medical community was complicit in women’s continued suffering through its failure to offer them the same medical access and care given to men and children.
Chapter 2
‘She now cries out’: Linda Neville and the Limitations of Kentucky’s Venereal Disease Control Policies

After reading a 1937 newspaper article about Linda Neville’s work with the blind, Rory O. Huntsman, the mayor of Scottsvill e, Kentucky, felt impelled to write to her declaring, “There is no doubt in my mind that if Christ were on Earth today, instead of walking along by the sea of Galilee and picking his disciples from the lowly fishermen, he would walk down the streets of Lexington and say, ‘Linda Neville, follow me.’”

Neville’s success as a champion for the blind solidified her status as a saintly figure among not just her fellow Kentuckians, but also nationally within the field of health. On the surface, Neville seemed a typical Progressive Era woman, fighting for children born with eye conditions, but a closer look reveals a woman tormented by the cases she saw and struggling to overcome personal and financial limitations that prevented her from saving all the children under her care from a lifetime of darkness. Neville’s legislative proposals put babies first and pushed mothers to the forefront of blame and to the background of care.

Neville was born in 1873 John and Mary Neville. Her father’s family were Unionist in the Civil War while her mother’s relatives supported and served in the Confederate Army. Linda’s father served as a professor of Greek and Latin at the State Agricultural and Mechanical College and was appointed vice-president of the University in 1899. He retired from his post in 1908 because of bad health. Mary Neville died from cancer when Linda was 14 years old and she came of age under the influence of her

9 Rory O. Huntsman to Linda Neville, November 1937, Linda Neville Papers (hereinafter referred to LNP) Box 73, F. 17, Special Collections, University of Kentucky Library.
father who stressed the value of education and ensured that Linda and her older sister, Mary, went to schools that stressed college preparation.\textsuperscript{11} As a teenager, Linda attended Miss Mary E. Steven’s School in Germantown, Pennsylvania. The private institution prepared young women for college entrance and exams and both Neville sisters received post-secondary educations at Bryn Mawr College. The curriculum at Bryn Mawr deviated from other women’s colleges as its focus was not on the domestic sciences, but courses such as mathematics, Greek, and Latin that prepared women to enter a competitive, but restricted job market and academia.\textsuperscript{12} In 1895, Linda graduated with a bachelor’s degree in Greek and Latin. She returned to Lexington where she took care of her ailing father and pursued a teaching career. Linda and her sister, Mary combined family responsibilities with teaching, a descriptive category of women seeking work following graduation presented by historian Joyce Antler.\textsuperscript{13}

Beginning in 1899, Neville began devoting more time to civic and charitable activities.\textsuperscript{14} She first involved herself in the aid and relief to the poor, serving on the Associated Charities Board of Directors. Neville visited homes and “directly acquainted with the poor and their needs.”\textsuperscript{15} She also worked with the Lexington Civic Leagues and was a member of the Women’s Christian Temperance Union and active in the women’s suffrage movement in Kentucky. This interest in charity and reform led Neville to discover her life’s work as a Progressive reformer seeking to care for and alleviate suffering of the blind. It was a cause close to her heart. Both Neville’s father and Aunt

\textsuperscript{11} Cornett, 19.
\textsuperscript{12} Cornett, 20.
\textsuperscript{13} Joyce Antler, “‘After College, What?’: New Graduates and the Family Claim,” \textit{American Quarterly} 32, no. 4 (Autumn, 1980); Cornett, 26.
\textsuperscript{14} Cornett, 31.
\textsuperscript{15} Cornett, 34.
Caroline suffered from eye ailments that rendered them blind. Neville grew concerned over “helpless sufferers” and soon learned of a contagion sweeping Appalachia and causing a number of adults and children to live a life of darkness.\footnote{16 Cornett, 36.}

Neville became involved in identifying and treating trachoma patients in the mountains of rural Kentucky. Trachoma is a bacterial infection of the eye that occurs mostly in rural settings marked by poverty, crowded living conditions or poor hygiene. It remains the number one leading cause of blindness worldwide, but has largely been eradicated in the United States. The bacteria spreads through contaminated objects and flies also spread the infection. Starting in 1908, Neville worked through the Hindman Settlement School, founded by fellow clubwomen Katherine Pettit and May Stone, to help needy eye sufferers while educating parents on how to prevent the infectious eye disease.\footnote{17 Sandra Lee Barney, \textit{Authorized to Heal: Gender, Class, and the Transformation of Medicine in Appalachia, 1880-1930} (Chapel Hill and London: The University of North Carolina Press, 2000), 88. Barney presents a valuable argument concerning the way in which various Kentucky women’s clubs and settlement workers supported one another in their various causes. Drawing on Theda Skocpol, Barney argues that elite and middle-class clubwomen were bound to each other by their ideological ties.} She collaborated with Dr. J.A. Stucky, an otolaryngologist, and together they set up trachoma clinics that operated until 1928 when trachoma no longer was an epidemic in eastern Kentucky.\footnote{18 Barney, 93.} Neville helped finance the cost of care for needy patients through the Mountain Fund, which she established in 1908 after friends and relatives donated money to help the blind in Appalachia. Through Neville’s mission to eradicate trachoma, she gained a respected status among the male-dominated field of medicine and gained experience in legislative lobbying, organizing, and creating charitable societies.\footnote{19 For a complete biographical account of Linda Neville’s life, see Cornett, “Angel for the Blind: The Public Triumphs and Private Tragedy of Linda Neville.”} 

Aside from the Mountain Fund, Neville also founded the Kentucky Society for the
Prevention of Blindness in 1910. These were all valuable assets that Neville became reliant upon in a never-ending campaign to end blindness — a campaign that eventually led her to address the scourge of venereal disease and its role in causing a world of darkness for many “innocent” victims.

Neville could not let go of her reform impulses that were fostered in the Progressive Age. Women during this era found projects in which they dedicated their lives. The suffragists put their heart and souls into gaining the right to vote while women like Jane Addams, Mary Breckinridge, and Neville became devoted to social work, public health nursing, and home economics.20 It is generally accepted among historians that the Progressive period ended in 1920, but Robyn Muncy argues that many women who worked as Progressives continued their reform activities into the 1930s and 1940s.21 Neville is an example of continuing reform efforts among female Progressives, bringing a Progressive Era lens to a growing mid-century problem. She wanted the importance of her work with the blind to continue even after trachoma cases had declined dramatically. She reflected on her days battling the disease in a letter to Dr. John McMullen, who was also active in the fight against trachoma through the United States Public Health Service. Needing to find a new cause in which to devote her life, Neville reflected in 1935 about “those old Trachoma Days,” writing, “Those mule-back rides, those court-room clinics,

21 Muncy argues that the New Deal represented the culmination of women’s reform activities. She uses agencies created during the Progressive Era, such as the Children’s Bureau and the School of Social Service Administration to illustrate how they interlocked to perform a “female dominion” in the male dominated field of policy making. Muncy focuses on the middle-class nature of reform that continued into the 1930s and 1940s and how this bias served to create welfare policies that were oppressive to women. Muncy finds that while women sought professional status in the Progressive Era, they discovered men were only willing to accept them as professionals in work that involved women and children. Neville illustrates this argument as her focus was on children afflicted with eye disorders, which led to a general acceptance by the male-dominated medical community in Kentucky.
— how sad I feel at the realization that all that is so far in the past.”22 But she found a new calling and asserted that “We are in a new stage in Ky. And we use new ways now for meeting our problems. I am getting older, so I must rush to put syphilis on our map just as trachoma was there.”23 Her reform impulses were entrenched and intertwined with her definition of self. Neville devoted as much of her life to venereal disease as she had trachoma and became obsessed with stopping its spread.

Neville offered varying accounts of how she was exposed to the horrors of venereal disease. Ultimately, it was through her work with trachoma patients in the mountains of Kentucky that brought her face to face with the effects of untreated syphilis and gonorrhea. In one of Neville’s recollections, she writes that when she first started her work with the blind, she was unaware of “social diseases.” This ignorance of the ravages of venereal infection lasted until 1908 when she came across a family living in a mountain county of Kentucky. Within this family, Neville found blindness in the father, the 16-year-old daughter, and in 1913 two younger brothers also suffering loss of eyesight. At first, she was baffled by what caused this familial outbreak in blindness until she brought the family to Lexington to be tested for syphilis. All members of the family tested positive for syphilis through the Wassermann blood test, which was a popular way to confirm a syphilis diagnosis beginning in 1906.24 The two younger brothers died before treatment began — a loss that opened Neville’s eyes to the dangers of untreated venereal diseases.25 The focus on venereal disease represented a second stage in Neville’s

22 Linda Neville to John McMullen, 14 February 1935, LNP, Box 73, F. 5.
23 Ibid.
24 Allan M. Brandt, No Magic Bullet: A Social History of Venereal Disease in the United States Since 1880 (New York and Oxford: Oxford University Press, 1985), 147-149. The test was developed by bacteriologist August Von Wassermann and was later replaced by the Kahn test developed by immunologist Reuben Leon Kahn.
25 Linda Neville, personal recollection, 1938, LNP, Box 74, F. 4.
reform activities. Kentucky no longer needed her help in the battle against trachoma, but Neville could not leave the war. Still focused on the prevention of blindness, she discovered a new project in venereal disease and its effects on the eyes of infants.

Even though Neville’s first exposure to these “social diseases” was in 1908, she did not dedicate her work to treating and preventing blindness associated with gonorrhea and syphilis until the 1930s. The dangers venereal disease caused to marriage and reproduction was a concern for doctors nationally since the 1890s. Prince Morrow, a Kentucky native born in Mount Vernon, was among the first doctors to publicize the problem of syphilis and gonorrhea infection as it relates to sterility and the inherit dangers it imposed on the continuation of the “race.”

In Kentucky, the issue remained a silent one mired in moral decay until Neville began a new crusade aimed at exposing venereal disease for its dangerous implications on the health of its “innocent victims” — the children.

The tireless reformer blamed the 1930s and 1940s outbreak of venereal disease on soldiers who were intimate with prostitutes while serving in World War I and World War II. Middle-aged at this time, Neville drew on her Victorian sensibilities relating to sexuality and the suppression of women’s sexual feelings. She also brought a middle-class bias to her understanding of sexual expression. In her study of working-class sexuality, Kathy Peiss argues that “reformers, social workers, and journalists viewed

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26 Brandt, 14.
27 Joan Jacobs Brumberg, The Body Project: An Intimate History of American Girls (New York: Random House, 1997). Brumberg analyzes sexual maturation in adolescents and cultural changes in the twentieth century. In relation to sexuality, she argues that girls did not talk about sex or their own sexuality before the 1920s. The moral value placed on virginity fell away as cultural innovations, such as the automobile created a society where girls became more mobile and less restricted by parental control. A generational divide arose between mothers born in the Victorian Era and their daughters who embraced the Roaring Twenties and a new-found way to express their sexuality, which was forbidden to the generation before them. Neville came of age in the Victorian Era and was “old-fashioned” in her view of women’s sexuality and the freedom to express female needs and wants.
working-class women’s sexuality through middle-classes lenses, invoking sexual standards that set ‘respectability’ against ‘promiscuity.’”28 Neville held a middle-class view of sexuality, which placed it in a rigid framework not followed by the working-class. She did not understand the working-class culture of women who freely mingled in gender-integrated places, such as factories, carnivals, and dance halls.29 Neville’s middle-class and Victorian biases led her to believe that the only victims of venereal disease were the children and women were just as responsible for contracting these diseases, as were the husbands who brought them home after visiting prostitutes. She saw no end to the infectious spread in Kentucky, writing, “The presumably large number of gonorrheal women around the aggregations of men/war workers/and soldiers of Kentucky will doubtless mean the birth of many babies whose eyes will be gonorrheal.”30 Neville documented the cases of infants whose eyes were infected with gonorrhea or who were born with congenital syphilis. She helped any and all she could, which led to a financially strained Mountain Fund and a reformer determined to take on any case of a child suffering, no matter the cost.

Statistics regarding the number of venereal disease cases and children born with gonorrheal eye infections or congenital syphilis are scattered because doctors were not obligated to report incidences of infection until the 1940s and many rural Kentuckians went untreated because of the lack of medical facilities and care in the mountains. The social stigma attached to venereal disease also discouraged those infected from seeking professional treatment and instead turned to folk remedies and “quacks” for quick

29 Pleiss 60-61.
30 Linda Neville to Phi Omega Pi, 19 October 1942, LNP, Box 75 F. 12.
In 1937, Dr. C.M. Moore, assistant collaborating epidemiologist for the City Board of Health in Lexington, reported there were 374 cases of syphilis and 158 cases of gonorrhea known by the board. There also were 11,959 visits made by patients to the venereal disease clinic operated by the health department in Lexington. Moore realized that there were more cases of infection than those reported, “the number of gonorrhea cases coming to our attention represents only a small percent of cases occurring among our population. These diseases constitute our major health problem and they are becoming increasingly worse each year. I view this situation with alarm.”

Neville’s Mountain Fund statistics indicated she treated 51 babies with gonorrheal eye infections between March 1936 and Jan. 1, 1940 and from 1947 to 1958 she received 58 cases of such infection from the Frontier Nursing Service. All cases came at a great cost to the Mountain Fund and to Neville’s own physical and emotional health.

By the time Neville started addressing venereal disease cases as it related to the ill effects it had on newborn children, the medical process of applying a one-percent silver nitrate solution in newborns’ eyes was firmly in place and backed by the force of law. The solution was effective in preventing and treating gonorrheal eye infection, but Neville found many patients she served through the Mountain Fund were not receiving this treatment. One of the earliest cases of venereal disease Neville was involved in highlighted this problem. In 1915, a doctor visited the child of an unmarried eastern Kentucky woman, whose stepfather was the father of the child. He traveled the distance on horseback and found the baby had a gonorrheal infection and felt that the family was

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31 Brandt, 133.
32 C.M. Moore report on venereal disease cases in Lexington, 1937, LNP, Box 73, F. 22.
“such poor nurses that it was dangerous to trust them with treatment.”³³ The isolation of
the mother and child led Neville to a realization on “that cold day in March 1915” that
she was “far from the solution of the problem providing prompt and adequate treatment
for the gonorrheal babies born in remote and almost inaccessible places, where such
babies’ families were too poor to provide for them in their homes both doctor and
nurse.”³⁴ Time was not on Neville’s side when it came to reaching and treating infants
born with gonorrheal infections of the eye. She despaired thinking about isolated homes
in mountain counties with no railroads or highways and wondered, “what would happen
if a newborn baby should have gonorrheal pus ooze from under swollen eyelids.” But as
she asked herself that question over and over again, Neville “used to always sadly
acknowledge to myself that what would probably happen would be that eyes would
become blinded beyond all hope of sight.”³⁵ Neville never expressed concern for the
mothers of these children and how they became infected with venereal disease or the
tragedy surrounding the young woman who was impregnated by her stepfather. Her
energies and sympathies lied with the babies only and while she expressed some
sympathy toward the impoverished conditions of the mothers, she often harbored ill
feelings toward what she thought as their irresponsible behavior.

