Reproductive Subjects: The Global Politics of Health in China, 1927-1964

by

Joshua Hubbard

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Associate Professor Pär Cassel, Co-Chair
Professor Wang Zheng, Co-Chair
Professor Susan Greenhalgh, Harvard University
Professor Mrinalini Sinha
Professor Elizabeth Wingrove

Joshua Hubbard

hubbardj@umich.edu

ORCID iD: 0000-0001-5850-4314

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Note on Transliteration

The geographic reach and temporal scope of this dissertation have made it difficult to maintain both historicity and consistency with regard to transliteration. Many of the actors that fill these pages lived under both Nationalist and Communist regimes, with extended stays in Europe, North America, or elsewhere in the world. Throughout their lives they used different English transliterations of their Chinese names, often simultaneously using English and variably transliterated Chinese names depending on particular audiences. Many actors indicate no transliteration preference in the archival sources, but appear in foreign accounts with inconsistent transliteration.

When an actor used a consistent English name or non-pinyin transliteration (eg: Kuomintang, T.V. Soong), I refer to them as such, often providing their Chinese name as well in characters at the first mention. This is the case for many Nationalist-era actors and institutions that later moved to Taiwan. For all others (including those who never used pinyin but also never established a consistent preference for transliteration), I default to pinyin, which has become standard for transliterating Chinese names in the historiography.

Abstract

In the middle third of the twentieth century, the distinct aims of international health organizations, new imperialisms, transnational feminisms, and Chinese state-building converged on the reproductive functions of Chinese women. *Reproductive Subjects* probes the reciprocal relations among these diverse actors to ask how and why childbirth and mothering in China proved integral not only to Chinese state-building, but also to early ventures in international health and a realignment of global political power in the decades surrounding the Second World War. *Reproductive Subjects* moves between scales, reading local, provincial, and national public health reports in China alongside the correspondence of international organizations and the writings of Chinese health professionals who studied and worked throughout Asia, Europe, and the Americas from the 1920s to the 1960s. By bringing together these dispersed archives, *Reproductive Subjects* outlines a global conjuncture—characterized by the flourishing of international organizations, unequal relations between putatively autonomous nation-states, the woman question, and the ascendancy of biomedical public health—that imbued Chinese women's reproduction with global political significance. This project demonstrates the multifaceted political utility of maternal and infant health (MIH) resulting from the linking of demographic measures of mortality to medicalized notions of women's shared yet variable capacity to reproduce and nurture. Though often framed within the rhetoric of Chinese nationalism, Chinese MIH remained critical to the broader work of foreign and international actors to manage international health and trade in the Pacific. These aims proved compatible—in fact, integral—to contemporaneous efforts to forge a Chinese state with the territory, population,

and administration required for legibility to an emerging international order of nation-states. Chinese-government propaganda emphasized scientific mothercraft as gendered service to the state. However, Chinese feminists in alliance with an international maternalist movement reframed the "facts" of maternal and infant mortality as evidence of state failure and demanded legal protections for health and welfare. By tracing the careers of health advocates whose lives crossed the founding of the People's Republic of China in 1949, *Reproductive Subjects* further demonstrates how the personnel and precedent of Nationalist-era MIH programs proved critical to the later management of both mortality and fertility in Communist China, Nationalist Taiwan, and the Cold War world.

Chapter 1: Introduction

On November 19, 1950, more than thirty Chinese women doctors and midwives gathered in Beijing. The meeting, jointly organized by the city's Women's Federation and Medical Federation, demonstrated the critical place of women's reproductive health for both women's political engagement with a newly founded state and China's status among nations. As reported in the *Guangming Daily,* the women gathered for the explicit purpose of "exposing the evils of U.S. imperialism," recently made manifest in the Korean Peninsula. Nationalistic rhetoric permeated the meeting, as, in succession, the women stood to "express resolute support for the movement to 'resist the U.S. and help North Korea.'"[1] Dr. Ye Shiqin 葉式欽, among the most outspoken participants at the meeting, asserted, "In the past, we remained extremely afraid of foreigners. Now, the Chinese people stand up together. When you invade us, we will give you the cudgel. We no longer fear you in any way."[2]

The stakes of Ye's repudiation of U.S. imperialism became heightened due to her precarious place amid a recently and radically altered political landscape. Ye, like many of the other medical practitioners at the 1950 meeting, had been deeply implicated in U.S.-based ventures in China before the Communist victory of 1949. Since 1948, Ye had held the post of Director of the First National Midwifery School (FNMS) in Beijing, an enterprise designed by

[1] Shi fulian 市妇联, "*Nü yiwu gongzuozhe juxing zuotan jianjue biaoshi qunali kangmei yuanchao fayanzhe fenfen yong juti shishi jielu meidi zui'e* 女医务工作者举行座谈坚决表示全力抗美援朝发言者纷纷用具体事实揭露美帝罪恶," Guangming ribao《光明日报》, November 22, 1950.

[2] Ibid.

the Rockefeller Foundation's International Health Division (IHD) to extend its operations in China. As the IHD partnered with the League of Nations Health Organization (LNHO), various other U.S.-based philanthropies, and the Chinese Nationalist government, an assemblage of political interests shaped and sustained a multidirectional network of maternal and infant health (MIH) institutions that, by 1949, stretched from Beijing to the Silk Road and from the Yangzi Delta to the Burma border. Due to the international actors shaping its development, this network became further linked to institutions throughout Asia, Europe, and the Americas, making Chinese experiments in MIH integral to early projects aimed at managing women's reproduction on a global scale. In 1950, the women medical practitioners at the Beijing conference framed these earlier endeavors in which they had participated as insidious operations of imperialism that proceeded under the cover of benevolent humanitarianism. Leng Bing 冷冰 of the Number Two Women's and Children's Health Clinic argued,

> American imperialists invaded us through a sinister method of murder with invisible blood. They wielded emergency aid, supplies, and the founding of schools as a means of lulling the Chinese people into apathy. Now, we fully and clearly understand. Now, they invade Korea and threaten our country's safety. This crazy dog has already bitten us. We must pick up a cudgel and strike it.[3]

Like Ye Shiqin, Leng repudiated the pre-revolutionary origins of her MIH practice as aiding U.S. interventions in China. Using state scripts, both women claimed a strategic position both to evade political persecution and continue their highly politicized work to advance the health and wellbeing of women. According to Women's Federation Secretary-General Hu Yizai 胡一哉, this act of repudiation proved sufficient to establish a new political basis for their continued medical practice. She reported, "These medical workers not only want to treat the illness of one or two people; they also aim to treat the illnesses of society. Everyone [at the meeting] had

[3] Ibid.

grasped the weapons of science, so now they can use these weapons to struggle against American imperialism."[4]

By 1950, Ye Shiqin had become well-practiced in framing her medical practice and political aims within state ideology. Her path to the helm of FNMS included positions within varied levels of the Nationalist state's public health system. In the wartime Nationalist capital of Chongqing, Ye had simultaneously held positions in municipal hospitals and the Sichuan Provincial Health Institute, where she served the aims of local and national governments to perfect, discipline, and expand the population subject to the Nationalist state's authority. Through the training of midwives later dispatched to rural areas and individual households, Ye, like many others among China's "second generation" of women doctors, extended state surveillance to childbirth and childrearing, making the most intimate matters of familial life subject to public and political scrutiny. Ye's appointment at FNMS in 1948 implicated her further in the aims of a disciplinary if, by then, failing state, which had long emphasized the compatibility of MIH with fascistic ideologies that appropriated women's reproductive labor to advance militarist aims. A prolific writer, Ye herself often explicitly framed her work in MIH within a vocabulary of modernization, eugenics, and nationalism, highlighting the political stakes of her medical practice to accommodate the political context in which she operated. For example, in a 1939 article, Ye wrote, "MIH is the most foundational work for saving the country. To have a strong country (*guo*) we must first strengthen the race (*zhong*). Advancing the health of pregnant and parturient women is the first requirement."[5] Here, in terms starkly different from those she uttered at the Beijing conference eleven years later, Ye asserted the validity of her

[4] Ibid.

[5] Ye Shiqin 葉式欽, "*Fuying weisheng* 婦嬰衛生," Funü shenghuo 《婦女生活》7, no. 8 (1939): 20.

medical practice in eugenicist terms, affirming women's reproduction as a valuable contribution to the advancement of the Chinese race and the Nationalist state's war against Japan.