County health departments and county officials often notified Neville of infected
babies in need of treatment. She benefited from train passes given by the Louisville-
Nashville railroad, which were used to transport mother and baby to Lexington where
they could meet Neville and receive treatment under the Mountain Fund at Good

³³ Linda Neville recollection, “In 1939 Fourteen Babies with Gonorrheal Eye Infection and Two More,” 17
January 1940, LNP, Box 74, F. 11.
³⁴ Ibid.
³⁵ Ibid.
Samaritan Hospital. It was unusual for railroads to become involved in charity work by handing out free passes. Neville wrote to the railroad requesting the passes on behalf of the Mountain Fund. Her status as a “saint” to the blind perhaps compelled the Louisville-Nashville railroad to honor all of Neville’s requests. In most of her case file notes, Neville expresses sadness toward the infants’ condition and borderline disgust concerning the behavior of their mothers. In 1922, Neville had two infants with gonorrheal eye infections under her care. The hospitals were overcrowded, so she had to place both in the same bed. Neville described one of the mothers as “insane” or “feeble-minded” and the other as “what I (and probably the world with me) would call bad.” 36 She recalled that the two women did not get along and it was reported to her that “one of the women tried to smother one of the babies, whether her own or the other woman’s baby I do not recall. That was a shock to me.” 37 She continued to express disbelief at what she viewed as the mothers’ ignorance or uncaring attitudes toward their children, but her harsh judgment was clouded by her overwhelming concern for the children and not the lives of the mothers or the circumstances under which they became impregnated or contracted a venereal disease.

Neville maintained a deep distrust concerning the mothers’ abilities to effectively continue treatment, indicating in one instance “the mother’s mental condition is such that she could not care for the case properly.” 38 Neville often expressed concern over the mother’s mental health and abilities, but made no mention of the father and his role in caring for the infant. She saw herself as a surrogate mother to these children suffering

36 Linda Neville to AT McCormick, 17 June 1922, LNP Box 114, F. 32.
37 Linda Neville, “In 1939 Fourteen Babies with Gonorrheal Eye Infection and Two More,” 17 January 1940, LNP Box 74, F. 11.
38 Linda Neville to Dr. AT McCormick, 17 June 1922, LNP, Box 114, F. 32.
from gonorrheal eye infections, even writing to one concerned mother of an infected child that she would “do no good to the baby by visiting it.”\textsuperscript{39} Her dismay was often based on the length of time mothers waited before seeking help for their children. Many babies that came into Neville’s care were emergency cases and had been suffering from gonorrheal eyes for weeks. Her blame was not just reserved for the mothers, but also for the midwives who failed to ameliorate the conditions by using silver nitrate in the eyes at birth. A one-percent solution of the antiseptic was dropped into babies’ eyes at birth to prevent infection from gonorrhea. Lucien Howe was the first to discover the merit of this practice in 1922, but it was commonly used since the late nineteenth century.

Neville sought to regulate midwifery as an extension of her campaign to eradicate blindness in children. She viewed midwives operating in Appalachia with suspicion and supported a more professional model of healthcare in the region.\textsuperscript{40} The Frontier Nursing Service, established by Mary Breckinridge in 1925, also addressed the perceived dangers of family midwives and sought to replace them with trained nurse midwives.\textsuperscript{41} In 1923, Breckinridge, a noted reformer and suffragist, traveled across eastern Kentucky to perform a comprehensive study of midwife practices. She interviewed fifty-three midwives and found “a substandard level of care, dangerous practices, and the need for a change.”\textsuperscript{42} Breckinridge was critical of “granny” midwives who all had children themselves and did not choose their work, but rather felt it had been “thrust upon them.”\textsuperscript{43} Untrained midwives offered no prenatal care and very little aftercare. Once the

\textsuperscript{39} Mountain Fund Case Files, 1934, LNP, Box 122, F. 1.
\textsuperscript{40} Barney, 119-120.
\textsuperscript{41} Melanie Beals Goan, \textit{Mary Breckinridge: The Frontier Nursing Service and Rural Health in Appalachia} (Chapel Hill: The University of North Carolina Press, 2008), 68.
\textsuperscript{42} \textit{Ibid}, 69.
\textsuperscript{43} \textit{Ibid}, 69.
mothers gave birth and the babies were dressed, the midwife left.\textsuperscript{44} One of the first cases of gonorrheal eye infection Neville experienced was the infant of a single mother who was assisted by a midwife during the delivery. The midwife failed to use preventative drops against gonorrheal infection and Neville did not receive the case until three weeks later when the damage to the infant’s eyes was far from relief.\textsuperscript{45}

Through what she viewed as neglectful and untrained deliveries overseen by midwives, Neville, along with the Kentucky State Medical Association lobbied the legislature in the 1910s to enact regulations for midwives. In her study on the transformation of rural health in Appalachia, Sandra Lee Barney argued that the regulations, which included supervising the midwife profession, “gradually eliminated alternative practitioners across Appalachia. Ordered by law to obey the principles of scientific medicine, mountain people also were offered attractive inducements to accept their place as patients in the new medical order.”\textsuperscript{46} The regulation and control of midwife practices that were championed by reformers like Neville ushered in a new era of health services in the region. This era was marked by the professionalization of medicine and made physicians the “sole arbiters of medical diagnosis, prevention, and intervention.”\textsuperscript{47} Neville, who received no medical training, remained active in the medical community through the Mountain Fund and saw her position as caretaker to afflicted children and medical service provider as indispensable. While never diagnosing cases of gonorrhea or syphilis, she oversaw the care given and instructed the nurses who were involved with her “patients.” Neville’s reaction against midwives was one rooted in

\textsuperscript{44} Ibid, 69.
\textsuperscript{45} Mountain Fund Case Files, 1911, LNP, Box 104, F. 17.
\textsuperscript{46} Barney, 120.
\textsuperscript{47} Barney, 135.
her experience, serving as the hope of last resort. The most desperate and urgent of cases came to Neville’s front door — cases that she thought could have been prevented with proper treatment.

The Mountain Fund received more gonorrhea cases in infants than syphilis, but the few instances of children suffering from congenital syphilis brought to Neville strained her emotionally. She wrote of these cases as if she, herself, felt the child’s pain. A nurse from a county health department in eastern Kentucky brought a mother and her eight-year-old daughter to Neville. The daughter was stricken blind and a blood test indicated a positive result for syphilis. Neville noted that the father was in jail and the daughter had been treated with injections of bismuth and home dosages of iodine. But it was “that mouth with those Hutchinson front teeth of a shape characteristically syphilitic and with decay beyond repair and bones damaged by syphilis and sore to the touch” that Neville never forgot. The influx of syphilitic and gonorrheal patients seeking help through the Mountain Fund caused a mounting debt. County health departments extended across the state beginning in the 1920s, which caused more cases of infants and children infected with gonorrhea of the eyes or congenital syphilis to be discovered and sent to Neville for financial help. From 1936 to 1940, fifty-one babies infected with gonorrhea of the eyes were cared for under Neville. According to Mountain Fund records, four gonorrheal babies cost the entity $1,072.40 for hospitalization and nursing. The debt caused great stress for Neville who reported that “the GC (gonorrhea) babies have

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49 Linda Neville, “In 1939 Fourteen Babies with Gonorrheal Eye Infection and Two More,” 17 January 1940, LNP, Box 74, F. 11.
required such long and expensive attention that each June for the past several Junes has found me with a debt that I have had to get paid by getting donations.”

Her appeals for donations even found their way to the area newspaper, *The Lexington Herald*. The publication featured a story about five babies who were undergoing treatment in 1937 at Good Samaritan Hospital for gonorrheal eye infections. Neville, along with four nurses, are predominantly pictured above the article holding the five infected infants. Neville appealed for donations, arguing that state appropriations are inadequate and appealed to the perceived immorality behind gonorrhea and syphilis. She said, “Let us maintain a sympathetic concern for all the babies who are made to suffer pain, and in some cases, permanent blindness because of the sinfulness of people.”

With mounting debt and as the number of children suffering from the inherited effects of venereal disease, Neville sought to reach beyond treatment and address prevention. She placed herself on the frontlines of the attack against venereal disease, stating she wished to address the problem as one of health and not morals, but layered within her lobbying rhetoric are moral indictments on the mothers who passed on their afflictions to their children.

In 1937, Neville and Dr. Arthur Thomas (AT) McCormack, director of the Kentucky State Board of Health lobbied the state legislature to pass a pre-marital health bill. The measure sought to prevent the spread of venereal disease through marriage by making physical examinations for venereal disease mandatory. According to the bill, before a county clerk issued a marriage license, both male and female applicants had to undergo a venereal disease examination through laboratory tests and present the clerk

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50 Linda Neville, Narrative from Oral or Written Reports, 1941, LNP Box 75, F. 1.
51 *The Lexington Herald*, 21 February 1937, copy of article in LNP, Box 73, F. 12.
with a certificate saying that they are free from any infection. The State Department of Health laboratory or a laboratory approved by the department were the only acceptable testing facilities and tests made by the department of health were free of charge. Females applying for marriage licenses to legitimize their unborn child were not required to submit to testing and if both applicants had the same venereal disease or sterility existed in one or both applicants, they were able to obtain marriage licenses under the condition that they agree to treatment.\footnote{“An Act to prevent the spread of venereal diseases through marriage and provide for an antenuptial examination to determine the presence of venereal diseases and to provide a penalty for the violation of the provisions of this act,” draft in LNP, December 1937, Box 73, F. 19.} Neville, McCormack, and other pre-marital testing supporters viewed the state as central in combating the spread of venereal disease through marriage. The bill represented an unprecedented intervention in marriage by the state, as it now had the power to deny marriage licenses to anyone that tested positive for gonorrhea or syphilis. Even though Neville pursued a pre-marriage health act in the 1930s, it illustrated how she brought her Progressive Era views to this new stage of activism. Progressives believed in the power of state and nation to effect change through the passage of policies that sought a restructuring of society and the economy.

Similar laws were passed in numerous other states throughout the 1930s, including Michigan, Colorado, New Hampshire, North Carolina, and Rhode Island. The stringency of state laws varied across borders.\footnote{“Pre-Marital Tests for Venereal Disease,” \textit{Harvard Law Review}, 53, no. 2 (Dec., 1939), pp. 309-313.} States such as Colorado and Rhode Island tested men for syphilis and gonorrhea while Wyoming and other states still left medical examinations up to the discretion of the physician. Kentucky’s pre-marital health bill was one of the first that proposed testing both men and women. Other states only tested males because it was commonly accepted that males engaged in pre-marital sex
with other women or prostitutes, while Victorian ideals of sexual purity still held ground in regard to women. Kentucky pushed itself to the forefront of venereal disease control through state intervention in its proposal to test both male and female marriage license applicants. Medical professionals and reformers saw marriage as the primary institution in which to attack the spread of venereal disease. Their efforts came with some, but little opposition.

Opponents of state initiatives requiring blood tests before marriage expressed concern over a potential loss of revenue from marriage licenses due to couples crossing state lines to obtain a marriage certificate where no health examination is required. Bordering states tried to work in tandem to pass similar laws as a preventative measure against couples seeking licenses in less restrictive municipalities. Neville communicated with Ruth O’Dell, a representative in the Tennessee legislature, over passing similar laws after Neville received objections from magistrates on the Kentucky-Tennessee border over the loss of “fees if people should go over to Tenn. to get married.” The need for similar bills was also evident to O’Dell after she received several similar complaints involving loss of fees from Tennesseans. She wrote to Neville stating her intention to “pass the same bill that you folks pass relative to the health examination” and noting she “was so anxious to have both states with the same restrictions and requirements.” The potential for border-jumping marriages was a concern throughout the nation and led to a national movement for state control of marriage. Most states worked together to pass similar laws as they became “aroused to full cognizance of the need for this additional

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54 Brandt, 16
55 Linda Neville to Rory O. Huntsman, 30 January 1938, LNP, Box 73, F. 21.
56 Linda Neville to Ruth O’Dell, 27 January 1938, LNP, Box 73, F. 21.
57 Ruth O’Dell to Linda Neville, 28 January 1938, LNP Box 73, F. 21.
check on the spread of venereal diseases.”

Pre-marital health laws created “marriage mills” in some neighboring states where “they reaped a golden harvest because in border counties, 95 per cent of the people who married crossed the state line to do it.”

Medical officials determined that couples jumped state lines to marry out of fear of having to face personal facts and responsibility. Lee D. Cady, a physician, hospital administrator, and president of the St. Louis Medical Society, argued blood tests that determined venereal disease infection caused couples to seek marriage licenses elsewhere. He blamed women as much as men for bypassing these laws, noting that “the women who go to another state to marry are as ignorant or as fearful of finding themselves infected with venereal disease as are men.” Cady placed responsibility for the success of pre-marital laws solely on the shoulders of women, writing that “it will be the women who will ultimately make such laws successful in enforcement.” Throughout the long history of venereal disease, he thought that men had been better educated on the topic, but little had been accomplished. Women held absolute power because they had “final word about any proposed marriage” and “it is she who will make the urgent demand for the enactment and successful working of antenuptial examination laws.” Even though men were thought to be the givers of venereal disease to “innocent” women, medical professionals somehow thought it prudent to place the responsibility of action on women as the upholders of morality in house and home. Any sense of personal responsibility for males was effectively transferred as a woman’s burden. Women were

59 Ibid, 778.
60 Ibid, 778-779.
61 Ibid, 779.
62 Ibid, 779.
blamed for any failure of venereal disease legislation while also being victims of its spread. It was a lose-lose situation in which venereal disease became a woman’s problem despite the central role of men in propagating its spread.

Pre-marriage health laws were not meant to only be preventative measures against “innocent” infections, but also were eugenic in nature. Cady agreed that these measures should be eugenic laws as they may “prevent some feeblemindedness, some insanity, some syndactylism, hare-lip, club-feet, some congenital syphilis, blindness, and the like.”\textsuperscript{63} Eugenics was rarely stated as a motivation behind the law, but was an underlying factor. Henry P. Talbot, director of the Bureau of Venereal Diseases for the Connecticut State Department of Health, noted that the “marriage of epileptics and imbeciles is not more likely to result in tragedy than the intermarriage of syphilitics.”\textsuperscript{64} Through mandatory blood tests, the state became a third party in marriage relations and the constitutionality of such intervention was questioned only once in Wisconsin, which was the first to pass a law requiring medical examination before marriage in 1916. In \textit{Peterson v. Widule}, the Wisconsin Supreme Court upheld the state law that required male applicants for marriage to file a physician’s certificate of freedom from disease. The court “declared that, under the police power, state could require the medical certificate and that the requirement did not infringe on an individual’s religious liberty.”\textsuperscript{65} Subsequent chapters will explore closely the national response to venereal disease, but Kentucky followed and sought to position itself on the forefront of legislation attempting to regulate its spread. Neville was central to obtaining a pre-marital health bill. In Neville’s

\textsuperscript{63} \textit{Ibid}, 779.
estimation, the state as well as the church, should play a role in preventing someone infected with venereal disease from getting married.