Beneath her engagement with the ideologies of both Nationalist and Communist states, international encounters shaped Ye's personal commitments to MIH. Immediately prior to her post at FNMS, Ye had worked as an apprentice to American Mary Breckinridge in rural Kentucky under the auspices of the Frontier Nursing Service. This encounter honed and affirmed her commitment to Chinese investments in midwifery specifically, given its utility for reaching women in rural and remote areas with few doctors and fewer hospitals. For Ye, witnessing the bodily suffering of women across borders and the varied resources available to women based on region, urbanity, and class fostered a feminist consciousness that maintained an international view of justice, solidarity, and the importance of access to healthcare.[6]

Ye's articulation of the political consciousness animating her medical practice across varied media included explicit engagement with women's movements within China and around the world. She consistently pointed to the global conditions undergirding her choice to promote biomedical midwifery and mothercraft. Throughout the later years of the Nationalist period (1927-49), Ye authored articles affirming women's indispensable value to both national and global governance. However, she often emphasized the reciprocal relations between women and the state, contributing to feminist debates over the subject, scope, and aims of the Chinese women's movement. Like many of her contemporaries, Ye affirmed national and international investments in women's reproduction to legitimize feminist political claims to suffrage, healthcare, and welfare. As she and her comrades argued in print and in the representative organs

[6] Ye Shiqin 葉式欽, "*Kenta* (Kentucky) *zhuchanshi fuwu tuanji* 肯塔 (Kentucky)助產士服務團記," Zhuchan xuebao《助產學報》1, no. 1 (1949): 41-44; see also Ye Shiqin 葉式欽, "*Funü dangzheng yu shijie heping* 婦女當政與世界和平," Zhenglun 《政論》1 (1948): 23-24.

of the Nationalist state, women's enactment of scientific mothercraft depended on state resources and legal protections to make healthcare readily accessible across differences of region, urbanity, and class. In one article on the issue of midwifery, she pointed to persistently high rates of infant mortality in China as state failure, echoing the claims of petitions made by feminists in representative bodies of the Nationalist state. After noting a mortality rate in China more than four times that in Europe or the U.S., Ye wrote "The life of the people is to a state, as the life of an infant is to a household. The responsibility of the government to its people is like the responsibility of parents to nurture."[7] Elsewhere, Ye cited widely held assumptions regarding women's unique ability to nurture as evidence that their obtainment of suffrage would thwart men's militarist tendencies and bring about world peace.[8]

In her embodiment of MIH's varied significance for global health, Chinese state-building, foreign philanthropy, and international feminisms, Ye mirrored her more famous predecessor, Yang Chongrui 楊崇瑞(also known as Marion Yang). Ye became Director of FNMS when Yang, among the original architects of the Nationalist state's MIH apparatus, left China to shape the development of the World Health Organization in the later 1940s. After the Communist victory of 1949, Yang returned to China to direct MIH programs overseen by the Ministry of Health of the People's Republic of China (PRC). Since the 1920s, Yang had been at the center of the distinct projects of U.S. philanthropy, international health, Nationalist state-building, and feminism across borders, as they converged on the reproductive functions of Chinese women. With her return to China and early work in the Ministry of Health, Yang, like

[7] Ye Shiqin 葉式欽, "*Zhongguo weihe yingshe zhuchan zhuanke xuexiao* 中國為何應設助產專科學校," Zhuchan xuebao《助產學報》1, no. 3 (1948): 6-8, 6.

[8] Ye Shiqin, "*Funü dangzheng yu shijie heping,*" 23-24.

Ye and many other Chinese women who fill the pages of this dissertation, reframed her medical practice, adapting what was by then a decades-long project to promote biomedical childbirth and childrearing for the political demands of a newly founded government.[9]

The title of this dissertation, *Reproductive Subjects,* highlights the varied political actors and aims surrounding biomedical reforms to childbirth and mothering in China during the middle third of the twentieth century. From the view of international health organizations and their allies, Chinese women became medical "subjects" of public health policy and experimental ventures in new modes of imperialism. For many Chinese officials, the management of women's reproductive health became a method of expanding and disciplining political "subjects" of the Nationalist and Communist states. However, the intertwined projects of international health organizations and Chinese states unexpectedly produced feminist "subjects," who shaped the design and development of public health schemes, leveraging national and international investments in women's reproduction to advance political claims for and by an increasingly capacious category of women.

This dissertation probes the constellation of distinct political projects that converged on the reproductive functions of Chinese women during the Nationalist decades (1927-49) and continued, in varied form, thereafter. I argue that MIH's unique articulation of intersecting hierarchies with the legitimacy of scientific fact made it a primary idiom of difference linking varied political projects at local, national, and global scales. From this multi-scalar perspective that exceeds the geographic borders, temporal span, and aims of the Nationalist state, the historical significance of Nationalist-era MIH programs comes into stark relief. The converging investments of nationalists, imperialists, philanthropists, and feminists produced a far-reaching

[9] These various aspects of Yang's political activism and career are documented throughout this dissertation. See Chapters 2, 5, and 7.

reproductive health landscape in China during the years surrounding World War II. As this coalition unwound in the wake of the founding of the PRC, the institutions, personnel, and assumptions on which it rested variably shaped the course of reproductive health schemes in Communist China, Nationalist Taiwan, and the broader Cold War world.

Terminology

Outlining the converging political aims shaping MIH in China has required the use of precise nomenclature. Following the precedent of other scholars in the history of health and medicine, I use the term "biomedicine" to refer to the contested body of medical knowledge purporting to rest on the scientific study of the body and disease. This choice highlights the transnational circulations and international encounters through which this body of knowledge arose during the nineteenth and twentieth centuries to maintain critical distance from a category that was neither inherently "Western" nor "modern."[10] I also collectively refer to local medical practices within China as "indigenous medicines," to highlight competing and distinct modes of healing that predated and evolved alongside biomedicine.[11] MIH reforms in public health schemes of the Nationalist decades, as described in the sources surveyed here, centered primarily on dynamic relations between biomedicine on the one hand and the vernacular practices of lay midwives on

[10] Bridie Andrews has outlined the motives behind the choice of "biomedicine" in much anthropological scholarship, while opting instead to use "Western medicine" "as a label, or place-holder, for a changing assemblage of theories, technologies, and practices that defies easy definition." My focus on the middle third of the twentieth century (in contrast to Andrews' longer timeperiod of 1850 to 1960) shapes my choice to use "biomedicine" in most cases. See Bridie Andrews, *The Making of Modern Chinese Medicine, 1850-1960* (Vancouver: UBC Press, 2014), 7, 7-9.

[11] See Sean Hsiang-lin Lei, *Neither Donkey nor Horse: Medicine in the Struggle over China's Modernity* (Chicago: University of Chicago Press, 2014), 6-10, 19; Andrews, *The Making of Modern Chinese Medicine,* 7-9, 212.

the other. Thus, I devote limited attention to debates concerning the continued relevance of elite, imperial-era "women's medicine," which continued in print among Chinese intellectuals.[12]

This dissertation focuses on "maternal and infant health" or *fuying weisheng* 婦嬰衛生, taking the moniker of reproductive health most prevalent during the Nationalist decades. As outlined in the dissertation, this field broadened through dialogue between local public health workers, international organizations, and transnational feminisms to become "maternal and child healthcare" or *fuyou baojian* 婦幼保健 by the later 1940s. In present-day public health, these terms have largely been subsumed under the still broader term "sexual and reproductive health" or *xing he shengzhi weisheng* 性和生殖衛生, which includes considerations of men along with women and children to provide a more comprehensive assessment of sexual and reproductive wellbeing.[13]

Finally, I make a particular choice in translating Chinese terms to foreground distinctions between race, nation, country, and state. Nationalist-era actors themselves made these distinctions, variably deploying one category or another to advance distinct political claims. To highlight these choices of historical actors, I resist the tendency to conflate varied Chinese terms into an English "nation" or "nation-state." *Minzu* 民族 denotes the ethnos or 'nation' of nation-state. The eugenic dimensions of public health discourse in the period under study sometimes blurred distinctions between *minzu* and *zhongzu* 種族, the present-day Mandarin word for 'race' also used to some extent in the Nationalist period. These closely related terms remained

[12] See Nicole Richardson, "The Nation *In Utero*: Translating the Science of Fetal Education in Republican China," *Frontiers of History in China* 7, no. 1 (2012): 4-31; Nicole Richardson, "Translating *Taijiao*: Modern Metaphors and International Eclecticism in Song Jiazhao's Translation of Shimoda Jirō's *Taikyō*," Jindai zhongguo funü shi yanjiu 近代中國婦女史研究 19 (December 2011): 255-87.