Neville appealed to church officials about the need to prevent the spread of venereal disease through emotional language that invoked the suffering of infants infected with gonorrhea or syphilis. She went for the heart of church officials through a retelling of her experiences that dealt with the “many tragedies of caused by venereal disease.” Neville hoped the church would take a leading role in shaping public opinion toward the acceptance of the proposed pre-marital health bill. There were realized difficulties in the way of practical enforcement of the legislation, but “… if only the preachers, men of Faith and the preaching of Faith, ought not to deafen the cries of little children, will lead the way Kentucky may cease witnessing the tragedies of blindness.” Through emotional appeals, Neville described herself as “… so agonized that she now cries out.” She went on to write that “even to unwilling ears she now cries out about the tragedy that is prepared for when by inheritance the tiny baby’s blood is tainted with syphilis.” Through the retelling of her experiences and the pain she felt for infected children, Neville succeeded in convincing churches to become involved in state control of venereal disease.

The Episcopal Diocese of Kentucky was among the first to pass a resolution in 1937 preventing a minister to perform a marriage ceremony unless each party presented medical proof indicating negative reports for gonorrhea and syphilis. Other

66 Linda Neville, written introduction to church officials, 1937, LNP, Box 73, F. 11.
67 Ibid.
68 Ibid.
69 Ibid.
70 Linda Neville, “Control of Venereal Diseases in Ky.: Help from the Churches”, January 1937, LNP, Box 73, F. 4.
denominations soon followed, either preventing ministers from marrying infected couples or promising to lobby the legislature for the passage of a premarital health bill. The Christian Disciples passed a resolution asking the Kentucky legislature for such a law and that provided education to youth on venereal disease. \(^{71}\) Neville’s influential work through the churches reached outside Kentucky, as the Friends’ Church of California, a Quaker denomination, wrote Neville informing her of their role in petitioning the California legislature in 1939 to pass a law requiring pre-marriage medical examinations and prenatal examinations of prospective mothers. \(^{72}\) The church took on the role of lobbyists after reading about the resolutions passed by the Episcopal Diocese of Kentucky and promptly adopted in 1937 measures committed to the control and elimination of venereal diseases. Other churches in California followed the Friends’ commitment to venereal disease control through state intervention with the request for health examinations being backed “by a million persons.”\(^{73}\)

Neville’s success in appealing to churches was limited by her gender. The Southern Baptists were a powerful denomination in Kentucky and Neville “wanted to go before the Baptist group in our state and was told there that, being a woman, I ought not to ask to go on the floor of a Southern Baptist Convention in Kentucky. I did not ask.”\(^{74}\) Neville maneuvered around these limitations by creating a statewide campaign that went beyond churches and legislators. She spoke to community organizations like the Kiwanis and Rotary clubs. Club members, in turn, lobbied their churches and legislators for the

\(^{71}\) Linda Neville to Dr. Wells, 9 May 1937, LNP, Box 73, F. 14.


\(^{73}\) Ibid.

\(^{74}\) Linda Neville testimony, Congress, House of Representatives, Committee on Interstate and Foreign Commerce, *Investigation and Control of Venereal Diseases: Hearing Before the Committee on Interstate and Foreign Commerce*, 75\(^{th}\) Cong., 3\(^{rd}\) session., 1938.
passage of a premarital health bill. She saw the necessity in recruiting private citizens to take action against venereal disease, but put most of her faith behind the power of the churches. Religious officials realized their limitations in controlling the spread of infection, noting that “It is not enough for a church to pass a law that its ministers cannot marry anyone without such a medical certificate, because in that case an afflicted person would go to some magistrate and be married and thus be the cause of misery in the world.”\textsuperscript{75} Church officials saw themselves as only one level of protection against the spread of disease and thought legislators and the state held the ultimate power in eradicating the suffering caused by syphilis and gonorrhea. The Episcopalian Bishop of Lexington in 1938, Mather Almon Abbott, stated his frank position on the church’s role, writing that “I regard the function of the church to be not primarily legislature, but inspirational. In other words, the Church is not the gun. The Church is the man behind the gun.”\textsuperscript{76}

The premarital health bill held no “magic bullet” against venereal disease and its far-reaching effects on the population. Women were targeted by health professionals in their fight to eradicate syphilis and gonorrhea with concern being over the health of their potential offspring and not the health of the woman herself. The danger surrounding pregnancy in a woman infected by gonorrhea is illustrated in a 1930 Kentucky Court of Appeals Case involving the death of a woman following an attempted abortion. In 1928, Dr. T.D. Goodman visited Bessie Kouns, a pregnant Boyd County woman, who was suffering from pain with considerable swelling and tenderness in her abdominal region. The treatment prescribed by the doctor was not working and an operation was needed to

\textsuperscript{75} Deacon Christopher Sparling, Rights of Christ Church Cathedral in Lexington to Sen. Leer Buckley, 1 February 1938, copy of letter in LNP, Box 73. F. 20.
\textsuperscript{76} Mather Almon Abbott to Linda Neville, 17 September 1938, LNP, Box 74. F. 3.
relieve the intestinal obstruction that had occurred. A second physician offered chilling and heartbreaking testimony on what happened when Kouns visited Dr. Dorroh, who performed the abortion:

She said that she went to Doctor Dorroh’s office about 7:00 o’clock, I believe on Saturday evening, and that Doctor Dorroh was drinking and didn’t recognize her, and that she had to remind him of an engagement she had with him to open her womb at that time, and she said that he swore and told her to get on the table, and that she did, and that when she got on the table he started to get ready to use an instrument and dropped that instrument on the floor and picked it up and stuck it in her uterus and nearly killed her.77

Kouns did die following the abortion and Dr. Dorroh was charged and convicted of a criminal abortion by the Boyd County Circuit Court. He was sentenced to two years in prison, but challenged the ruling with part of his defense being that Kouns had visited him several times before for gonorrhea treatments and the disease itself could have had a role in the abortion and her subsequent death. Dr. Dorroh’s medical office staff testified that because of her infection, “she had attempted to perform an abortion by the use of a lead pencil and she was suffering greatly from it.”78 The appeals court reversed the judgment against Dorroh based on evidence of a venereal infection and a statement Kouns made before the abortion indicating that she believed she was going to die. The court considered this statement as a dying declaration instead of one based in terror after she came in contact with the drunken, swearing doctor and his unsanitary medical instruments.

The judges sitting on the Court of Appeals used Kouns’ gonorrheal infection to overturn a guilty verdict and essentially laid the blame of her death at her own tombstone. The premarital health bill did not remedy tragic situations where women became aware

77 Dorroh v. Commonwealth, Court of Appeals of Kentucky, 236 Ky. 68, 32 S.W. 2d 550; (1930).
78 Ibid.
of their infections after becoming pregnant and then faced high-risk births. Pregnant women were blamed for placing their unborn children at risk, but the health dangers these women faced were never discussed or acknowledged by physicians. How these women became infected also had little bearing once pregnancy was an issue. The burden of responsibility sat solely on the shoulders of women in ensuring that they did not conceive if they were known to have gonorrhea or syphilis. The men in these relationships held none of this responsibility and still had the ability to step outside the marriage and bring the infection home to not just their wives, but in some disturbing cases, also their children.

In *Unspeakable: Father-Daughter Incest in American History*, Lynn Sacco offers a compelling argument linking an outbreak of gonorrheal infection in young girls in the twentieth century and incest. Her meticulously researched account notes that doctors and reformers were “shocked” when they found an epidemic of gonorrhea among girls in all classes of society in the 1920s. Faced with this knowledge, doctors systematically revised their etiology of gonorrhea while maintaining that venereal disease is best attacked through the eradication of prostitution and extramarital sexual contacts. They ignored the evidence that indicated young girls being subjected to incest by their fathers and placed even more blame on the mothers. In a 1939 Kentucky Court of Appeals case, a Madison County man sought the overturn of his sentence of seven years after being convicted of raping his 12-year-old daughter. The father claimed his wife concocted the allegations for the purposes of revenge.

The mother had left the home to stay with relatives and the children, a daughter and 10-year-old son, remained with the father in Madison County. During the trial, the 12-year-old girl testified against her father:

> It would be about eleven o’clock; I would go to sleep and he would come and get in bed with me. Got on me and smothered me. Next morning my brother went after the cows, and he (referring to the father) said ‘if you tell this on me it will ruin you and me both.’ He said he would kill me if it took him one hundred years to do it. I tried to get loose and he choked me. My brother heard me crying. I told him what he was doing to me.  

The mother returned after she learned of the allegations and an examination of the girl revealed that she was infected with gonorrhea. In her testimony, she said “she did not know what the trouble was, but something was burning or hurting her about her private parts.”

The presence of venereal disease in girls often brought to light cases of child rape or incest that would have not otherwise been revealed. This was the case in the previously mention trial and in a 1936 incident where an eight-year-old girl was diagnosed with gonorrhea and later revealed that she was raped by a family friend who was 28 years old. The girl did not tell her parents of the incident until her mother noticed her “pulling at her clothes indicating she was annoyed or that something was wrong with her.” Following an examination and diagnosis of gonorrhea, an investigation determined that she was raped. The family friend was arrested and took a venereal disease test, which indicated the presence of gonorrhea. However, the appeals court overturned the defendant’s conviction and lifetime sentence based on the prosecution’s failure to inform the jury that

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80 *Williams V. Commonwealth*, Kentucky Court of Appeals, 281 Ky. 70; 134 S.W. 2d 983; (1939).
81 Ibid.
82 *McManus v. Commonwealth*, Kentucky Court of Appeals, 264 Ky. 240; 94 S.W.2d 609; (1936).
the defendant did not consent to such an examination but was done against his will.\textsuperscript{83} The actions of perverse men or even “heads of households” left pre-pubescent girls scarred and marked with venereal disease infections and their mothers shouldering the blame for not doing enough to protect their children or please their husbands. Medical professionals and reformers ignored the dark underbelly of how infections were spread within the family. Neville made no mention of possible cases of incest in her medical files and focused only on the infants and not how the young girls became infected or impregnated in the first place. She, too, chose to look the other way and did not consider possible transmission from father-daughter relationships.

Premarital health laws passed by states did little to prevent venereal disease infections. Medical professionals viewed greater state intervention of marriage as a solution to a centuries-old problem. By making marriage the battleground in which disease was fought, the real issues of transmission and infection were ignored and blame was transferred from men to women. Wives became responsible for ensuring a wholesome and happy marriage in order to keep their husbands from seeking sexual relations elsewhere. This was an impossible burden placed on women. Medical professionals were complicit to the sexual double standard, forgiving men of their indiscretions without educating and holding them responsible for the havoc their infections had on women’s bodies and offspring. Premarital health laws were pursued from eugenic ideals and the concern over the future of the race. The laws sought to protect unborn children, not adults.

Such measures made perfect sense to Neville, whose primary concern was always the babies and not the mothers. She witnessed the horrific toll gonorrhea and syphilis

\textsuperscript{83} \textit{Ibid.}
took on children’s bodies and development. Through this experience, came the need to prevent further births of infected infants from happening. Neville, like most reformers, endlessly trumpeted one call to action — the health of babies. This became her motivation for decades and illustrates the reasons why she pursued the passage of a premarital health bill in Kentucky through cooperation with medical professionals, legislators, and community organizations. She too seemed to be ignorant of the underlying issues involving sexuality and the spread of venereal disease, but Neville was not a trained physician and saw her responsibility lying only with the children she treated and not the mothers of these children, whom she often described as neglectful and ignorant.  

The fathers of infected children are absent from Neville’s case files and from medical literature addressing the infected newborns. Mothers shouldered the blame for becoming infected, becoming pregnant while infected, and giving birth to a child who inherited that infection. It was a “bad” mother who allowed such an event to take place and a blameless father who stood by “helplessly” or was absent throughout the course of conception, infection, pregnancy, and birth. This dialogue of female blame took on a new meaning as government and medical professionals began to impede on the personal liberties of women to wage a war against venereal disease. Women found their bodies as the site in which the battle began and they became prisoners within a society that viewed venereal disease as a woman’s problem.

84 Molly Ladd-Taylor and Lauri Umansky, eds. “Bad” Mothers: The Politics of Blame in Twentieth Century America (New York and London: New York University Press, 1998). Ladd-Taylor and Umansky argue that mother-blaming was exacerbated during the Progressive Era because of the growth of state power and influx of childbearing experts. Middle-class women promoted a social reform movement historians call maternalism. Maternalists used the concept of “good” mothers, or those who had middle-class sensibilities and values, to build a welfare state. Ladd-Taylor and Umansky argue that “good” mother rhetoric caused maternalists to become more critical of mothers were deemed bad because of their class status or ethnicity.
Chapter 3
“Spartan Mothers”: Venereal Disease in Pregnancy and Raising Efficient Citizens

Linda Neville took her fight for venereal disease prevention to the nation’s capitol in 1939. She was called to testify in a Congressional hearing on the investigation and control of venereal diseases. In her speech, Neville highlighted what she perceived as unique barriers in Kentucky to preventing the spread of gonorrhea and syphilis. She questioned “how we are going to educate the people about something they have no experience, especially when many of the people who get these diseases are so ignorant they do not know how to be educated?” Neville drew on her experiences helping rural mothers of Appalachia who gave birth to children infected with gonorrheal eyes or syphilis. She saw them as “backwards” in their knowledge of medicine and childbirth and thought sex education would do little to change their practices. Even though medical, church, and school officials began to pursue a national policy of sex education as it relates to venereal infections, Appalachian mothers were excluded from this dialogue and cast aside as dirty women who needed instruction in sanitation to prevent the spread of venereal disease. Nationally, women’s health still remained neglected, as concern for the health of babies continued into childhood. Mother’s were held responsible for protecting their children against contracting any “loathsome” disease and falling into

85 Congress, House of Representatives, Committee on Interstate and Foreign Commerce, Investigation and Control of Venereal Diseases: Hearing Before the Committee on Interstate and Foreign Commerce, 75th Cong., 3rd session., 1938.
86 In Appalachia On Our Mind (Chapel Hill: The University of North Carolina Press, 1978), 60-84. Henry D. Shapiro analyzes how local color writers and reformers who entered the area beginning in the 1890s created the “idea” of Appalachia. Appalachia became a distinct region separate from the rest of the nation and its people were described as peculiar and classified as a single class or population. By defining the area and its residents as something “other” than normal, reformers justified their purpose in transforming the region.
vice. They ways in which women were expected to educate their children varied according to class, racial, and regional stereotypes.

An overwhelming concern for the health of babies manifested itself in the Sheppard-Towner Maternity and Infancy Act passed by the federal government in 1921. The measure was the first social welfare initiative in the nation and focused on decreasing infant mortality occurring during or immediately after birth. The Federal Children’s Bureau administered provisions in the act, which provided federal matching funds to states enacting programs that educated women on “proper” childbirth methods and infant care. Promoters of the provisions under the Sheppard-Towner Act proclaimed that it sought to reduce not only infant mortality, but also the number of deaths that occurred in women giving birth. Even though women’s health was a stated initiative under this provision, it was not the primary motivation behind its passage. Education for nurses under Sheppard-Towner put infant health ahead of the health of the mother, as seen in one proclamation that “This twentieth century does belong to the child, and unless we as nurses — not public health nurses as usually so designated, but all nurses — meet this challenge and take advantage of the great opportunities presented to us for the betterment of child life, we shall be liable to the reproach of those who follow us.”