[13] For more on these trends, see Paul F.A. van Look, Kris Heggenhougen, Stella R. Quah, eds., *Sexual and Reproductive Health: A Public Health Perspective* (New York: Academic Press, 2011), 34-36; 316-318.

conceptually distinct from *guo* 國 or *guojia* 國家. In the twentieth century, *guo* or *guojia* could be used to refer to the "country" or to the "state" of nation-state in references to the Chinese polity. Thus, I translate *zhong* or *zhongzu* as "race" and *guo* or *guojia* as "country" or "state" depending on context, leaving *minzu* untranslated as a contested and shifting Chinese concept of the *ethnos,* variably translatable as a precisely defined "nation" or "race" in English. Teasing out these nuances of Chinese-language discourse remains critical to my argument of the distinct if converging political motives surrounding MIH. A commitment to strengthening the *minzu* need not necessarily align neatly with allegiance to a particular polity. The distinctions between these Chinese categories will become clearer to readers as they see how different actors made choices about which term to use in each case.[14]

Methodology

The insights put forth in this dissertation become visible through a particular set of methodological choices regarding scope, scale, and emphasis. In terms of temporality, the dissertation's scope of 1927 to 1964 crosses the boundary dividing the Republican Era (1912-1949) from the Socialist Period (1949-1976) to highlight continuity and change across the rupture of 1949. For histories of public health, this approach is distinct given the general tendency of scholars to emphasize the years prior to or, more recently, during the Second Sino-Japanese War (1937-45) or the period following the founding of the PRC, even when gesturing toward continuities across these eras. In contrast, this dissertation traces the development of MIH

[14] I draw here from conceptual distinctions made by Rebecca Karl in her work on the late Qing dynasty. See Rebecca E. Karl, *Staging the World: Chinese Nationalism at the Turn of the Twentieth Century* (Durham: Duke University Press, 2002), 117-125, *passim.* I also take this distinction from Nationalist-era thinkers who took pains to disaggregate *minzu* and *guojia.* See, for example, Chen Changheng 陳長蘅, Sanminzhuyi yu renkou zhengce《三民主義與人口政策》(Shanghai: Shangwu yinshuguan 商務印書館, 1930), 28-30; see also Margherita Zanasi, *Saving the Nation: Economic Modernity in Republican China* (Chicago: University of Chicago Press, 2006), 3-6.

programs begun in the Nanjing Decade (1927-1949) throughout the eras of the Second Sino-Japanese War and Chinese Civil War (1946-1949) into the early years of the PRC and Nationalist rule in Taiwan.

In terms of scale, this dissertation deploys a multi-scalar method that considers intertwined local, national, and global dynamics. This approach builds on recent work in the history of public health in China that includes but exceeds the biopolitical projects of a narrowly defined Chinese state to highlight the localized effects of projects designed to manage reproductive health on a global scale. Further, this method highlights motives and ideologies outside a narrowly conceived Chinese nationalism or allegiance to a particular state. Rather, my approach considers the distinct aims of imperialists, nationalists, feminists, and local practitioners to account for the multifaceted investments in Chinese women's capacity to reproduce and nurture, and their varied operations at local, national, and global scales.

To account for these linked scales, this dissertation draws from twenty-one archives scattered across three continents. In each chapter, I read provincial and national public health policy in China alongside the correspondence and surveys of international health organizations. The writings of Chinese feminist physicians who operated throughout Asia, Europe, and the Americas during the period under study further enrich this archival source base. By drawing from these dispersed and diverse archives, this dissertation provides a richly textured depiction of public health policy and practice.

Despite harboring distinct motives, many of the actors surrounding the development of MIH in China operated in and through state institutions. Thus, in this dissertation, I do not refer to "the state" as a discrete entity with a narrowly defined set of aims. Rather, building on the work of scholars such as Sean Hsiang-lin Lei and Wang Zheng, I take the state to be a site of

contestation, through which varied actors compete for influence and resources.[15] Both within and between state organizations, individuals with contrasting political philosophies shaped multifaceted national policies that provincial officials later adapted to suit their own, distinct agendas and the particularities of locales.

Further, this approach builds on scholarly insights regarding the importance of transnational flows of people and ideas to highlight also historical, global conditions and macropolitical dynamics that shaped the rise of Chinese MIH at a particular moment in history. Thus, I bring histories of modern China into conversation with broader histories of gender and feminism, health and medicine, and politics and imperialism to demonstrate both the effects of global developments for Chinese history and the reciprocal impact of the Chinese case for global history.

The central questions of this dissertation remain how, why, and to what effect did Chinese women's reproduction accumulate dense, international political significance in the twentieth century. My pursuit of these questions has brought local actors, global conditions, and feminist investments in public health to the fore. This dissertation outlines the material and discursive forces that bound nation-state-building to local governance, feminist political claims, and global health. These varied projects aligned as a result of a global conjuncture in the decades surrounding World War II, characterized by the woman question, the rise of international philanthropy, new modes of imperialism, the universalizing of the nation-state system, and the advent of public health. Amid this global conjuncture, MIH, which supplied scientific measures of women's varied capacity to reproduce and nurture, emerged as the nexus of multiple vectors

[15] Lei, *Neither Donkey nor Horse,* 45-68, 261; Wang Zheng, *Finding Women in the State: A Socialist Feminist Revolution in the People's Republic of China, 1949-1964* (Berkeley and Los Angeles: University of California Press, 2017), *passim*; see also Wang Zheng, "'State Feminism'? Gender and Socialist State Formation in Maoist China," *Feminist Studies* 31, no. 3 (Fall 2005): 519-51.

of politically salient difference, including hierarchies of genders, bodies, races, nations, and states.

This dissertation aims to extract insights from the particularities of Chinese history to intervene at the realm of the universal, or what might be called "theory." Here, I follow the methodological directives and models of a variety of scholars working in Asian studies, broadly construed.[16] I am guided less by the question of whether or not a particular theory derived from Western histories is applicable to the Chinese case and more by the question of what theoretical insights might be gained by sustained and critical engagement with archival sources. My aim here is to bridge emerging fault lines in the historiography on China between scholarship prioritizing empirical findings and that deeply invested in forwarding theory.[17]

With these aims and methods, "Reproductive Subjects" primarily engages four historiographies: political histories of modern China, global histories of the long interwar period, histories of public health and medicine, and histories of women, gender, and feminism. In the sections that follow, I outline this project's contributions to each of these four fields. In each case, my aim is not to provide an exhaustive record of existing scholarship, but rather to situate this work's interventions in relation to prominent questions.

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[16] This method has been developed through a series of works published within the last two decades. See Dipesh Chakrabarty, *Provincializing Europe: Postcolonial Though and Historical Difference* (Princeton: Princeton University Press, 2000); Afsaneh Najmabadi, *Women with Mustaches and Men without Beards: Gender and Sexual Anxieties of Iranian Modernity* (Berkeley and Los Angeles: University of California, 2005); Kuan-hsing Chen, *Asia as Method: Toward Deimperialization* (Durham: Duke University Press, 2010).

[17] These divisions in the field have been noted by several scholars. See, for example, Paul A. Cohen, "Revisiting *Discovering History in China,*" *China Unbound: Evolving Perspectives on the Chinese Past* (New York: Routledge, 2003), 185-99, 193-94; Rebecca Karl, "Thematic Review: The State of Chinese Women's History," *Gender & History* 23, no. 2 (August 2011): 430-41; Rebecca Karl, Tom Lamarre, Claudia Pozzana, Alessandro Russo, Naoki Sakai, Jesook Song, Angela Zito, "'A Relentlessly Productive Venue': Interview with Senior Editor, Tani Barlow," *positions* 20, no. 1 (Winter 2012): 345-72.