87 J. Stanley Lemons, “The Sheppard-Towner Act: Progressivism in the 1920s,” The Journal of American History 55, no. 4 (March 1969): 776. Lemons argued that the bill represented a link between the Progressive Era and the New Deal. Even though historical periodization marks the end of Progressivism in 1920, Lemons linked the Sheppard-Towner Maternity and Infancy Act to the Social Security Act of 1935. Congress eliminated Sheppard-Towner in 1929, arguing that it was too socialist in nature and demonstrated a communist approach to healthcare. But many of its provisions and protections were included five years later while America was struggling through the Great Depression. In my analysis, I also find Progressive Era ideas of the state playing a role in people’s lives lasting beyond the 1920s, which highlights a problem with constraining analysis to situate the Progressivism within its known era (1890-1920). Looking beyond the prescribed “era” illustrates that Progressive ideas were evident beyond the 1920s and did not necessarily “die” but transformed and changed to meet new needs in the United States.

Women’s health was peripheral to a medical community concerned with taking childbirth from the realm of family and placing it in the authority of medical doctors and nurses.89

Figure 1: A 1936 poster from the Works Progress Administration urged women to seek professional medical help during pregnancy. Library of Congress.

Traditional practices of birthing among rural and poor women were under assault through this act. Middle-class medical professionals blamed untrained midwives for the rising numbers of infant deaths. They ignored any social and economic factors that caused the birth of unhealthy infants to sick mothers and instead focused on regulating and controlling midwives who approached childbirth with a combination of tradition and

folk remedies. In her analysis of midwife education, Molly Ladd Taylor argues that nurses believed they were helping rural and impoverished mothers, but “their attempts to make midwifery scientific and professional denied the value of traditional skills and folk healing, thus furthering the medicalization of birth.” The act required midwives to receive training in child birthing and infant care and be certified by the medical profession. But Ladd-Taylor found that many of the programs under Sheppard-Towner did not reach the most remote and impoverished areas. Racial discrimination also limited the scope of the act. Kentucky had a three-month program to train midwives, but it was reserved only for whites. There was a general “ambivalence toward black and immigrant midwives” who were viewed as too ignorant and dirty to benefit from the training offered under the act. Many “granny” midwives operating in rural Appalachia were also seen as “outsiders” unable and unwilling to replace their traditional birthing techniques with a middle-class view of birthing.

The Frontier Nursing Service, first established as the Kentucky Committee for Mothers and Babies by Mary Breckinridge in 1925, focused on bringing healthcare access and education to rural women. The FNS sought to replace lay midwifery with trained public health nurses. Melanie Beals Goan found that while some criticism of midwife practices in Appalachia were justified, other techniques “posed less of a true threat and simply contradicted the modern conventions.” It was hard for professional healthcare workers to gain trust in areas isolated from the practices of modern medicine. Women relied for centuries on the techniques employed by midwives and the sight of

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90 Ibid., 262.
91 Ibid., 255-256.
injecting children with “vials of strange liquid and to send them hundreds of miles away for treatment in the name of progress, mountain residents understandably remained skeptical and hesitant.”93 Breckinridge, like many other women seeking to bring modern medicine to rural areas, mistakenly believed that poor women would openly accept their new scientific theories of childcare and birth. Rural birthing methods were embedded in family tradition.94

Public health nurses met resistance from mountain mothers because “educated midwives and nurses demanded radical changes in centuries-old traditions.”95 Sandra Lee Barney illustrates how reformers used “both the carrot and the stick” to entice rural women to embrace scientific medicine and birthing. They described the advantages of physician-assisted child birthing while also regulating midwifery through educational requirements and certification. A combination of medical and scientific practices emerged from the imposition of modern medicine in Appalachia. Paramount in Appalachian mothers decisions on how to give birth were economic and cost-saving initiatives. Public health nurses were more expensive but offered some advantages that lay midwives did not, such as post-natal care. But midwives were cheaper and helped with domestic chores whereas public health nurses did not.96 Appalachian women demonstrated agency in choosing a hybrid system of healthcare that incorporated both traditional practices and scientific medicine. Midwives remained an important part of

93 Ibid., 134.
94 Sandra Lee Barney, Authorized to Heal: Gender, Class, and the Transformation of Medicine in Appalachia (Chapel Hill and London: The University of North Carolina Press, 2000). Barney illustrates medical professionals in Appalachia were often met with resistance from rural mothers because of the prevalence of traditional medical remedies.
95 Ibid., 119.
96 Ibid., 117.
childbirth, but as reformers increased their attacks on the practice, poor women were left with little choice in medical care.

The Sheppard-Towner Maternity and Infancy Act actually led to a declension of midwifery skills. Many midwives in impoverished areas of the nation still offered their services without the benefits of the education that the act did offer because they refused to submit to middle-class views of birthing. Midwives provided valuable services to women during and after birth. They often stayed to take care of housecleaning, tend to the other children, and cook dinner while the mother rested. Some of their traditional remedies also had value. A common practice among trained medical professionals and stressed on midwives was the use of a one-percent silver nitrate solution in infants’ eyes at birth. This was a preventative and treatment measure for gonorrheal infections of the eyes. Instead of the silver nitrate, midwives squirted breast milk in the eyes, which had natural antibodies. Breathing techniques used by midwives during labor also helped calm the mother and relieve some of the pain. Sheppard-Towner sought to remove birthing from the female sphere and out of the hands of family and kinship ties. The measure “failed to keep healthcare and childbirth in women’s control because of cultural insensitivity, reliance on state authority, and blind faith in modern services” and served only to put the nation’s most at-risk mothers in a system where their health needs were sacrificed for the ultimate goal of forcing middle-class values on an area and a people viewed as backwards.

97 Ladd-Taylor, 270.
98 Ibid., 259.
99 Ibid., 270.
In 1923, the Children’s Bureau embarked on a study of child welfare in rural areas. Public health reformers studied maternity and infant care in a number of “mountain” counties. Their reports reveal the limits of the Sheppard-Towner Act and its limited reach. In one Georgia county, 505 mothers were studied to determine the conditions in which they gave birth and the quality of care given to the infant. Glenn Steele, a woman caseworker with the bureau, demonstrated a rare concern for the pregnant women in her report. Steele also composed a number of reports on infant mortality in Pittsburgh and promoted relief aid to mothers and veterans. In the mountain area of Georgia, Steele found a “Spartan fortitude” in women who went through pregnancy and childbirth without any medical supervision or aid. But she was also careful to note the ignorance of mountain women who did not “realize the need for the hygiene of pregnancy.” They sought treatments for such painful conditions as milk leg, a painful swelling of the main vein in the leg, through non-medical professionals who prescribed rusty nails soaked with vinegar. In one instance Steele documented a case where a woman who suffered from gathered breasts, an inflammation in one or both breasts, was so desperate for relief that her husband lanced them with a jack knife. Spartan fortitude indeed, but Steele failed to see that these treatments were done out of necessity and desperation. Access to medical care was limited and poverty necessitated

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100 Robyn Muncy, *Creating a Female Dominion in American Reform, 1890-1935* (New York and Oxford: Oxford University Press, 1991). Muncy argues that the Children’s Bureau, created in 1912, was the “first female stronghold in the federal government.” It represented white middle-class women’s ability to make policy in progressive reform. The bureau focused on children’s health as it saw them as the future of the nation. It’s “standard operating procedure” involved door-to-door work visiting mothers and their children. Muncy finds that the Children’s Bureau was one of the few female-dominated organizations to survive the shrinking of progressive reform after World War I. The establishment that focused on child welfare “helped shape the foundation of the American welfare state” and allowed women to create a new field of professional work for themselves.


102 Ibid., 18.
the need to find cheap cures or painful at-home remedies. These are aspects of society
that literature on “hygiene and sanitation of the home” could not fix.

The Sheppard-Towner Act did succeed in reducing infant deaths, but its failure to
recognize the economic and social conditions behind mortality rates limited its prolonged
usefulness. At times, women health workers sometimes did state the connections between
poverty and infant mortality, but found education, not enacting social programs, as the
only way to reverse the trend in mortality. Grace Abbott, Children’s Bureau chief, did not
deny that “babies died when wages were low,” but also found death also related to
overcrowding in homes and poor sanitation. She blamed mothers for the deaths of their
children because they did not follow the rules of an emerging scientific practice of child
rearing and care. In promoting the need for education, not a change in socio-economic
conditions, Abbott found infant mortality to be “an index of social, economic, and
sanitary conditions, but a better index of what mothers know about the care of their
children.”103 The death of a baby stood squarely on the shoulders of the mother who did
not seek to educate herself on the science of pregnancy and childbirth.

Expectant mothers across the nation wanted to learn how to better prepare for
birth and craved to understand new ways to not just rear healthy children, but to alleviate
their own pains during pregnancy. Sociologist Kristin Barker analyzed communications
between lay women and women public health officials with the Children’s Bureau. She
looked at the concerns of working-class women from the eastern regions of the United
States and found that many of their letters focused on their health during pregnancy and
they sought remedies for complaints like nausea, abdominal pain, constipation, and

Academy of Political and Social Science 151 (September 1930): 92.
overall sickness. The responses women received from officials disregarded the women’s health problems and focused on the health of the infant and the need to see a physician for the sake of the baby, not the mother.\textsuperscript{104} A few of the correspondences on the part of the mothers did indicate an inability to seek professional medical help because of finances and many wrote to the bureau as a way to seek free advice and consultation. Their inquiries were, however, only met with cold responses urging them to see a doctor and pamphlets instructing them on the proper care of infants.\textsuperscript{105} It was within this framework of overriding concern of fetuses that prenatal care first emerged as necessary treatment for all expectant mothers. The growing prevalence of venereal disease and the risk of spreading gonorrhea and syphilis in utero also spurred medical officials to urge states to open prenatal clinics.

One of the largest successes of the Sheppard-Towner Maternity and Infancy Act was establishing a number of prenatal clinics in rural areas. Kentucky opened fifty-two such facilities through assistance with the act and West Virginia ranked first in the nation with the construction of 66 prenatal clinics.\textsuperscript{106} The detection and treatment of venereal disease was a primary purpose in creating prenatal care. Medical professionals expressed concern over the effects syphilis or gonorrhea had on the development of the fetus and not the dangers these diseases exposed women to during or after pregnancy. Doctors viewed syphilis as enemy number one when it came to decreasing infant mortality rates. There was a high probability of premature or stillborn births in syphilitic mothers.\textsuperscript{107}

\begin{footnotes}
\item[105] Ibid., 334.
\item[106] Abbott, 66.
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the woman carried to term and delivered a seemingly healthy baby, the concern revolved around inherited, or congenital syphilis, which had crippling effects on the child’s bones and overall development.

Public health campaigns urged expectant mothers to receive testing before their fifth month of pregnancy because the placenta forms a barrier to the infection up until the fifth month. Such slogans as “Start the cure five months before the baby comes and save nine out of ten babies from syphilis” were popular, but “the cure” was extremely dangerous and had long-term health consequences for the mothers. Arsenic and mercury were the two drugs used to treat syphilis during pregnancy. Arsenic was used for its germicidal effect while mercury was thought to increase the efficacy of the arsenic. The treatments were given weekly with doctors injecting the arsenic in the veins and the mercury in the muscle. Pregnant women were to continue receiving the treatments until delivery, but the risk for irreparable kidney damage, infection, and extreme intestinal disturbances were high.\(^8\) The effectiveness of this treatment was measured in terms of the health of the infant and not the mother. In one study of 403 pregnant African-American women receiving treatment for syphilis in Atlanta, Georgia, less than three percent

\(^{108}\) Ibid., 538.
Figures 2 and 3 are posters created by the Works Progress Administration in the 1930s. The posters warned against congenital syphilis and promoted the need for treatment in the last five months of pregnancy and a blood examination before pregnancy. Library of Congress.

gave birth to infected infants. The study, however, does not indicate if the women, themselves, were cured of the disease through the arsenic and mercury compounds. The dangerous treatment options available for pregnant women with syphilis caused many to fear medical help. For some women, taking a chance on carrying the baby to term without treatment was a better option than undergoing a grueling, painful, and dangerous procedure that involved the routine injection of poison and mercury in their systems.

Even though the Sheppard-Towner Act succeeded in illuminating the need for prenatal care, the initiative lapsed in 1929 after a backlash from the American Medical Association, which viewed the program as a socialist threat. The act did little to lower the rate of congenital syphilis. Katharine L. Lenroot, Children’s Bureau chief, continued to

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109 Ibid., 538.
express concern over the numbers of babies born with syphilis in 1939. She cited statistics that indicated 60,000 babies were born each year with syphilis. Lenroot further sounded the alarm, writing that one million syphilitic women of child-bearing age resided in the United States, leading her readers to consider the possible scenario that all of these women were poised to give birth to children debilitated by brittle, deformed bones, and overall weakness in body and mind.\(^{110}\) She expressed the need to diagnose and treat mothers for syphilis only for the future health of the infant and advocated the continuation of the treatment for the baby, not the mother. In Lenroot’s analysis, “We must save the children whose only fault was that they were not quite careful enough in the choice of their parents.”\(^{111}\)

Syphilis infections were viewed as running rampant among African-Americans and the lower classes. The American Social Hygiene Association focused much of its education work on certain populations — particularly African Americans and Appalachians who were viewed as too ignorant to understand the transmission, prevention, and treatment of venereal disease. Scientists also used race-based arguments to explain the seemingly higher rate of syphilis infection in blacks than whites.\(^{112}\) Through a number of published articles, Roscoe C. Brown, a medical doctor with the United States Public Health Service, advanced his racist view that “The difference between the races in incidence of venereal disease is probably due partly to a difference


\(^{111}\) Ibid., 6.

\(^{112}\) Statistics regarding the rate of syphilis in blacks compared to whites are unreliable because more whites infected with venereal disease sought treatment from private physicians who did not always report such incidences to the public health authorities. Economic situations dictated that most blacks seek treatment at public health clinics under the control of the government. At these clinics, rates of syphilis and gonorrhea were consistently documented and reported to the Public Health Service.
in social pressure, partly to a difference in ability to control the sex instinct.”113 Scientific racism in venereal disease control and prevention is best documented in the U.S. Public Health Service’s horrendous Tuskegee Experiments between 1932 and 1972.114 Medical professionals ignored economic factors and the lack of affordable, accessible health care in their assertions that blacks and Appalachians held high infection rates because of ignorance.