Political Histories of Twentieth-Century China

The political historiography of twentieth-century China has endured a paradigm shift in recent decades, and another paradigm shift is on the horizon. Paul Cohen made perhaps the most significant contribution to the earlier refashioning of the field with his 1984 text, *Discovering History in China.* In a reflective critique, Cohen outlined the flaws of prevalent approaches in the historiography that had distorted the Chinese past. Pointing to three dominant frameworks—"China's response to the West," "tradition and modernity," and "imperialism"—Cohen argued that despite clear differences between these approaches, all shared "a Western-centeredness that robs China of its autonomy and makes of it, in the end, an intellectual possession of the West."[18] As a remedy, Cohen advocated a "China-centered history of China" that directed historians to focus on "Chinese problems set in a Chinese context."[19]

As Cohen pointed out, the movement toward this China-centered history had begun before he identified it as such. Beginning in the 1970s, historians turned to the internal dynamics of Chinese politics and society. In addition to Cohen's influential text, the increased accessibility of Chinese archives for Western researchers further spurred this development. A rich historiography too expansive to survey in detail outlined the social and economic forces within China that shaped rebellions, reform, and revolutions throughout the nineteenth and twentieth centuries.[20]

Cohen revisited his critique in an essay published in 2003. In response to scholars who had criticized his lack of a critical position on the China-centered approach he endorsed, Cohen

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[18] Paul A. Cohen, *Discovering History in China: American Historical Writing on the Recent Chinese Past* (New York: Columbia University Press, 1984, 1996, 2010), 151.

[19] Ibid., 154.

[20] One notable example of this turn toward internal dynamics before Cohen's critique is Frederic Wakeman, Jr., *The Fall of Imperial China* (New York: The Free Press, 1975).

expanded on his earlier assessment to survey the work produced in its wake. Here, Cohen provided an overview of China-centered histories he admired, which, he argued, adopted an integrative approach that used the internal dynamics of Chinese history to better understand the implications of China's relations with the rest of the world. However, Cohen also pointed to the constrictive effects of a narrowly conceived China-centered approach and the insidious persistence of Western-centered notions that continued to plague the field. In his assessment, even sophisticated and careful scholarship had produced a history of China rooted in Western perspectives. He wrote,

> In exploding one parochial belief—that modernizing change could not be initiated by the Chinese themselves, only introduced by the West—have we inadvertently insinuated into Chinese history another—to wit, that the only kind of change important enough to be worth looking for in the Chinese past is change leading toward modernity, as defined by the Western historical experience?[21]

Despite Cohen's warning, historians of China have largely affirmed "modernity" as the primary historical development worth exploring,[22] even as they have grown more attentive to alternative modernities. In most cases, this framework highlights the interplay of imported and indigenous knowledge to emphasize a Chinese modernity produced through negotiation and contestation. "Modernity" has saturated the field, becoming an overdetermined framework that, at times, obscures more than it illuminates. As Joan Judge noted in her 2008 monograph *The Precious Raft of History,* "modernity is an amorphous concept…Modernities can be repressed, contested, colonial, competing, hygienic, lost—to give a few examples from the recent field of

[21] Versions of this essay appear in both a 2003 book and the 2010 edition of *Discovering History in China.* See Cohen, *Discovering History in China,* xv-xvii; see also Paul A. Cohen, "Revisiting *Discovering History in China.*"

[22] Timothy Cheek has also made this observation, in an article advocating for a reconsideration of "revolution" as a subject of study in the field. See Timothy Cheek, "The Importance of Revolution as an Historical Topic," *Journal of Modern Chinese History* 7, no. 2 (2013): 250-53.

East Asian studies alone."[23] Judge ultimately found modernity useful for her goal of communicating the ambiguous historical processes of turn-of-the-twentieth-century China.[24] I have found this category less useful for analyzing the political dynamics in which I am most interested. This dissertation outlines the development of infrastructures and knowledges, in which some might see a process of modernization or insights into Chinese paths to and perceptions of the modern. However, my interests lie primarily in political claims and power relations within and beyond the Chinese state.

To be sure, the power relations I outline remained conditioned by global developments of the interwar period, many of which have been incorporated into scholarly definitions of "modernity." Yet, the contours of this condition of "global modernity" remain amorphous and ill-defined across scholarship within and beyond Chinese studies. Definitions of "modernity" as a global condition have variably emphasized processes of rationalization, secularization, accumulation, and linear temporality. Others have highlighted more concrete historical developments stemming from industrial capitalism, imperialism, science and medicine, and globalization.[25] For this dissertation, I have opted to refer to a particular global conjuncture of the long interwar period rather than the ambiguous "modernity," which, given the current state of modern Chinese historiography, might invite several different misinterpretations. I have shunned the use of the term in this dissertation with an intent to dissociate the developments outlined here

[23] Joan Judge, *The Precious Raft of History: The Past, the West, and the Woman Question in China* (Stanford: Stanford University Press, 2008), 2-3.

[24] Ibid., 2-3.

[25] In his recent dissertation, Malcolm Thompson outlined how many of these conditions shaped the rise of a particular governmental logic of population in China, which had relevance for the field of public health. See Malcolm Thompson, "The Birth of the Chinese Population: A Study in the History of Governmental Logics," (PhD diss., University of British Columbia, 2013). Scholarly definitions of "modernity" appear across a literature far too expansive to cite in great detail. For one recent example, see Prasenjit Duara, *The Crisis of Global Modernity: Asian Traditions and a Sustainable Future* (Cambridge: Cambridge University Press, 2015), 93-94.

with dominant questions of how or when China became modern and with the tendency to conflate multifaceted political motives to a Chinese pursuit of and debates over "modernity." With the framework of a "global conjuncture," I aim to place greater emphasis on the synchronous history of a particular historical moment, in contrast to the diachronic history of the development (however circuitous and contingent) of (Chinese) modernity.

Cohen's 2003 critique of persistent, Western-centered frameworks pointed to a relevant debate within Chinese political history as particularly illustrative. From the late 1980s to the early 2000s, many political historians of China focused their research on state-society relations in the Chinese past. This historiographical trend in the field gained momentum after 1989, a year that saw the Tian'anmen Square massacre, the dismantling of the Berlin Wall, and an English translation of Jürgen Habermas' *The Structural Transformation of the Public Sphere*. The debate that drove the field for well over a decade (and that still surfaces, to some degree, in more recent scholarship) focused on the applicability of the terms "public sphere" and "civil society" for the political and social dynamics of modern Chinese history. A number of scholars pointed to the commercialization of the Chinese economy, the emergence of voluntary associations tangential to or outside the state, and varied cases of local autonomy as evidence of something akin to a "public sphere" in late imperial China. Others argued that the dominance of the state throughout much of late imperial and modern Chinese history thwarted the development of anything that could be labeled "civil society" or a "public sphere." Other historians, including Cohen, remained critical of the use of these analytical categories, so deeply rooted in Western histories, for studies of the Chinese past.[26]

[26] A special issue in the journal *Modern China* included contributions from many of the scholars invested in this debate, and included a discussion of the historical context for this historiographical trend. See Symposium, "'Public Sphere'/'Civil Society' in China?" *Modern China* 19, no. 2 (April 1993). See also William T. Rowe, "The Public Sphere in Modern China," *Modern China* 16, no. 3 (July 1990): 309-329.

A more nuanced treatment of the categories framing this debate came with Eugenia Lean's 2007 *Public Passions,* which moved away from narrowly conceived Habermasian notions of a "public sphere" to consider more fluid and ephemeral "publics" in an unexpected decade of Chinese history. Whereas previous scholarship, as Lean noted, followed Habermasian notions of an autonomous and liberatory public sphere to the late Qing period and the 1920s, Lean considered the dimensions of participatory publics in the 1930s, a decade characterized by suppression and censorship. Lean's conception of "publics" drew from scholarship outside Chinese studies to further problematize the notion of a rational public sphere differentiated from the realm of the sentimental, feminine, and domestic.[27]

This dissertation builds on Lean's complicated notion of political participation as well as the recent historiography of medicine and feminism to blur distinctions between state and society, particularly in the authoritarian dynamics of Chinese political history since the 1930s. Whereas Lean's analysis focused on the political engagement of publics that were "sometimes working against the state, and sometimes initiated by the state,"[28] my work, following Wang Zheng and Sean Hsiang-lin Lei, seeks to understand the advancement of varied political agendas within the multifaceted and porous assemblage of actors, resources, and institutions that might be referred to as "the state."[29]

This critical relationship to "the state" also intervenes in a historiography largely bifurcated by 1949. By identifying a host of political actors operating both in and outside of state institutions, this dissertation traces political developments that cut across the demise of the

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[27] Eugenia Lean, *Public Passions: The Trial of Shi Jianqiao and the Rise of Popular Sympathy in Republican China* (Berkeley and Los Angeles: University of California Press, 2007), 1-20, *passim.*

[28] Ibid., 9.

[29] See, for example, Wang Zheng, *Finding Women in the State,* 6-8, 16-17, *passim*; Lei, *Neither Donkey nor Horse,* 261.

Nationalist state on the mainland and the founding of the PRC. As I outline more fully in Chapter Seven, the varied political investments that converged in the Nationalist decades diverged in the postwar period, with distinct constellations of players building on either Nationalist or Japanese infrastructures with contrasting political ideologies on both sides of the Taiwan Strait. Thus, I do not trace a linear narrative of continuous development, but rather note the cumulative effects of successive projects to manage women's reproductive health. Often, later projects included the same players with new positions, strategies, and allegiances. By outlining a more complex political process than mere state-building, I follow Janet Chen in moving beyond an assessment of the relative successes and failures of Nationalist and Communist states.[30] Rather, I outline a more textured political terrain that linked China to the broader world and shaped the development of reproductive health throughout the middle third of the twentieth century.

In this regard, this dissertation contributes to a growing movement within Chinese studies to engage the field of global history. Like "modernity," "the nation" remains a pervasive and ultimately indispensable category in the field.[31] However, recent work has sought to disentangle the multiple categories conflated in much historiography on "the nation" through a variety of methodological tacks. Some, like Prasenjit Duara, have challenged the tendency to see nationalism as the root of all political action to the neglect of histories irreconcilable with the History of the nation-state.[32] More recently, Rebecca Karl has disaggregated "nationalism" from

[30] Janet Y. Chen, *Guilty of Indigence: The Urban Poor in China,* 1900-1953 (Princeton: Princeton University Press, 2012), 9.

[31] For only a few of many examples, see Karl Gerth, *China Made: Consumer Culture and the Creation of the Nation* (Cambridge: Harvard Asia Center, 2003); Tom Mullaney, *Coming to Terms with the Nation: Ethnic Classification in Modern China* (Berkeley and Los Angeles: University of California Press, 2011); Zanasi, *Saving the Nation*.

[32] Prasenjit Duara, *Rescuing History from the Nation: Questioning Narratives of Modern China* (Chicago: University of Chicago Press, 1995); see also Prasenjit Duara, *The Global and Regional in China's Nation-Formation* (New York: Routledge, 2009).

"nation," "state," and "nation-state," noting late-Qing engagements with nationalism that exceeded any simple association with a particular polity. As Karl noted based on the late-Qing case, the differing Chinese terms that have been translated as "nation" bore precise meanings that reflected distinct imaginaries.[33] This dissertation finds similar precision in the terms used by many Nationalist-era actors, who variably referred to the *minzu, zhongzu,* or *guojia* as distinct political categories.

In addition to Karl's work, this dissertation contributes to a growing body of largely unpublished scholarship engaging global frames for political histories of twentieth-century China.[34] As developed here, this global framework retains the best of the "China-centered" approach, reading Chinese archives through the context of the global while also noting the integral role of Chinese cases to global developments in imperialism, public health, and feminism.

Histories of the Global Interwar Period

This dissertation also contributes to histories of the interwar period by outlining a global conjuncture that made the mundane acts of childbirth and mothering in China a site of convergence for new imperialisms, global health, international feminisms, and Chinese nation-

[33] Karl, *Staging the World*, 115-120, *passim.*

[34] This dissertation contributes to an emerging "global turn" in modern Chinese history that builds on the earlier work of scholars like Rebecca Karl, William Kirby, and Kenneth Pomeranz within Chinese studies while engaging with the growing field of global history. For some recent and forthcoming examples, see Tom Mullaney, *The Chinese Typewriter: A Global History* (Cambridge: MIT Press, 2017); Robert Cole, "'To Save the Village': Confronting Chinese Rural Crisis in the Global 1930s," (PhD diss., NYU, 2017); Shelly Chan, *Diaspora's Homeland: Modern China in the Age of Global Migration (forthcoming monograph);* see also William C. Kirby, "The Internationalization of China: Foreign Relations at Home and Abroad in the Republican Era," *The China Quarterly* 150 (June 1997): 433-58; Kenneth Pomeranz, *The Great Divergence: China, Europe, and the Making of the Modern World Economy* (Princeton: Princeton University Press, 2000); Karl, *Staging the World.*

state building. The dates bounding this period vary across the historiography, but many have taken a view that extends beyond the end of World War I and/or the beginning of World War II.[35] Based on my primary focus on dynamics related to China, I push the limits of this period further than most. This dissertation's focus on the decades between 1927 and 1964 overlaps with global histories of the interwar period while looking forward to the immediate effects of interwar developments in the early Cold War Pacific.

A wide-ranging body of scholarship has cumulatively produced a rich picture of the interwar period as "a transitional moment." The First World War had devastated Europe and served as a catalyst for refashioning the relationship between European powers and their colonies. The former order of colonialism eroded further through Wilsonian notions of "self-determination" and the formation of the League of Nations, which helped to universalize an international system comprised of putatively autonomous nation-states. The rise of international health organizations and philanthropies, including the LNHO and the affiliated organizations of the Rockefeller Foundation, provided alternative civilizing missions that further challenged the legitimacy of European colonial powers.[36]

As most clearly articulated by Akira Iriye, this shifted political landscape enabled the flourishing of international cooperation irreducible to relations between governments. Akira Iriye's *Cultural Internationalism and World Order* took a broad view of international relations to include the "thinkers, artists, and musicians" that constituted an "alternative community of

[35] For a justification for extending this period back to the Spanish American War, see Joshua L. Miller, *Accented America: The Cultural Politics of Multilingual Modernism* (New York: Oxford University Press, 2011).

[36] I draw heavily here from Mrinalini Sinha's outlining of global interwar developments, with a particular focus on the British Empire. See Mrinalini Sinha, *Specters of Mother India: The Global Restructuring of an Empire* (Durham: Duke University Press, 2006), 23-65.

nations and peoples on the basis of their cultural interchanges."[37] In his more recent work, Iriye focused more narrowly on "intergovernmental" and "international non-governmental" organizations, dissociating what he perceived as these entities' emphasis on a "global consciousness" from the international system of nation-states that developed in tandem with this "global community." Iriye gave limited attention to the Rockefeller Foundation, which, as others have noted, remained integral to developments both within China and the broader world between the wars. In one of the few mentions of the Rockefeller Foundation in *Global Community,* Iriye associated the organization with the efforts of U.S. officials to use cultural exchange as an "instrument of waging cold war," noting that both Rockefeller and Ford Foundations often collaborated with the U.S. government. The League of Nations and its affiliates appear in Iriye's work as more representative of the "new intergovernmental organizations" that shaped the global community he sees in the interwar years.[38]

Despite a fresh, non-state-centered perspective on international relations, Iriye minimized the extent to which governments made use of non- and inter-governmental organizations, including the League of Nations, to shore up their political power during the interwar period. The Wilsonian notions regarding the self-determination of nations sparked anti-colonial nationalist movements throughout the world, including the May Fourth Movement that left such an indelible mark on the political landscape of modern China. However, amid this "Wilsonian Moment", the League of Nations claimed certain areas of Africa, the Pacific, and the Middle East as mandates unfit for self-rule, to be governed by seven designated mandatory powers, all victors in the First

[37] Akira Iriye, *Cultural Internationalism and World Order* (Baltimore: Johns Hopkins University Press, 1997), 2-3.

[38] Akira Iriye, *Global Community: The Role of International Organizations in the Making of the Contemporary World* (Berkeley and Los Angeles: University of California Press, 2002), 21, 52-53.