In 1938, The Mountain Eagle newspaper in Whitesburg, Kentucky, reported that Letcher County was considered as one of the worst infected counties in the eastern part of the state.115 A law was enacted in the region that forbade anyone from engaging in interstate travel without a written permit from a local health officer indicating freedom from infection. Accounts of syphilis infections in Appalachia were represented with violent examples. When Linda Neville testified in front of the congressional hearing on the control of venereal diseases in 1939, she described a case that involved three girls with congenital syphilis. The disease had “eaten out the roof” of one girl’s mouth and they were all three orphans since their mother “had chopped off a baby’s head with an ax since she had gone insane from syphilis and could not be cured.”116 The mother was committed at Eastern State Mental Institution and the girls were sent “to a fate worse than death.”117 In another instance of violence caused by syphilis, Eileen McGrath, industrial

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114 James Howard Jones, Bad Blood: The Tuskegee Syphilis Experiment (New York: The Free Press, 1982). Jones documents the 40-year study where close to 400 black sharecroppers infected with syphilis were observed, but never told they were infected with disease or received treatment after penicillin became the standard in 1947.
115 “Numerous Cases of Venereal Disease in Letcher County,” The Mountain Eagle, August 27, 1942, 3.
116 Congress, House of Representatives, Committee on Interstate and Foreign Commerce, Investigation and Control of Venereal Diseases: Hearing Before the Committee on Interstate and Foreign Commerce, 75th Cong., 3rd session, 1938.
117 Ibid.
assistant with the American Social Hygiene Association, reported that one West Virginia coal miner turned into a “raving maniac” after stopping syphilis treatments too soon and “tried to push a fellow miner down a pit.” 118 The ASHA held many meetings on social health at coal mine communities in the 1940s. Reports from these meetings reflected a cultural insensitivity that families living in mining areas were not able to understand problems associated with venereal disease and disregarded any health concerns created by infections. 119

At one health education meeting held at the West Virginia mining town where the man reportedly was crazed by a syphilitic infection, residents were shown a video of the prevalence and effects of venereal disease, which was “greeted with gasps of astonishment.” 120 Doctors administered blood tests to a number of the miners and their families, but those tested laughed at blood test reports that indicated a syphilis infection and “claimed that they were fine.” 121 A Wassermann test was used to determine the presence of syphilis. After blood was drawn from an individual, it was introduced to an antigen. If there was reaction to the antigen, a person was diagnosed with syphilis. The reliability of these tests are now considered questionable because a positive reaction can be gained if other illnesses like tuberculosis are present. The Wassermann test measured

118 Eileen McGrath, “Coal Mine Health Meeting,” Journal of Social Hygiene 27, no. 9 (December 1941): 440-441.
119 In Miners, Millhands, and Mountaineers, Industrialization of the Appalachia South, 1880-1930 (Knoxville: The University of Tennessee Press, 1982) 161-198, Ronald D. Eller illustrates life in mining towns, which declined shortly following the 1929 stock market crash. The meetings held in the 1940s were conducted in what remained of these towns. The conditions Eller describes, such as the absence of sanitary facilities and running water, were cited by health reformers as one primary cause for poor health. The town of Wheelwright in Floyd County, Kentucky was developed by the Elk Horn Coal Corporation in 1917 and later purchased by Inland Steel Corporation in 1930. Medical records from the company doctors indicate widespread a syphilis outbreak in the community in the 1920s. See Wheelwright Collection, 1916-1979, Special Collections, University of Kentucky Libraries, Lexington, KY.
120 McGrath., 440.
121 Ibid., 440.
the severity of the reaction and thus the infection on a scale of one to four, with four being the most severe case. Attempting to highlight the supposed ignorance of syphilis and the meaning of the test results, doctors reported that one African-American girl living in the coal mining community became confused as to why she could not donate blood. “What’s the matter with using my blood, doc?” she asked. “The nurse tells me it’s four plus. That’s the best ain’t it?”

122 The four-plus diagnosis indicated that she had a severe syphilis infection. By using this example of a young girl’s confusion over what a four-plus Wassermann diagnosis meant, public health officials tried to show the ignorance of both Appalachians and African-Americans.

Appalachian and African-American women were not only seen as ignorant, but also dirty. Public health officials often blamed the spread of gonorrhea on what they saw as the unsanitary living conditions in mountain communities. They saw mountain mothers as “Typhoid Marys”

123 posing danger to the health of their children. In Judith Walker Leavitt’s case study of Mary Mellon (Typhoid Mary), she argued that in the twentieth century women were targeted as public health threats because scientists’ recent discovery of the germ theory and the transmission of bacteria through food contamination created a gendered notion of how infection is spread. Health authorities recognized gender divisions of work and “believed not just that the bacilli and food handling made the women dangerous but that women were more dangerous than men because cooking

122 Ibid., 442.
123 Mary Mallon became known as “Typhoid Mary” in 1906 after she was accused in court of transmitting typhoid fever through her work as a cook. In 1909 a court ruled that Mallon was a danger to public health and ordered her quarantined at North Brother Island where she remained until her death in 1938. See Judith Walzer Leavitt, Typhoid Mary: Captive to the Public’s Health (Boston: Beacon Press, 1996).
was a traditional and necessary female activity.”  

Blaming mothers for infecting their children with venereal disease did not end in the womb. Once the child was born, social hygienists stressed the importance of maintaining a sanitary household to prevent children, particularly girls, from contracting a gonorrheal infection. The medical community ignored all science related to the germ theory when it came to determining the cause of gonorrhea vaginitis in young girls. One report insisted that “rape can be, but as a rule is not, the cause of this (gonorrhea) infection in children.”  

Doctors, instead, placed blame on mothers who kept a dirty house, not the wolf in sheep’s clothing lurking around the home. Mothers need not keep a watchful eye on their husbands or family friends, but rather make sure that all dirty bed linens and towels were appropriately washed. Medical doctors wrote article after article stating that overcrowding in the home, bad personal hygiene, and carelessness caused infection in young girls. In one survey of gonorrheal vaginitis in children, it was found that 100 percent of those cases was caused by “sleeping in the same bed with an infected female family member.”  

Medical officials were complicit in child rapes that were occurring. They deflected from the real problem through a policy that centered women as infecting agents because they were responsible for cleaning the home and taking care of the children.

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127 In *Unspeakable: Father-Daughter Incest in American History* (Baltimore: The Johns Hopkins University Press, 2009) Lynn Sacco details how the medical community ignored evidence of incest and
The germ theory and focus on public health led to a home economics movement in the early twentieth century. Influenza, tuberculosis, and pneumonia deaths in 1900 opened up a new field of home economic education, which focused on “scientific” housecleaning and ridding the home of bacterial menaces.\textsuperscript{128} In her analysis of home economics as it related to public health, Nancy Tomes asserted that “the heightened sense of responsibility for preventing infectious diseases promoted by home economists and other health reformers probably brought in its wake a new intensity of guilt.”\textsuperscript{129} Feelings of guilt and shame were felt if, despite sweeping every corner of the home, a child still fell ill. Even as fears over deaths from influenza or pneumonia subsided in the 1920s, they were replaced with the menace of venereal disease. The same techniques of house cleaning were stressed as a way to prevent children from contracting gonorrhea and nowhere was this more stressed than in Appalachia, where people were seen as living in “abject squalor.”\textsuperscript{130}

In the winter of 1919-1920, the Children’s Bureau investigated a “mountain county” of Kentucky after the Kentucky Board of Health requested help in determining “why a state famous the world over for its prosperity should turn out so large a percentage of physically defective men” as shown by World War I draft records.\textsuperscript{131} The bureau interviewed 123 families with 256 children between the ages of two and eleven.

\textsuperscript{129} Ibid., 607.
\textsuperscript{130} E.V. Tadlock, “Coal Camps and Character,” \textit{Mountain Life and Work} 4, no. 4 (January 1929): 23.
Lydia Roberts, a social worker with the Children’s Bureau, described the families as “all native whites and of mountain stock.” 132 Of the children examined, only five were found to have no defects, which ranged from general illness to heart defects, enlarged tonsils and decayed teeth. Roberts took particular care to describe in detail the mothers of these children who “trudged through mud, dirt, and scraped for money so their children could have decent clothes for a physical examination.” 133 She characterized the mothers as prematurely aged and seemed sympathetic to their plight as young wives and mothers who “assume the care of home and family.” 134 But the sympathy stopped there, as Roberts blamed the condition of the children on their unsanitary living conditions and not on the lack of medical services in the area or the abject poverty that families lived under.

Doctors and social reformers started to connect the psychological and physical conditions of children with their environment in the 1930s. Dr. Bland Morrow worked in Eastern Kentucky and attempted to document the effects of poverty on a particular patient named Ned. Morrow described how poverty had made Ned not feeble-minded, but “queer and unnatural.” 135 Morrow tried to use poverty to describe why he suffered from attacks where he fell limp and silent, but not unconscious. Jim and Celia, Ned’s parents were characterized as weak and spiritually fatalists. “They expect the worst from

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132 Reformers viewed Appalachian residents as having a pure white bloodline because of what they saw as the extreme isolation of the region and what it meant bloodlines. John C. Campbell’s classic study on Appalachia and its people, The Southern Highlander & His Homeland, 2nd ed. (Lexington: The University Press of Kentucky, 1969) was originally published in 1921 and put forth a theory that connected the region’s isolation with a white, Anglo-Saxon or Scotch-Irish bloodline. Shapiro argued that this genetic theory was used by many reformers to justify the possible success of their work with “mountain whites” as opposed to populations also marked as “others.” Despite what they saw as a common bloodline, reformers and color writers still put forth physical differences between them and the mountain residents, but saw these differences as shaped by their environment than by genetic “defects”.

133 “Nutrition and Care of Children,” 5.

134 Ibid., 3.

life, they even get a sort of morbid satisfaction out of the worst when it comes.”136 Jim’s failure as a father was excused by Morrow because Jim was depressed and haunted by the impoverished conditions. Morrow placed more blame on Ned’s mother, writing that she was “over-emotional, chronically nervous, and short of temper. Her methods of discipline lack consistency, which leave the children in a chronic state of bewilderment as to what may be expected from her.”137 Morrow connected Ned’s fits not just with his being reared in poverty, but confusion over his mother’s actions. However, Morrow overlooked the fact that every time Ned fell limp and silent, he was taken to the hospital where he received a warm meal and a bed to sleep in. These “fits” were a survival mechanism for Ned and a chance to escape poverty, even if it was just for one night.

Morrow’s focus on Ned’s mother was reflective of the exacerbation of mother-blaming in the twentieth century. Public health workers, child-rearing experts, psychology, and emerging scientific discoveries of disease transmission all pressured mothers to read the latest literature on raising healthy children.138 If a mother failed to do so or exposed her child to venereal disease, she was a “bad” mother. Women’s own health and psychological needs were of little concern to professionals seeking a future made of strong men to serve in the military or work in industries. Women were replaceable, but the youth were the future and there was no room in this future society for boys raised like Ned who can “grow up to be a chronic alcoholic” because of his mother.139

136 Ibid., 11.
137 Ibid., 11.
The medical community’s focus on mothering was part of a backlash that sought to place women back in the homes after they had entered the workforce in larger numbers in both World War I and World War II. Societal changes produced by both wars and new inventions like the automobile that granted women unfettered mobility exacerbated fear over the growing economic independence of women. Mothers who started to divide time between family and work were categorized as neglecting their duties as wives and caretakers. By placing the home and education in the home as central to controlling venereal disease, social hygiene reformers urged women to abandon their new independent roles as wage earners and return to their domestic confinement. In trying to determine “what the family is good for,” one article advanced the notion that “economically emancipated women tend, unconsciously to assume indifference to the home as a badge of freedom.”140 Stressing home economics and “scientific” housekeeping was one way to guilt women back into the home, but making women the central purveyors of sex education to their children also burdened them with the responsibility of teaching traditional views on intimacy, despite their modern values. Reformers instructed mothers on the proper messaging in “sex talks,” which was embedded with Victorian sensibilities on sex.

Social reformers targeted adolescent girls as in particular need of education in social hygiene. They warned that girls held a natural contempt for their mothers and “feel a greater nearness to their fathers than do boys.”141 Contemptuous feelings toward mothers meant that in educating daughters on the “birds and the bees,” the father’s

presence needed no explanation, but the mother had to explain the importance of her role within the family.\textsuperscript{142} A mother who spent most of her time outside of the home and engaged in activities independent from the family unit was not seen as useful to the daughter and promoted a dangerous lifestyle that could lead to sexual promiscuity and venereal disease infection. The question of what to do with the teenage girl in a society where young women began working in industry and frequented public dance halls and bars became a predominant concern. One social reformer asked, “Where is the mother while all this goes on?”\textsuperscript{143} The assumption was that the mother was also earning a wage in industry and visiting local honky-tonks. Engaging in this type of modern activity was viewed as dangerous to the future of the race, as it set a bad example for adolescent girls.

“She still has to have the babies that are necessary to carry on the race and she is having those babies with less care than ever before,” one reformer warned.\textsuperscript{144}

Sex education for adolescent girls focused more on their future role as mothers and less on sex hygiene. Girls did not learn about sexual intercourse, their bodies, or diseases that could spread from sexual contact in the same way that boys did. Their education focused on the traditional values of child rearing and demonizing their sexual urges as unnatural and something they should ignore. Sex education in boys naturalized their urges and was more comprehensive in its detail of intercourse and the risk for infection. Mothers were burdened with the responsibility of teaching not only their

\textsuperscript{142} Ibid., 546.
\textsuperscript{144} Ibid., 427. In \textit{Sexual Reckonings: Southern Girls in a Troubling Age} (Cambridge and London: Harvard University Press, 2007), Susan K. Cahn studies adolescent girls in the South. She argues that when girls explored new sexual mores, they threatened the white South’s beliefs in racial and sexual differences. From 1920-1960, the instability of adolescent female sexuality represented “larger instabilities” of the region. Cahn illustrates how concerns over the sexuality of young girls were intertwined with rigid notions of race and sex and the maintenance of an organic society in the South.
daughters, but also their sons about sex. They often groped for ways to approach this subject with limited guidance on how to do so. For one New York mother, educating her two boys about sex came at a legal cost.

Mary Ware Dennett decided to teach her eleven and fourteen-year-old sons about sex but found pamphlets available in 1930 as inadequate. She tried to open the conservation by writing her own pamphlet titled the “Sex Side of Life.” Dennett’s educational aide helped both boys and girls learn about sex organs, their operation, and the way children are conceived and born. She described both male and female sex urges as normal, but once she published 25,000 copies and mailed them to organizations like the Young Men’s Christian Association, Young Women’s Christian Association, and the Public Health Department, a New York court convicted her of mailing obscene material. The court ruled that the material was “lewd and incited sexual desires and libidinous thoughts.” For mothers like Dennett, teaching sex education was a dangerous undertaking, but one that was deemed necessary for the future economic and military health of the nation.

Social reformers saw social hygiene education as a way to strengthen the future economic stability of states, communities, and the nation as a whole. They believed that “if a life is saved or a disease cured, or if a child is rescued from becoming an inefficient

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146 The Comstock Act became a federal law in 1873 and criminalized the sending of any “obscene or lewd” materials. The law also prohibited using the mail to send any information related to contraceptive use and practices. Margaret Sanger, an advocate for birth control, struggled under Comstock laws throughout her efforts to make public information regarding the use on contraceptives. She was jailed in 1915 for distributing a pamphlet titled *Family Limitation*, which detailed how to use a variety of contraceptive methods. Prosecutors dropped the case, but Sanger continued to tour and speak publicly about family planning and the use of birth control, leading to several other arrests. For more on Margaret Sanger and the birth control movement, see Ellen Chelser, *Woman of Valor: Margaret Sanger and the Birth Control Movement in America* (New York: Simon & Schuster, 2007) and Patricial Walsh Coates, *Margaret Sanger and the Origin of the Birth Control Movement, 1910-1930: The Concept of Women’s Sexual Autonomy* (New York: Edwin Mellen Press, 2008).
citizen, money is saved in the long run to those who would otherwise have to support the inefficients and their dependents.” Eliminating the economic burden caused by syphilitics or those needing treatment for gonorrhea motivated public health campaigns against venereal disease. It was the woman’s job as a citizen to take on the responsibility of ensuring a healthy race that was fit to fight and fit to work. They were replaceable as mothers and child rearers, but their sons were not. America valued its boys and went to great lengths during times of war to protect them from the modern girl who did not quite adhere to the traditional sex education she may have received as a troublesome adolescent.