World War. Thus, the League of Nations in particular, despite the universalizing of a system of autonomous nation-states, also served the interests of imperial powers. Though the U.S. never joined the League formally, several U.S. players operated within the League's affiliated organizations to expand U.S. influence on the interwar world stage.[39]

Interwar norms of anti-colonial nationalism counterintuitively spurred the rise of new imperial powers—including Japan, the U.S., and the U.S.S.R.—who criticized European imperialism while using the emerging nation-state system to shore up their dominance. As Prasenjit Duara has outlined, drawing from world-systems theory, the expansion of the nation-state system in the wake of the First World War produced a competitive order that rested on the fusion of two logics: territorial and capitalist. The scramble for resources amid this competitive environment manifested at two scales, connecting the dynamics of nationalism to those of a "new imperialism" that Duara labels "the imperialism of 'free nations.'" Both nationalism and this new imperialism "extend[ed] the benefits and pains of creating an integrated, globally competitive entity" unevenly.[40] New imperial powers often invested heavily in less powerful states to promote development, constructing a sphere of influence through which stronger states enhanced their economic and political position globally. Drawing further from Hannah Arendt and Eric Hobsbawm, Duara thus concluded that "imperialism was largely the business of

[39] Susan Pedersen, *The Guardians: The League of Nations and the Crisis of Empire* (New York: Oxford University Press, 2015), 1-14, *passim*; see also Antony Anghie, "Colonialism and the Birth of International Institutions: The Mandate System of the League of Nations," in Antony Angie, *Imperialism, Sovereignty, and the Making of International Law* (New York: Cambridge University Press, 2004), 115-95.

[40] Prasenjit Duara, "The Imperialism of 'Free Nations': Japan, Manchukuo, and the History of the Present," in Prasenjit Duara, *The Global and Regional in China's Nation-Formation* (New York: Routledge, 2009), 40-59, 41; see also Giovanni Arrighi, *The Long Twentieth Century: Money, Power, and the Origins of Our Times* (New York: Verso, 1994); Immanuel Wallerstein, *Historical Capitalism* (New York: Verso, 1983).

competitive nation-states, and nationalism was mobilized to further their interests, by the twentieth century nationalism had become the driving force behind imperialism."[41]

Duara argued that Manchukuo, a short-lived state in Manchuria largely subservient to Japan, evinced the first "full-blown instance" of this "imperialism of free nations," even as he notes similar tacks taken by the U.S. and U.S.S.R. throughout the interwar world.[42] But these dynamics of the interwar world also point toward a re-assessment of U.S.-based interventions in Nationalist China. As this dissertation shows, the interwar linking of nationalism and new imperialism shaped an alignment of interests between the territorial expansion and economic development of a post-Wilsonian nation-state in China, the proliferation of intergovernmental institutions, and experimental ventures for expanding U.S. influence in the Pacific through philanthropy and the nation-state system.

Duara's conception of the "imperialism of free nations" allows for a more historicized analysis of the particular conditions shaping relations between China and the world than the dominant framework of "semicolonialism" most prevalent in the historiography of modern China. "Semicolonial" has been used most often to highlight the particularities of China under the unequal treaties, reading the conditions of the early Republican period (1912-1949) back in time to the First Opium War (1839-42). In much recent work, "semicolonial" has become a moniker for the coexistence of native administrations and various foreign concessions in coastal treaty-ports that shaped both everyday interactions across these zones and cultural production by native elites.[43] In contrast, "the imperialism of free nations" highlights a global shift in the actors

[41] Duara, "The Imperialism of 'Free Nations,'" 44.

[42] Ibid., 40; see also Prasenjit Duara, *Sovereignty and Authenticity: Manchukuo and the East Asian Modern* (Lanham, MD: Rowman and Littlefield, 2003), 245-247.

[43] Much recent scholarship, largely focused on treaty-ports, has debated the relevance and particularities of "semicolonialism" in China. See Bryna Goodman, "Improvisations on a Semicolonial Theme, or, How to Read a

and modes of imperialism, linking the peculiar status of Nationalist China to the transitional moment of the interwar era that foreshadowed the global Cold War. Further, this formulation accounts for the transnational conditions shaping local histories in the interior beyond the administration of treaty-ports. The contingent accumulation of territory and influence in the interior by the Nationalist state remained compatible with—in fact, integral to—new modes of imperialism that built spheres of influence through putatively autonomous nation-states.

Following Mrinalini Sinha's conception of an "interwar imperial social formation," I demonstrate how the gendered, local dynamics within a given nation-state remained intertwined with these global developments. As Alison Bashford, Matthew Connelly, and Malcolm Thompson have shown, the management of populations—which included the proliferation of public health schemes both on a global scale and in nations around the world—became the nexus linking state-building, geopolitics, capitalism, and medicine in the decades surrounding the Second World War.[44] These dynamics affirm Sinha's assessment of a global linking of the political and the social realms that connected the woman question to shifting imperialisms, thereby opening new spaces for women's collective political agency.[45] As I demonstrate in this dissertation, MIH became a particularly magnetic point of convergence for these varied dynamics of the interwar period, as it collected the diversified investments of nation-state-building, international health organizations, new imperialist powers, and international feminisms.

Celebration of Transnational Urban Community," *Journnal of Asian Studies* 59, no. 4 (2000): 889-926; Shu-mei Shih, *The Lure of the Modern: Writing Modernism in Semicolonial China, 1917-1937* (Berkeley and Los Angeles: University of California Press, 2001), *passim.*

[44] Alison Basford, *Global Population: History, Geopolitics, and Life on Earth* (New York: Columbia University Press, 2014); Matthew Connelly, *Fatal Misconception: The Struggle to Control World Population* (Cambridge: The Belknap Press of Harvard University Press, 2008); Thompson, "The Birth of the Chinese Population."

[45] Sinha, *Specters of Mother India,* 16-19; Mrinalini Sinha, "Mapping the Imperial Social Formation: A Modest Proposal for Feminist History," *Signs* 25, no. 4 (Summer 2000): 1077-1082.

Histories of Medicine and Public Health

Histories of public health and medicine in modern China have primarily centered on the development of medical knowledge and/or public health as a component of state-building. The most insightful studies in this subfield have examined the integral role of medicine and health to the dynamics of Chinese modernity, shaped by transnational flows of knowledge and the interaction between pluralized indigenous and "Western" medicines. Ruth Rogaski, though noting the "uncanny" similitude between East Asian notions of "hygienic modernity" (*weisheng* 衛生 in Chinese or *eisei* in Japanese) and Foucault's conception of biopower, remained primarily focused on demonstrating how discourses of health and hygiene remained vital to "how Chinese elites envisioned modernity and sought to transform the nation."[46] Sean Hsiang-lin Lei and Bridie Andrews pursued the links between medicine and Chinese modernity beyond the treaty ports, demonstrating with empirical rigor and nuance the coeval development of indigenous and Western medicines that ultimately produced hybridized public health schemes.[47] As this rapidly growing subfield has shown, what some have referred to as "modern Chinese medicine" emerged through more than a century of negotiation, contestation, and conflict. Thus, the advent of "modern Chinese medicine" remains irreducible to the mere import of Western medical knowledge or the preservation of a static Chinese medical tradition.[48]

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[46] Ruth Rogaski, *Hygienic Modernity: Meanings of Health and Disease in Treaty-Port China* (Berkeley and Los Angeles: University of California Press, 2004), 300, *passim*; see also Michel Foucault, *Discipline and Punish: The Birth of the Prison,* Alan Sheridan, trans. (New York: Vintage Books, 1979, 1995); Michel Foucault, *The History of Sexuality: Volume 1, An Introduction,* Robert Hurley, trans. (New York: Vintage Books, 1978).

[47] Sean Hsiang-lin Lei, *Neither Donkey nor Horse*; Andrews, *The Making of Modern Chinese Medicine.*

[48] See Andrews, *The Making of Modern Chinese Medicine.* See also Howard Chiang, "Historical Epistemology and the Making of Modern Chinese Medicine," in Howard Chiang, ed., *Historical Epistemology and the Making of Chinese Medicine* (Manchester: University of Manchester Press, 2015), 3-36.

Scholarship on fertility, reproduction, and childrearing in China has contributed to this nuanced formulation of modern Chinese medicine. Taken together, the work of Frank Dikötter, Charlotte Furth, Yi-li Wu, Shing-Ting Lin, and Nicole Richardson demonstrates contestation and negotiation surrounding knowledge of women's bodies from the imperial period to the twentieth century.[49] By the nineteenth century, medical knowledge of women's reproduction became a site not only for conflicts between biomedicine and the genre of "women's medicine" explicated by Chinese *literati,* but also between both of these medicines and the varied vernacular practices of lay midwives. These lay midwives persisted amid the scorn of *literati* doctors, biomedical experts, and public health officials, making childbirth and mothercraft in China a thickly layered domain of ritual and medical practice.[50]

These dynamics between vernacular practices and the largely biomedical orientation of foreign philanthropists and public health workers operating under the auspices of the Nationalist government constituted the primary tensions of the MIH project examined in this dissertation. With a focus on policy and practice, this dissertation rarely engages with the intellectual debates regarding the relevance of *literati* "women's medicine," which continued to varying degrees in print and academic circles.[51] Readers most interested in the shifting contours of modern Chinese

[49] Frank Dikötter, *Sex, Culture, and Modernity in China: Medical Science and the Construction of Sexual Identities in the Early Republican Period* (Honolulu: University of Hawaii Press, 1995); Frank Dikötter, *Imperfect Conceptions: Medical Knowledge, Birth Defects, and Eugenics in China* (New York: Columbia University Press, 1998); Charlotte Furth, *A Flourishing Yin: Gender in China's Medical History, 960-1665* (Berkeley and Los Angeles: University of California Press, 1999); Yi-li Wu, *Reproducing Women: Medicine, Metaphor, and Childbirth in Late Imperial China* (Berkeley and Los Angeles: University of California Press, 2010); Shing-Ting Lin, "'Scientific' Menstruation: The Popularisation and Commodification of Female Hygiene in Republican China, 1910s-1930s," *Gender & History* 25, no. 2 (2013): 294-316; Nicole Richardson, "The Nation *In Utero*.

[50] I borrow both the term "vernacular medicine" and the notion of childbirth as a "thickly layered" domain from Nancy Rose Hunt's work on the history of medicine in the Congo. See Nancy Rose Hunt, *A Colonial Lexicon: Of Birth Ritual, Medicalization, and Mobility in the Congo* (Durham: Duke University Press, 1999), 70, 323; Nancy Rose Hunt, *A Nervous State: Violence, Remedies, and Reverie in Colonial Congo* (Durham: Duke University Press, 2016), 7-12, *passim.*

[51] See Richardson, "The Nation *In Utero*."

medical knowledge and practice will find in these pages evidence that endeavors to reform childbirth and mothercraft accommodated and ultimately integrated vernacular practices in ways that varied across regions, decades, and particular cases. But my primary interests lie outside these now well-tended questions.

Michel Foucault's conception of biopower, or the power over life itself, continues to shape interdisciplinary studies of public health both outside and, to a lesser degree, within Chinese studies. For historians of medicine and public health in the non-Western world, Foucault's Eurocentric formulation of modern governmentality has produced a body of scholarship that remains deeply wedded to Foucault's insights regarding the relationship between medical knowledge and the exercise of power, yet skeptical of Foucault's argument regarding the productive operations of biopower and the dispersal of power across institutions tangential to the state.[52] This has been particularly true in studies of colonial contexts. Many scholars have followed David Arnold's 1993 model, which took Foucault's insight of medicine as integral to relations of power as its point of departure for an examination of colonial India. For Arnold, the power dynamics of the colonial context dictated a focus on "Western medicine" as "intimately bound up with the nature and aspirations of the colonial state itself."[53] Thus, Arnold emphasized medicine's integral role to state-centered modes of discipline and domination, rather than an element of power/knowledge emanating from multiple sources both within and beyond the state.[54]

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[52] For more on this trend in the history of medicine, see Ishita Pande, *Medicine, Race, and Liberalism in British Bengal: Symptoms of Empire* (New York: Routledge, 2010), 1-15.

[53] David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley and Los Angeles: University of California Press, 1993), 9.

[54] Ibid., *passim.*

In Arnold's wake, histories of health and medicine focused on the Global South have further examined the operations of what Ann Laura Stoler dubbed "the biopolitical state."[55] In much of this work, biomedicine aids and enables a "politics of exclusion" by producing scientifically grounded hierarchies that vindicate colonial domination. Nancy Rose Hunt has recently characterized this preoccupation of the field with a focus on studies in South Asia and Africa, noting, "medical historians have tended not to move too far beyond the clinical and demographic and the state-derived."[56]

But modes of discipline and domination, though integral to the modern operation of biopower, do not fully account for the concepts and questions pursued throughout Foucault's writings on biopower and biopolitics. As a growing number of medical historians have begun to recognize, biopower's effects remain both disciplinary and productive. While science and medicine objectified bodies to construct hierarchical relations of dominance and subjugation, they also produced new institutions, categories, and subjects. Gyan Prakash, based on the Indian context, argued that these dimensions of biopower remained impossible in colonial contexts, given that the institutions of colonial governance required the subjugation of indigenous peoples and therefore precluded the biopolitical production of agentic, self-governing subjects.[57] But Ishita Pande questioned this assessment of biopower in the Global South, arguing that both the disciplinary and productive operations of biopower became subsumed in a "scientific 'universalization of difference.'"[58] As Pande outlined, the public health policies of the colonial

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[55] Ann Laura Stoler, *Race and the Education of Desire: Foucault's* History of Sexuality *and the Colonial Order of Things* (Durham: Duke University Press, 1995), 20, 34-35, 84-85.

[56] Hunt, *A Nervous State,* 7.

[57] Gyan Prakash, *Another Reason: Science and the Imagination of Modern India* (Princeton: Princeton University Press, 1999), 127; see also Pande, *Medicine, Race, and Liberalism in British Bengal,* 5-7.

[58] Pande, *Medicine, Race, and Liberalism in British Bengal,* 6-7.

state in India at once shored up foreign domination and produced individual subjects who used biomedicine's new categories to "talk about the self, thus participating in the disciplinary regime."[59] For Pande, this broadens the political terrain of public health to include subjects' agentic engagement with the disciplinary operations of biopower beyond "physical revolts" and "conversations between practitioners of divergent medical systems, as has been more common in the historiography of colonial medicine."[60]

These debates have received little explicit engagement from historians of health and medicine in China, due, in part, to China's unique place in the international political order of the nineteenth and twentieth centuries. Despite treaties designed to open China to foreign powers on unequal terms, continued dependence on foreign aid, and a full-scale invasion by the Japanese Empire, China remained a putatively autonomous if often incoherent and fragmented polity, never formally colonized by Western powers beyond the concessions of coastal treaty ports. Thus, the modes of domination outlined by medical historians of colonial Africa and South Asia seem ill-fitting to the Chinese case. However, equally unfitting would be any framing of Nationalist China as a strong and sovereign state, independent of foreign influence and comparable to the "modern" states on which Foucault based his conception of biopower.

Within the historiography on China, scholars have borrowed Foucault's notion of public health as intimately wed with state power (often implicitly), framing Nationalist-era efforts to develop a national public health system as an integral component of "modernization" and/or "national reconstruction." Some have further acknowledged public health's role in extending

[59] Ibid., 7.

[60] Ibid., 7.

state surveillance and propagating ideals of citizenship.[61] But, particularly in the scholarship on maternal and infant health, scholars have noted the Nationalist state's ultimate failure—either due to corruption, disingenuousness, or sustained military conflict—to construct the expansive national public health apparatus indicative of a modern state, realized only after the founding of the PRC in 1949.[62]

In fact, the particularities of the Chinese case during the middle third of the twentieth-century provide a unique opportunity to examine the tensions between biomedicine's implication in imperialism and state discipline on the one-hand, and the more diffuse and productive operations of biopower on the other. As existing scholarship has shown, the Nationalist state's political weaknesses thwarted its ability to carry out fully the disciplinary project of a modern "biopolitical state," despite the stated ambitions of certain officials to use public health to strengthen the economic and political position of the government. Nonetheless, public health institutions grew rapidly during the Nationalist decades, due to a constellation of projects that included foreign interventions, feminist advocacy, national policy, and localized medical practice. As this dissertation outlines, different actors with distinct aims connected demographic metrics—namely, maternal and infant mortality—to biomedical notions of un/hygienic childbirth, thereby linking the management of the population as a whole to the disciplining of