“Feeble-minded,” “constitutionally inferior,” “degenerate,” “delinquent,” “drug-addicted,” “alcoholic,” and “diseased” — these words were used in 1920 not to describe murderers or rapists, but the real menace to society at that time — prostitutes. “Morally-loose” women became the embodiment of venereal disease during World War I. The United States Public Health Service created quarantine facilities after the war in 1918 to imprison and treat women suspected of having a venereal disease or operating in such a manner where the contraction and spread of venereal disease was possible. Within these facilities, officials poked, prodded, and analyzed their “subjects” to determine the psychiatric and physical causes behind alleged promiscuity in women. On the surface, it may seem officials created the centers for the sake of science and the betterment of society, but in actuality, the quarantine facilities represented an attempt by the government to control the sexuality of all women, not just prostitutes. Fear over the contagion of venereal disease and its effect on the United States’ fighting force during both World War I and World War II became an excuse to enact harsh penalties on women who were becoming more mobile and liberated in American society.

In 1920, Public Health Reports released a five-part study on “delinquents” quarantined in extra-cantonment zones of Kansas and Kentucky. Physicians and psychiatrists descended on the State Industrial Farm for Women in Lansing, Kansas and the Jefferson County Jail in Louisville, Kentucky to perform medical and mental analyses on women imprisoned for either being infected with venereal disease or operating in such

a way to make infection possible. "Public recognition of prostitution as a menace to military fitness" compelled these studies of "sexual delinquency" During this time "an aroused public saw certain too familiar 'misdemeanors in a new light; it saw them (sexually immoral women) as an inevitable means of transmitting loathsome diseases."

The reform community redefined the repression of prostitution in the early twentieth century as a war emergency with urgent appeals by medical officials seeking to maintain "fine traditions of home and State and race and nation." Social reformers recast a moral campaign against sexual vice as a wartime medical emergency. A society at war opened new opportunities for women. The workforce changed during World War II and women became more mobile as they stepped outside domestic confinement to fill the roles of men drafted to serve overseas. Women saw more employment opportunities open in the 1940s and embraced these opportunities and the chance for economic and personal liberation. This transformation caused fear among the patriarchal authorities who sought to put women back in their proper roles as homemakers or chaste women yearning for marriage.

Through the incitement of fear related to the "contagion" of venereal disease, the government effectively placed women's sexuality under its control by stripping them of their personal liberties and using them as lab rats under the auspices of medical and governmental authority.

In the psychiatric studies of quarantined women in Kansas and Kentucky, health officials sought to determine what made women turn to prostitution or become immoral

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149 Ibid, 1196.
150 Ibid, 1196.
151 Joanne J. Meyerowitz, Women Adrift: Independent Wage Earners in Chicago, 1880-1930 (Chicago: The University of Chicago Press, 1988) xix. Meyerowitz studies women workers in Chicago and uses them as a window to “investigate American womanhood stripped of family and domestic roles.” She argues that their departure from middle-class family life led society to label them as in a state of moral decay. They did not abide by the theory of “separate spheres” and went against Victorian principles of sexuality by openly expressing their sexuality.
sexually. The Surgeon General of the United States Public Health Service oversaw the studies performed between 1918 and 1919. Either the women analyzed entered containment as “persons likely to have a venereal disease and conducting themselves in such a manner as probably to lead to its dissemination,” or women arrested for sexual immorality. Researchers employed vague language throughout the report, including no real definition of what made a woman “delinquent” or how a woman was determined to likely have a venereal disease. The reasons listed for detainments are equally as vague, but all somehow led to the belief of a woman behaving in a sexually immoral manner. Court charges for the arrest and quarantine of women included disorderly conduct, which usually meant prostitution, drunkenness, breach of peace, begging on streets, and illegitimate pregnancy. Medical officials interpreted any charge as evidence of promiscuity, noting that women arrested on charges not indicative of prostitution “were either engaged in prostitution, or had some relation thereto, or had lived with men while not married.” Even a woman arrested for being drunk did not escape an assertion that she too was sexually immoral, as it “could not be definitely proved that she had engaged in sexual immorality, although this was strongly suspected by the husband and by a social-service worker who had seen the woman in jail on a previous occasion.”

153 Ibid, 1255; Women Adrift; Meyerowitz argues that middle class women reformers feared that women who had not ties to home or family in urban settings would easily drift into prostitution as a means of support. Many of the moral courts established in urban settings worked as an early intervention for women deemed as easy prey for those promoting prostitution. I disagree with Meyerowitz argument that women adrift became accepted figures of the urban landscape in the 1930s. Wage-earning women became synonymous with prostitution during the 1930s and into the 1940s. They were not an accepted part of urban culture, but targeted by court, medical, and government officials as morally degenerate women. See also Nancy E. Odem, Delinquent Daughters: Protecting and Policing Adolescent Female Sexuality in the United States, 1885-1920 (Chapel Hill and London: The University of North Carolina Press, 1995).
154 Ibid, 1255.
155 Ibid, 1255-1256.
Reasons given for the imprisonment of these women illustrate how authorities intertwined the label of promiscuity and prostitution and applied these labels to women who were not necessarily prostitutes but seen alone outside the home. Police or health officers promptly arrested women travelling "suspiciously" outside the home and labeled them as venereal-diseased-infected prostitutes in need of control through state authority.

Repression of prostitution was not a new initiative emerging in the early twentieth century, but government officials intensified repression campaigns under the rhetoric of patriotism and wartime necessity. Courts and law enforcement transplanted the “sexually immoral” label from a select group of women operating in disorderly houses or as streetwalkers to all women, particularly those of the lower class during the war years. Following the Progressive Era’s closing of red light districts in the early 1900s, prostitution was essentially “driven underground” and became integrated “into the underworld of crime.”\footnote{Ruth Rosen, The Lost Sisterhood: Prostitution in America, 1900-1918 (Baltimore and London: John Hopkins University Press, 1982) 37.} Since the abatement of red-light districts failed to rid the nation of the “Social Evil” a number of large cities, such as Chicago, Philadelphia, and New York created courts that primarily addressed charges relating to prostitution or other “moral” issues. The purpose of these institutions was to reduce commercialized prostitution by placing all such cases in one court, which demonstrated “the tremendous volume of the business and result in raising public consciousness.”\footnote{George E. Worthington and Ruth Topping, “A Stdy of Specialized Courts Dealing with Sex Delinquency: I. The Morals Court of Chicago,” Journal of Social Hygiene 7, no. 4 (October 1921).} The real effects of such courts, however, illustrate how the courts and police targeted the “lower-class” of prostitutes (streetwalkers) along with other women moving freely about in city streets.
In 1921, the Bureau of Social Hygiene and the American Social Hygiene Association released a report on the inner-workings and effectiveness of a number of moral courts. The Morals Court of Chicago began in 1913 under the recommendation of the Chicago Vice Commission, which had eliminated the red light districts prior to the court’s establishment. The policies of Chicago’s and other cities’ courts allowed for the stripping away of women's civil liberties, while excusing men of their moral transgressions. Nancy E. Odem identifies two stages of moral reform from 1885-1920 in her study on the sexuality of young single women. The 1920s saw a transformation in moral reform efforts that “replaced the model of female victimization with one female delinquency that acknowledged the sexual agency of young women.”

The workings of moral courts demonstrate how Progressives tried to control the sexuality of young women instead of blaming their male partners or customers. Women no longer were cast as the victims of sexual vice, but they were now the victimizers who preyed on morally adrift men. Police arrested women under suspicion and officials did not pursue the “better class of hotels and houses.” The Bureau of Social Hygiene concluded, “For this reason, the so-called better class of prostitutes and their customers were passing through the machinery of the courts.”

When police arrested women under suspicion of prostitution, they were immediately jailed and not allowed to post bail until they underwent a forced medical examination to determine the presence of gonorrhea or syphilis. Men arrested for engaging in immoral acts with prostitutes could, however, post and be released on bail without a medical examination. Holding women for a venereal disease inspection made it legally possible to imprison them without bail on a misdemeanor charge. Legal

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158 Odem, 4.
159 Ibid, 360.
160 Ibid, 360.
authorities detained women for weeks waiting for the morals court judge to hear their case. Courts did not officially file charges against them until the suspect in the case attended a hearing. City officials found a way to use the specter of venereal disease to strip women of their freedoms and detain them for long periods, thus limiting their mobility, without official charges or probable cause.161

Sources regarding the operations of and women charged in morals courts were written from an elite male and female perspective, which presents difficulties in uncovering the thoughts and actions of the women arrested. It is possible to glean acts of resistance among these women in documentation relating to the courts. There are few instances of escapes through bathroom windows, but most telling is the cases of women who refused to submit to venereal disease testing. Those who did not agree to a medical examination remained jailed without a hearing until medical officials performed such a test. The Bureau of Social Hygiene reported three cases of women who refused venereal disease testing and a court official was overheard saying, “They’ll give us a fight on it, but they will submit later on,” indicating force was used to make women undergo medical examinations.162 Prostitutes also learned ways in which to navigate around the legal system by paying to obtain health certificates so that if they were arrested, they

161 In To ‘Joy My Freedom: Southern Black Women’s Lives and Labors After the Civil War (Cambridge and London: Harvard University Press, 1997), 227-230, Tera W. Hunter examines “work or fight” laws put in place during World War I to restrict black women’s mobility in the workforce. The war created new employment opportunities for black women and the laws invoked ideas of patriotism and civic duty to place women back into domestic servitude. Similar to the way venereal disease and public health was used to strip women of their freedoms and limit their mobility, “work or fight” laws served as a monitoring system for black women. Hunter uncovers a number of arrests that resulted from black women not taking positions of servility or not working hard enough as domestic servants and washerwomen.

162 Ibid, 362.
could secure bail promptly. These are hardly actions of women who are “feeble-minded” or “psychopathic.”

The sexual double standard present in the early twentieth century was evident in the workings of moral courts. Chicago had no ordinance in which a man was committed for any offense that involved prostitution. Women operating in a brothel or “disorderly house” received jail sentences while the men who owned the house received a $200 fine with no jail time. Men caught with prostitutes also were not required to undergo venereal disease examinations and received lighter sentences than suspected prostitutes receive. In the Philadelphia Morals Court, which only received cases of street-walking or the “lower-class” prostitute, working women typically received a six-month sentence while the men caught soliciting the prostitute for sex received a fine of $10 and court costs. Government authorities viewed women as the evil conduits of venereal disease to groups of seemingly innocent men seeking ways to relieve what society viewed as their natural and irrepressible sexual urges. Before the abatement of red light districts, prostitutes were seen as protectors of pure white womanhood, because without prostitutes the sexual urges of men would manifest itself in violent rapes. Ruth Rosen argues that throughout history women were forced into prostitution because it “constituted a necessary evil in that it provided an outlet for male sexual drives.” In the antebellum South, slave owners made black female slaves serve as prostitutes on plantations and in brothels so

163 Bascom Johnson and Paul M. Kinsie, “Prostitution in the United States,” Journal of Social Hygiene 19, no. 9 (December, 1933).
164 Worthington and Topping, 379.
166 Rosen, 9.
167 Ibid., 6.
that white womanhood would be protected from “uncontrollable” male sexual drives, but as Rosen states “the ‘protection’ of nonwhite women was not considered.”

War, an economic depression, and the need to maintain a fit and healthy fighting force turned society’s gaze onto the perceived immorality of women who were modernizing in a changing world. As law enforcement drove prostitution underground, social hygienists surfaced and employed a campaign based on fear mongering and seeped in moral righteousness to explain the dangerous spread of venereal disease. Part of this campaign involved the attempt to understand why the sex industry had experienced a boom during war and how to suppress the growing number of sexually liberated women.

Social hygienists diverged on the causes of prostitution. Psychiatrists who studied women quarantined or jailed often found mental deficiency as the reason for prostitution while others dedicated to the eradication of the trade blamed the economic conditions. The focus on economic conditions in relation to the increase in the number of prostitutes was especially poignant during the Great Depression. In 1932, Virginia Murray, director of the New York Traveler’s Aid Society, addressed the connection between the economy and the sex trade. She was one of the few to address the real problem of unemployment and limited opportunity, writing that “with mills, mines, and factories shut down all over the United States, the lives of whole families are broken up and thousands of girls are traveling about hunting work.” She noted that older women prostitutes also were on the rise because either they were widows seeking an income following the deaths of their husbands or they were the family’s only source of income after husbands became unemployed.

168 Ibid., 6.
169 Virginia Murray, “The Relation of Prostitution to Economic Conditions,” Journal of Social Hygiene 18, no. 6 (June 1932).
In their analyses of the social factors relating to prostitution, women reformers were more likely to blame the economy and capitalistic system and not the morals of the prostitute. Alida C. Bowler, research worker for the President’s Committee on Trends in Social Work, offered a scathing attack on capitalism, arguing that prostitution was an attractive choice because a woman can earn more in the trade than other occupations open to women. Bowler addressed wage discrimination and found that within a capitalist society, prostitution was but a natural choice. She urged officials to address the underlying economic factors, pleading with them not to “escape the fact that for her services as a prostitute the average physically attractive girl in a week will be able to make as much or more as she could earn in a month at the legitimate occupations for which she is qualified.”

This alone made it seem “but natural that many of our girls, pretty, but not so dumb, looking about for ways and means to increase their purchasing power, yield easily to the persuasive tongues of those who seek to recruit them.”

Women who entered prostitution in the decade preceding World War II became known as “Depression girls” because they became prostitutes out of financial distress and necessity. Few reformers connected prostitution to the economy and workforce discrimination. In fact, arguments used by Progressives during World War I continued into the 1930s and 1940s. Reformers still saw women who entered the trade as somehow morally or mentally deficient and used these judgments to explain away the great “Social Evil” without taking into consideration economic conditions and other societal changes.

171 Ibid, 478.
172 Johnson and Kinsie, 484.
that had taken place since World War I. There was a great deal of continuity in reform policies between the two world wars.

In her study on prostitution in America, Rosen argues that after 1910 prostitutes were one of the first populations that doctors tested for hereditary and genetic defects. Tests conducted by reformers and within the emerging psychiatric field were “flawed by functional illiteracy and language barriers,” but then used to determine feeble-mindedness as the leading cause of prostitution.\textsuperscript{173} Rosen found that classifying a woman as feeble-minded had nothing to do with mental capacity and was instead determined based on a “contempt for middle-class niceties and values.”\textsuperscript{174} Health officials attempted to delve into the psyche of quarantined women and suspected prostitutes, but class bias and sexism influenced their conclusions.

Walter L. Treadway, assistant surgeon for the United States Public Health Service, released his findings on the psychiatric studies of “delinquents” in 1920. He attempted to explain constitutional factors in prostitution by pigeonholing infected prostitutes into three personality groups: egoistic, seclusive and fatuous, and obtrusive. Treadway also described the egoistic woman as being “psychopathic” because she was domineering, lacked a motherly instinct, and had no desire for children.\textsuperscript{175} His description of the women he studied that fell within this group indicated that they were more likely to demonstrate acts of resistance to their imprisonment. He noted that “many were exacting in their demands on those who were responsible for their care and comfort

\textsuperscript{173} Rosen, 21.
\textsuperscript{174} Rosen, 22
and were constantly finding fault with the most trivial incidents." 176 Researchers documented egoistic women as the ones who “spoke freely” and had no respect toward authority. Treadway illustrated this type of personality through the example of one woman who was particularly displeased with her imprisonment.

The United States Army drafted the unnamed woman's husband during World War I and she followed him to his encampment. There she was arrested for prostitution (there are no details given as to her actions that led to this arrest) and subsequently tested positive for a venereal disease infection and quarantined at an industrial farm. After her arrest and quarantine, the woman “complained a great deal about her imprisonment, minimized her guilt and tended to find fault with everyone with whom she came in contact.” 177 Examples such as this reveal resistance among quarantined women that Treadway described as egoistic. They were “always complaining of being ill-treated” and “extremely assertive” of their rights. 178 Women also showed their contempt for such psychological examinations by skirting around questions using “minute details irrelevant to the questions.” 179 Treadway viewed strong-willed, out-spoken women as demonstrating a personality type that most likely led to prostitution. These women were described as “borderline psychopathics” because “their love affairs were very perfunctory, as they did not show the tenderness, self-sacrifice, and self-subordination

176 Ibid, 1577.
177 Ibid, 1578.
178 Ibid, 1579; See also Hunter, To ‘Joy My Freedom, 130-144. Hunter illustrates subtle forms of resistance by black domestic workers and washerwomen. Through such actions as taking scraps from the evening meal home or borrowing clothes before washing and returning them, black women asserted “the right to customary appropriations of products of their labor.” White employers did not see the underlying protest and significance of these actions and instead saw the “stealing” as a “moral failing of an inherently inferior race.” This is similar to medical officials not recognizing the small acts of resistance in women quarantined and instead blamed their acting out on an absence of morals and intellect.
179 Ibid, 1579.
that one would naturally expect in a genuinely deep love.”180 They rejected middle-class norms of society through their refusals to marry and have children. Their disregard for tradition led to Treadway’s conclusion that these women be “forever segregated from society.”

The second personality characteristic of suspected prostitutes was that of either being seclusive or fatuous. Treadway described seclusive women as being shy and fatuous women as demonstrating silly or stupid behavior.182 Treadway saw these women as “child-like” and potential victims of agents recruiting prostitutes. The third personality type was an “obtrusive” personality, which was characterized by mood swings from episodes of excitement to deep depression. Today, mental health experts may consider these women as manic-depressives, but Treadway linked their “manic” episodes to increased activity in the sexual sphere.183 In the case of one woman describing her manic episode, she told Treadway that she was “money mad” and earned $150 in one week as a prostitute at a rate of $2 per customer.184 Whether manic, shy, silly, or strong-willed, all personality types among women indicated a pre-disposition toward prostitution. Common among all women studied was “a lack of tenderness and regard for their paramours; that their sensual feelings were well developed, but there was no tenderness combined with these, a necessary requisite for the instinctive biological demands of mating.”185 Medical examiners did not submit men to the same scrutiny for visiting prostitutes. Psychiatrists found that the fundamental factors of prostitution are the “normal and aggressive

180 Ibid, 1582.
181 Ibid, 1580.
182 Ibid, 1584.
183 Ibid, 1588.
184 Ibid, 1589.
185 Ibid, 1592.
reproductive instinct of male and the ignorance, inferiority, and defenselessness of a large number of girls and women whose mental condition makes it difficult or impossible for them to make a living by legitimate means.”¹⁸⁶ Men were forgiven for their sexual transgressions while health officials criminalized women’s bodies and found immorality lying within their psyches. Women arrested for suspicion of prostitution and thus found infected with a venereal disease and quarantined were characterized as morally deficient simply because they did not meet middle-class mores of placing marriage and children above all else. They were free-willed women living a sexually liberated lifestyle in a society that condemned such actions. Their choice to live without husbands or children led health officials to label them as “psychopathic” and push for the permanent segregation of such women from society.¹⁸⁷ Psychological studies of suspected prostitutes demonstrate how health and government officials’ concerns went beyond the spread of venereal disease to controlling the movements and morals of women. The battle against women’s sexuality and mobility took on a new meaning during World War II, as America waged war on two fronts and against two different enemies: The Axis and women.

¹⁸⁷ Ibid, 1593; Christina Simmons, “Modern Sexuality and the Myth of Victorian Repression” in Passion and Power: Sexuality in History (Philadelphia: Temple University Press, 1989), Kathy Peiss and Christina Simmons, eds. 157–170. Psychiatrists compared the sexuality of women in the 1920s and 1930s with what Simmons argues is a myth of Victorian repression of sexuality. This created idea “rehabilitated male sexuality and cast women as villains if they refused to respond to, nurture, or support it.” She describes a “sexual revisionism” taking place in the 1920s and 1930s that revolved around a focus on rehabilitating male sexuality, attacking women’s power to assert control over male sexual needs, and creating a new female ideal. Even though old morals regarding the myth of sexual repression were being criticized and replaced with more tolerance for sexual activity, the idea that it should occur within marriage still reigned supreme. The creation of Victorian repression and transformation of sexuality in the 1920s and 1930s was about how best women can meet men’s natural urges. Within this framework, independent women who chose not to pursue monogamous husband-wife relationships went too far in sexual liberation because they cast aside men and tried to demonstrate too much control.
More attention was given to female sexuality and venereal disease during World War II, but efforts to control women’s movements and bodies originated with the United States’ entry into the first Great War. Historian Marilyn E. Hegarty argues that there was a change in thinking from World War I to World War II. By the 1940s, government and health officials believed that they should not interfere with white male heterosexuality.\textsuperscript{188} However, this was the case since the early twentieth century and only intensified with the United States entry into World War II. Congress passed the Chamberlain-Kahn Act in 1918, which allowed for the quarantine of women suspected of venereal disease infections or sexual immoral behavior for the protection of the military and naval forces. During 1941 congressional hearings on the May Bill, which prohibited prostitution within “reasonable” distance of military and naval establishments, the Chamberlain-Kahn Act was cited as a “test” that proved the potential success of the May Bill.\textsuperscript{189} Andrew J. May, a Kentucky senator and chairman of the House Committee on Foreign Affairs, introduced the measure, which was the first to give federal government control over prostitution within the states. State authorities enforced the Chamberlain-Kahn Act on the local level. During hearings on the May Bill, senators expressed concern over the constitutionality of federal interference with areas lying outside military encampments.

Federal government’s increased role was justified by describing venereal disease infection among soldiers and sailors as a national “emergency” that “city, county, and state procedures cannot be depended on to meet.”\textsuperscript{190} The failure of municipalities to effectively control the spread of venereal disease through prostitution necessitated federal

\textsuperscript{190} Ibid, 599.
government action. Legislators cited the 1919 Supreme Court ruling in *McKinley et al. vs. the United States* as the constitutional power behind the May Bill. A Georgia court convicted the plaintiffs in the case of operating brothels close to a military encampment in the southern part of the state. They challenged their sentence, arguing that Congress had no constitutional authority to regulate where such “houses of ill fame” are constructed. The Supreme Court ruled, however, that while raising and supporting armies, Congress “may make rules and regulations to protect the health and welfare of the men composing them against the evils of prostitution.” Now backed by legal precedent, the federal government abandoned a strategy of regulating prostitution and began an intensive repression campaign.

With a renewed sense of urgency, military officials stressed the importance of controlling the sexuality of women during wartime. The prostitute became “a symbol of sexual excess and the easiest target for regulation.” In a speech at the 1940 American Public Health Association annual meeting, Dr. Charles R. Reynolds, retired major general of the U.S. Army told his audience that “venereal diseases cannot and do not originate in the Army. Throughout military operations it is the prostitute who supplies the venereal infection; it is the prostitute who must be controlled to prevent venereal diseases in the military forces.” Ignoring the fact that to be infectious, one must become infected, Reynolds relieved men of all responsibility in contracting and spreading venereal disease and placed the burden on women, particularly “sexually immoral” women who “were seen as both physically and morally responsible for the spread of

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191 Ibid, 600.
venereal disease. They were seen not merely as agents of transmission but as inherently
diseased, if not the disease itself.”¹⁹⁴ The movement from regulation to repression
characterized prostitutes as predators who prey on innocent military men and as a
domestic enemy to America’s fighting force.

Figure 3: This is one of many posters produced during World War II that warned
against having casual sex with women in America. National Library of Medicine, 1940.

Harry P. Cain, mayor of Tacoma, Washington in 1940, highlighted his city’s shift
from regulation to repression in an account militarily titled “Blitzing the Brothels.”
Government agencies billed the account as an American success story where Tacoma

¹⁹⁴ Spongeberg, 6.
“blasted its houses of ill fame and sent the whole tawdry array of madams, procurers, pimps and commercialized ‘femmes de guerre’ packing.”

These ‘femmes de guerre’ were described as enemy agents working with the Axis to defeat America. The battle in Tacoma placed the “old guard” of World War I (regulation) against the “new guard” of World War II (repression) and the local government viewed the new repression measures that prevailed after regulation as an unequivocal failure.

Cain first listened to the “old guard” who persuaded him that “men must have outlets for their passions, that wars are fought by virile men who conquer foes on the battlefield — and the woman on the street.” In its attempts at regulation, Tacoma created a system of surveillance, which photographed, fingerprinted, followed, and subjected prostitutes to weekly venereal disease tests. This system of regulation failed as madams used the measures to bring in more girls and market them as certifiably free of venereal disease. Surveillance of the enemy had failed, “the first round of the battle had been fought, and the victory had gone to the spirochete and the gonococcus.”

The city’s next line of defense was repression, which involved a proposal to close every house of prostitution — to “close them tight and keep them closed.” Tacoma held a mass meeting to educate the public about its new repression campaign and brothel owners attended this meeting. Cain reported that “from the first the madams with their underworld shrewdness must have known that their hour had struck.”

The Social Hygiene Association cited the city’s effective regulation of prostitution for the drop in

195 Harry P. Cain and Sidney B. Taylor, “Blitizing the Brothels,” *Journal of Social Hygiene* 29, no. 9 (December 1943).
196 Ibid, 596.
197 Ibid, 597.
198 Ibid, 598.
199 Ibid, 598.
venereal rates. Cain proclaimed that “Most prostitutes everywhere are infected. Under regulation or non-regulation, they are and always will be infected. Close their slimy dives, drive them out of town and their menace is ended.”\textsuperscript{200} The closing of brothels in Tacoma and across the United States did not eliminate prostitution, but sent it underground, making the trade more dangerous for women who no longer had the protection of housing and became victimized by pimps.

In the age of repression, the body of the prostitute became synonymous with disease, infection, and evil. However, prostitutes bared no symbolic “A” marking their immorality, which placed all civilian women at risk for being categorized as enemies working for the Axis power. In an editorial supporting the quarantining of women suspected of having venereal disease, the American Public Health Association claimed that “prostitution is the great reservoir of venereal disease” and diseases “have always been a menace to the health and efficiency of soldiers and sailors.”\textsuperscript{201} The concern among medical professionals focused on maintaining a fit fighting force of men and not the health of women. Prostitutes were marked as enemies of the Allied Powers military officials urged citizens to “give neither aid nor comfort to the enemy.”\textsuperscript{202} The U.S. Armed Forces initiated a campaign in the 1940s that urged the control of women’s sexuality so that soldiers did not become “easy prey to the wiles of prostitution, or to any other form of vice.”\textsuperscript{203} Anti-vice propaganda relieved men of any responsibilities for their actions and placed the burden of maintaining a healthy fighting force, and essentially winning the war, on the backs of women. Studies that concluded venereal disease

\textsuperscript{200} Ibid, 599.
\textsuperscript{201} “Prostitution Is An Axis Partner,” \textit{American Journal of Public Health} 32, no. 1 (January 1942).
\textsuperscript{202} Ibid, 86.
\textsuperscript{203} F.R. Lang, “What the Navy is Doing to Protect Its Personnel Against Venereal Disease,” \textit{American Journal of Public Health} 31 (October 1941): 1034.
originated in women perpetuated the common conception that “immoral” women were diseased Axis partners. Reynolds warned public health officials that venereal disease was the prevailing threat to the future of America and its military. Citing incidents of venereal disease dating back to the Revolutionary War, Reynolds argued that “it is the prostitute who supplies the venereal infection; it is the prostitute who must be controlled to prevent venereal diseases in the military forces.” The danger did not lie with the soldier who visited a prostitute, but with the prostitute alone. Under the auspices of venereal disease and war, women’s sexuality became a theater in which battle raged with the greatest casualty being concern for women’s health and the effects of venereal disease on their bodies and lives.

The Army relied on cooperation with the civilian population in the repression of prostitution. Commander Charles S. Stevens, head of the Division of Preventative Medicine for the U.S. Navy’s Bureau of Medicine and Surgery, extolled that the United States must control the spread of venereal disease to “keep as many men at as many guns as many days as possible” and to “keep as many men at as many tools as many days as possible.” His solutions to controlling venereal disease went beyond the repression of prostitution. He described the practice as “vicious” and “demoralizing,” and the women in the trade as “exploiters” of seemingly innocent men. Stevens urged physical examinations for all civil service personnel prior to employment. Job applicants were not eligible for employment if they showed a history of syphilis and the military suspended their eligibility for employment until treatment the applicant received for gonorrhea

204 Ibid, 1276.
infections. Similar to other military officials, he insisted that seamen acquired venereal disease from the civilian population and infection did not originate in the Navy ports. The strength of America’s fighting force and future security in the war depended on “a tremendous effort in the civil communities to place the infected population under treatment until they are no longer infective.” Stevens’ suggested plan also included a campaign of law enforcement to suppress commercialized prostitution, using force to treat the infected, and a plan for rehabilitation of prostitutes. The third aspect of his plan was an afterthought, as he offers no details on potential rehabilitation programs, but carefully characterizes prostitutes as villains luring unwilling men into their lairs of immorality and disease.

Military propaganda surrounding the need to support military men and keep them healthy through the repression of vice inundated society. Beginning in 1940, communities took greater responsibilities in ensuring men were “fit to fight” through strict enforcement of the existing laws dealing with the practice of prostitution. Law enforcement was more active in shutting down brothels and jailing streetwalkers, but the military sought to change public opinion regarding not just the sex trade, but places deemed as likely spots for clandestine prostitutes.206 Honky-tonks, dance halls, hotels, and rooming houses were all marked as areas where the potential to encounter prostitution, and hence venereal disease, was high. A.B. Price, a former assistant surgeon for the Louisiana State Board of Health and F.J. Weber, assistant surgeon with U.S. Public Health Service in New Orleans, proposed the tracking of women who worked as waitresses or hostesses in cafes, beer parlors, and tourist camps near army encampments.

They urged health officers to create a roster of “all female employees in establishments serving food and drink” and submit these women to “a routine examination for communicable disease.” Their proposal labeled all women who operated in public places as infected prostitutes, even though many were waitresses or women men paid to dance with in taxi halls.

Amusements like dance halls and resorts were representative of a working-class sexuality that was different from middle-class standards of sexual behavior, according to Kathy Peiss’ study of working-class culture. It was in these places that cultural differences emerged among the classes. In dance halls, working women’s dancing emphasized a freedom of movement and touching, while middle-class women were still doing the waltz and two-step. Her analysis of vice reports and reformers’ observations indicate a middle-class misunderstanding of working-class culture, which did not relate respectability to chastity. Peiss holds that working-class women did not shy away from premarital sex with steady boyfriends or with engaging in sex for favors or “treats.” She writes that this “fluid definition of sexual respectability was embedded with the social relations of class and gender, as experienced by women in their daily round of work, leisure, and family life.”

Health and military officials shared the same middle-class values of sexuality as reformers and vice officers. This clouded view of working-class culture led to the belief that prostitution was common practice in places of amusement like dance halls and bars. The military shaped its policy on venereal disease control during World War I with the Chamberlain-Kahn Act. Restrictions on women who

207 Ibid, 915.
209 Peiss, 67.
operated in entertainment venues began during World War I, but came under increasing scrutiny during World War II. The policy of control for the areas and civilians in the outliers of military encampments during both wars ignored any responsibility the soldier or seaman may have in spreading venereal disease. When it came to its own men, the military was concerned with not controlling their sexuality, but with treating any venereal disease infections contracted.

In public, the Army editorialized the need for “clean” activities for its servicemen like sporting events and theatre outings. But behind closed doors, officials freely gave out prophylactic kits to soldiers and invested money in early intervention and treatment of venereal disease infection. Soldiers received the best treatment possible for venereal disease while military and medical officials casted aside treatment and early intervention for women civilians to carry forth a policy of blame and scapegoating. In Mary Louise Roberts’ analysis of the U.S. Army’s venereal disease policies during its liberation of France in 1944, she finds conflicts arising between the French and Americans centered on the hypocrisy of the U.S. Army’s reaction to venereal disease. Roberts argues that both the French and U.S. Army believed that sex was necessary to maintain male vigor, but prostitution became a contentious issue between the two nations from 1944-1946. On

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210 Elizabeth Fee, “Venereal Disease: The Wages of Sin?” in Passion and Power: Sexuality in History, eds. Kathy Peiss and Christina Simmons (Philadelphia: Temple University Press, 1989) 179. Beth Bailey and David Farber also illustrate the contradictory nature of the military’s policy on venereal disease as it relates to prostitution in Hawaii during World War II in The First Strange Place: Race and Sex in World War II Hawaii (Baltimore and London: The Johns Hopkins University Press, 1992), 95-132. Even though Hawaii was part of America, it was off the mainland and viewed as culturally different. Bailey and Farber detail Hotel Street, the sex district in Hawaii. They argue that the U.S. military and Hawaiian officials approved of regulated brothels because “in the face of what they saw as unstoppable urges and acts, the houses seemed to keep venereal disease rates relatively low.” Similar to Ruth Rosen’s argument in The Lost Sisterhood, prostitutes were used to protect “respectable” white women from rape. The military also saw relations with prostitutes as a morale booster for its men, saying that “any man who won’t fuck, won’t fight.” Military police heavily regulated the brothels, setting the price at which the women could charge for their services and even stepping in when Hawaiian law officials tried to increase supervision of vice and push the women back into one district of operation. Prostitutes went on strike against this crackdown in 1942 and won a compromise that allowed them to appear in public and operated outside the brothels.
American soil, the May Act served to repress prostitution near military encampments, but in France GIs freely engaged in sexual relations with French women and often did so in public locations such as parks, cemeteries, and streets.\textsuperscript{211} These displays of public sex illustrated the hypocrisy of the U.S. Army’s policy toward controlling venereal disease, as “the army did not really care if a GI had sex with a French woman.”\textsuperscript{212} Roberts writes that while sex was condemned, the military made condoms available and privately supported brothels. The military’s actual policy on venereal disease and sex was discretion. The American presence in France and societal assumptions regarding the “natural” needs of men caused a systematic exploitation of French women and contextualized their bodies as places soldiers could conquer off the battlefield. The military’s disregard for policies enacted at home poisoned Franco-American relations. Roberts argues that “by flaunting its disregard for its own sexual and social norms in France, the U.S. Army related a potent message concerning its opinion of the French people: that they were hardly worthy of good behavior on the part of the GIs.”\textsuperscript{213}

Controlling sexual encounters abroad was of little concern to medical and military officials. Providing adequate treatment for women quarantined with venereal disease in America also was of no concern for officials. The government created rapid treatment centers in the 1940s to control venereal disease in America. These centers administered treatment for syphilis and gonorrhea to women who were not trusted to follow traditional treatments for venereal disease.\textsuperscript{214} The process was intense and involved several IV drips.

\textsuperscript{212} Ibid, 1006.
\textsuperscript{213} Ibid,1029.
\textsuperscript{214} John Parascandola, “Quarantining Women: Venereal Disease Rapid Treatment Centers in World War II America,” \textit{Bulletin of the History of Medicine} 83, no. 3 (Fall 2009), 442.
of arsenical drugs combined with bismuth compounds to treat syphilis. Sulfa drugs taken orally easily treated gonorrhea. The process was less intense than treating syphilis. In his study on rapid treatment centers, John Parascandola finds that the arsenic drugs were complicated to administer and sometimes had toxic side effects. Because of these side effects, “patient compliance with this regimen was sometimes a problem, and public health officials were doubtful that the average prostitute would stick with the therapy for the duration.”\textsuperscript{215} Women forced into these centers went through a grueling process where they had to lie in bed daily for six to eight hours while receiving an intravenous drip of an arsenic-based drug. Doctors trained nurses to look for signs of chemical toxicity and 1946 statistics indicate that one per three hundred patients in all centers died while being treated.\textsuperscript{216}

The majority of women who underwent treatment at rapid treatment centers did not do so voluntarily. They were quarantined under state laws that allowed the isolation of infectious persons and they were not able to leave unless told by medical staff that they were free from venereal disease. Parascandola argues that local authorities detained women for a variety of reasons and not just for prostitution. Essentially, any suspicious behavior was subject to the quarantine and suspension of writ of habeas corpus. These centers were not about treating infected women for the good of their health, but about containing a risk to the health of the nation’s military. The term “rapid” in and of itself suggests the disregard for women’s health. Toxicity from the arsenical compounds was a concern because of the rate at which nurses administered the treatment. With prostitutes singled out as the carriers of disease, there was very little emphasis placed on vocational

\textsuperscript{215} Ibid, 442.
\textsuperscript{216} Ibid, 444.
training or rehabilitation in these facilities that focused only on stopping the spread of venereal disease to men. In fact, Parascandola indicates that very few male patients were brought into the centers. He cites a 1944 study of 146 patients in a Washington, D.C., rapid treatment center where there were 119 women and only twenty-seven men.\textsuperscript{217}

The forced nature of these centers represented a dangerous precedent concerning the control of women during wartime. The government effectively used state quarantine laws to suspend civil liberties under the guise of protecting the nation’s health during wartime.\textsuperscript{218} Women not of the middle or upper classes were the targets of these laws and became the “Typhoid Marys” of venereal disease. The actions taken by medical professionals and military officials illustrated a complete disregard for the health of these women out of concern for keeping men “fit to fight.” If health and stopping the spread of venereal disease were the real policies behind the repression of prostitution, quarantine facilities, and rapid treatment centers, then authorities would have targeted men as well as women were and held to the same exacting standards of morality and sexual control. This was not the case. Social reformers, medical officials, military commanders, and governmental authorities victimized, stigmatized, and scapegoated women during the campaign against venereal disease in wartime. Their health was inconsequential to what America saw as its most important citizens — men who conquered on the battlefield and in the bedroom.

\textsuperscript{217} Ibid, 457.
\textsuperscript{218} In \textit{To 'Joy My Freedom}, Tera Hunter demonstrates how a similar process of suspending civil liberties occurred among domestic servants in the early twentieth century. White southerners blamed domestic servants for spreading tuberculosis through contact with clothes and food despite the inability of TB to spread in that manner. Atlanta passed an ordinance in 1905 that required washerwomen to have sanitary inspections of their homes and allowed police to enter the home in search of germs. Incidents of contagions in the home were reported to the health boards. Hunter argues that “both black and white poor women were subjected to invasions of their privacy under the pretext of health care.”
Epilogue

The focus on preventing infant mortality and anti-venereal disease campaigns intersected in often disturbing ways. A theory of eugenics layered beneath many health initiatives that arose in the 1920s. Public health work in Appalachia and the restriction of prostitution and women’s sexuality provides a window to analyze how eugenics also shaped the campaign to control venereal disease and “professionalize” motherhood. The ways in which women’s health took a backseat to ensuring a fit and superior nation of healthy men and boys brings to light significant questions about the role of eugenics in shaping womanhood and how medical professionals and reformers viewed females in society.

The science of eugenics deeply influenced venereal disease policies and maternal health organizations.219 In his study of eugenics and public health, Martin S. Pernick found that associations concerned with the prevention of infant mortality and anti-venereal disease organizations had formal sections of eugenics.220 He expanded the definition of eugenics to include not just having “good” genes but also “being a good parent, raising good children, or promoting a good health for future generations.”221 Eugenics had roots in Progressive Era reform and influenced many public health officials and workers who entered women’s homes throughout rural regions. On the surface, it

219 Margaret Sanger’s work with the 20th century birth control has come under criticism by historians who highlight her eugenic views in relation to birth control measures. In a February 1918 article for the Birth Control Review, “Morality and Birth Control,” Sanger highlighted her eugenic views, writing that “all of our problems are the result of overbreeding among the working class, and if morality is to mean anything at all to us, we must regard all the changes which tend toward the uplift and survival of the human race as moral.” For more on Sanger and the birth control movement, see Ellen Chesler, Woman of Valor: Margaret Sanger and the Birth Control Movement in America (New York: Simon & Schuster, 2007). Also see New York University’s Margaret Sanger Papers Project online resource at www.nyu.edu/projects/sanger.
221 Ibid., 1769.
may seem problematic connecting eugenics to public health policies, but the two influenced each other with different goals in mind.

Unlike eugenics, public health reformers realized that genes had nothing to do with the prevalence of venereal disease or infant mortality. In fact, initiatives like the Sheppard-Towner Act viewed all women capable of giving birth to healthy children through education, sanitation and professionalization of childbirth practices. However, Molly Ladd-Taylor compares government funded health services with compulsory sterilization influenced by eugenics and illustrates how the “two progressive and even eugenic policies that rationalized reproduction from the 1910s to the 1930s were based on very different welfare policies.” Sheppard-Towner initiatives were justified in terms of race progress and once the Great Depression occurred, sterilization was “portrayed as a bargain for taxpayers who would otherwise have to pay for charity or the costs of institutionalizing the ‘unfit and sick’ children.” Grace Abbott, chief of the Children’s Bureau, had an honorary post on the American Eugenics Society board and the science rising from eugenic studies influenced many maternalists, even though the goal of saving babies and not letting “nature” take its course contradicted eugenic thought.

The connections between eugenicists and maternalists raise interesting questions about possible connections between venereal disease control policies, eugenics, and the medical quarantine practices of women in the United States. More than 33,000 people were legally sterilized by 1939 with the majority having the procedure done against their will. Doctors used compulsory sterilization on women deemed “feeble-minded” even

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223 Ibid., 138.
224 Ibid., 142.
though it was often an arbitrary designation placed on working-class and poor mothers. Steven Noll demonstrated the tragedy of sterilization policies in his study of Willie Mallory, a poor Virginia mother who sued Dr. A. S. Priddy, superintendent of the Virginia State Colony for the Feeble-Minded, for damages resulting in her forced sterilization in 1917. Mallory lost her case, but her story is important in understanding how the medical community targeted and stripped women of their civil liberties out of concern for the race and the nation.

The idea that the “feeble-minded” were forced to undergo sterilization procedures also leads to interesting questions concerning prostitutes in venereal disease quarantine facilities during World War I and World War II. Medical professionals in the field of psychiatry entered these facilities to determine the cause of prostitution and many of the women, whether proven to be prostitutes or not, were deemed “feeble-minded.” If the state saw sterilization of the “feeble-minded” as necessary for the betterment of the nation, then what did this mean for women under quarantine? Analyzing what records may exist from these facilities may reveal an even darker secret in American history related to venereal disease control policies and may put names and stories to the more than 33,000 people who were subjected to forced sterilization.

Susan Cahn’s study of adolescent girls’ sexuality in the South highlights a disturbing reality regarding the connections between sex, eugenics and sterilization. She argues that sterilization procedures began with young white women who were viewed dangerous to the society’s rigid definitions of sexual behavior and race relations. Eugenicists “believed that they genetic purity of ‘the race’ rested on the sexual purity of

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young white women, who were responsible for the future of ‘nordic civilization.’”

Her study of farm colonies in the South found that a number of women were sterilized for gonorrheal infections. Doctors misled women to believe that the only cure for gonorrhea was sterilization, which illuminates important questions regarding medical ethics and venereal disease control policies in the United States. Reformers used the theory of eugenics to justify their work among Appalachian mountain whites. Residents of Appalachia were thought to have “pure” Anglo-Saxon blood and there was an overt need to maintain this pure blood line. Cahn argues that despite this theory, “reformers of the period identified the same group of poor white southerners as a source of racial degeneracy justified compulsory sterilizations.”

This work challenges scholars to further investigate sexuality in Appalachia through the lens of Cahn’s work on adolescent female sexual “deviance” and my focus on adult female sexuality and the politics of mother-blaming. The ambivalent attitude of the medical community toward women’s health may indeed only be the beginning of a history where women’s wombs and reproduction capabilities belonged to the state and where they were all too replaceable in a society that valued men more than women.

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Evelyn Ashley Sorrell
Birthdate: September 14, 1983, Mount Sterling, Kentucky

EDUCATION:
Morehead State University, Morehead, KY
B.A. in History and Journalism, 2007 (Magna Cum Laude)

ARTICLES IN REFERENCE WORKS:

PROGRAM PARTICIPATION:

AWARDS AND HONORS:
Victor Howard Award, Morehead State University, 2007, awarded for best senior thesis.
George C. Young Scholarship, Morehead State University, 2007, scholarship award for top history student.
W. David Brown Scholarship, Morehead State University, 2005-2007, scholarship award for best journalism student.
Named Outstanding Undergraduate Student in the Department of Communication and Theatre, 2006, Morehead State University
Phi Alpha Theta, Morehead State University chapter, 2007
Phi Kappa Phi, collegiate honor society, 2006-present