[61] Yang Nianqun's recent work has engaged with Foucault more directly, with an emphasis on Foucauldian notions of space with regard to biopower. See Yang Nianqun 楊念群, Zaizao Bingren: Zhong xi yi chongtu xia de kongjian zhengzhi, 1832-1985 《再造"病人"－中西医冲突下的空间政治（1832-1985）》（Beijing 中国人民大学出版社, 2006）; Nicole Barnes has also engaged with Foucauldian notions of biopower, primarily emphasizing its disciplinary operations through organs of the state. See Nicole Barnes, "Protecting the National Body: Gender and Public Health in Southwest China during the War with Japan, 1937-45" (PhD diss., UC Irvine, 2012), 32-33, 132-133; see also Lei, *Neither Donkey nor Horse,* 261. David Luesink has also drawn from Foucault's conception of anatompolitics in his recent dissertation on anatomy in the early Republican decades. See David Luesink, "Dissecting Modernity: Anatomy and Power in the Language of Science in China," (PhD diss., University of British Columbia, 2012), 28-33, *passim.*

[62] See, for example, Johnson, *Childbirth in Republican China: Delivering Modernity* (Lanham, MD: Lexington Books, 2011), 126-127, 136-137, 168-169.

individual bodies. As these two, analytically distinct fields—population and reproduction—became increasingly intertwined, they produced notions of difference rooted in scientific measures of women's bodies that at once structured foreign interventions in China, Nationalist interventions in the interior, and feminist claims to rights and resources. In the case of Nationalist China, we are confronted with diffuse operations of biopower profoundly shaped by the intertwined disciplinary aims of foreign and indigenous states, yet also sustained and enacted by individual subjects constituted through biomedically defined notions of difference. My return to this Foucauldian framework, which accounts for both the disciplinary and productive effects of biopower, directs me toward the varied, unintended effects of public health schemes, and the extension of biopolitical terrain from state institutions and medical practitioners to self-governing individuals. Further, by engaging these conceptual questions, this dissertation brings Chinese reproduction into dialogue with a broader historiography of public health in the non-Western world to highlight the dispersed, global, and multifaceted operations of biopower that linked imperialisms to state-building amid an emerging political order characterized by unequal relations between putatively autonomous nation-states.[63]

This dissertation also makes a number of empirical interventions with regard to MIH specifically. Within Chinese studies, the limited scholarship on MIH in the Republican Decades has focused more narrowly on the issue of childbirth and has largely minimized the geographic reach and impact of Nationalist-era MIH programs, even while noting that later programs in the PRC drew from these precedents. In a 2008 article, Tina Phillips Johnson asserted that plans for

[63] Alison Bashford has also pointed toward an operation of biopower beyond colonies or nation-states in the interwar period. See Alison Bashford, "Global Biopolitics and the History of World Health," *History of the Human Sciences* 19, no. 1 (2006): 67-88. See also Michel Foucault, "17 March 1976," "*Society Must Be Defended:" Lecutres at the Collége de France 1975-1976,* David Macey, trans., Mauro Bertani and Alessandro Fontana, eds., (New York: Picador, 1997, 2003), 239-264.

extending midwifery education into the Chinese interior "were not carried out…due to the political and civil strife of the Nationalist period."[64] Later in her 2011 monograph, Johnson affirmed this assessment based on a temporal scope bounded by the outbreak of war with Japan.[65] While briefly noting the founding of midwifery training centers in certain locales beyond coastal cities during the Nanjing Decade, Johnson argued, "Certainly in the countryside the number of modern midwife-assisted births was infinitessimal."[66]

This dissertation builds on Johnson's work focused on the urban East during the Nanjing Decade to demonstrate the cumulative development of MIH in the interior from the 1930s to the 1960s.[67] Using qualitative and quantitative information provided across surveys and reports, the provincial case studies outlined here suggest proportionally modest yet significant and rapid increases in the number of MIH institutions, personnel, and patients in western China during the 1930s and 1940s. Here, I build on the recent dissertations of Nicole Barnes and Mary Augusta Brazelton to demonstrate the continued development of public health in western China past the 1937 Japanese invasion, often counterintuitively aided by the displacement and political urgency

[64] Tina Phillips Johnson, "Yang Chongrui and the First National Midwifery School: Childbirth Reform in Early Twentieth-Century China," *Asian Medicine* 4 (2008):280-302, 286-87.

[65] Johnson briefly addresses the post-1937 history of reproductive health in the epilogue of her 2011 book, emphasizing the Second Sino-Japanese War as a period in which Nationalist programs faltered. Tina Phillips Johnson, *Childbirth in Republican China,* 167-170.

[66] Ibid., 156.

[67] Ibid., *passim.* In addition to Johnson's work, scholarship published in Chinese and Japanese has also noted the professionalization of medicine and midwifery in the Republican decades as related to broader developments of medical knowledge, nationalism, and state-building. See, for example, Yang Nianqun, Zaizao Bingren; Yao Yi 姚毅, Kindai Chūgoku no shussan to kokka shakai: yishi, josanshi, sesseiba 近代中国の出産と国家社会：医師,助産士,接生婆, (Tokyo: *Kenbun shuppan* 研文出版, 2011); see also Joan Judge, "Chinese Women's History: Global Circuits, Local Meanings," *Journal of Women's History* 24, no. 4 (Winter 2013): 224-243, 233-234.

of the war.[68] By accounting for actors and institutions that operated throughout the war years and across the Chinese Revolution, I largely sidestep questions of Nationalist failure and Communist success to highlight cumulative projects that exceeded the purview of either regime.

To be sure, the textured political terrain of the Nationalist decades meant that the development of MIH infrastructures proceeded unevenly across the territory now governed by the PRC. In her 2011 monograph on women in rural Shaanxi during the early PRC, Gail Hershatter found that Nationalist-era midwifery programs had limited impact in the areas she studied.[69] Nonetheless, as this dissertation shows, MIH projects with Nationalist-era origins continued throughout the 1940s and 1950s in many rural and remote areas, even as the very orchestrators of these projects repudiated their earlier work to accommodate a radically altered political context in the 1950s. Thus, the failures of Nationalist-era programs, including those operating under the auspices of the Nationalist state, have been overstated. The provincial cases outlined in this dissertation caution against any generalization of Nationalist failure based on isolated cases, to instead emphasize geographic variation beyond the urban east. In some areas of Western China, provincial-level authorities began to accommodate vernacular practices, recruiting and training lay midwives while incorporating their ritual practices before the founding of the PRC in 1949. More significant than absolute or proportional numbers, this dissertation demonstrates that the trend toward expansion seen in the early years of the PRC began and gained momentum in some areas of China prior to 1949 and continued, in varied form, thereafter.

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[68] Barnes, "Protecting the National Body"; Mary Augusta Brazelton, "Vaccinating the Nation: Public Health and Mass Immunization in Modern China, 1900-60," (PhD diss., Yale University, 2015).

[69] Gail Hershatter, *The Gender of Memory: Rural Women and China's Collective Past* (Berkeley and Los Angeles: University of California Press, 2011), 154-81.

This dissertation also builds on Johnson's highlighting of a variety of actors and interests shaping the development of MIH in China, while devoting greater attention to their distinct if converging motives and the macropolitical dynamics within which they were embedded. My analysis incorporates the voices and perspectives of a variety of Chinese MIH practitioners, in addition to the famous Yang Chongrui, who traveled throughout Asia, Europe, and the Americas and helped shape transnational discourses of maternalism and international developments in public health. In addition to several MIH physicians with varied allegiances and affiliations, I also include the biography of a midwife, Yang Yongni, and note how encounters between MIH workers and local women shaped public health policy and practice in the provinces.

Johnson argued throughout her 2011 book that foreign organizations and actors aided a select group of Chinese health advocates in a project that brought childbirth increasingly under the purview of the state even as the Nationalist government ultimately failed to enact large-scale reforms.[70] Other scholars writing on foreign public health philanthropy in China have similarly emphasized cooperative relationships between foreign actors and Chinese elites.[71] What remains unanswered is the question of why so many different actors and organizations became vested in Chinese public health and MIH specifically. To answer this question, I understand public health philanthropy as critical to the "imperialism of free nations," largely sidestepping debates within and beyond Chinese studies regarding whether or not such endeavors might be characterized as

[70] Johnson, *Childbirth in Republican China,* 126, 130, 156, *passim.*

[71] See Mary Brown Bullock, *An American Transplant: The Rockefeller Foudnation and Peking Union Medical College* (Berkeley and Los Angeles: University of California Press, 1980); John R. Watt, *Saving Lives in Wartime China: How Medical Reformers Built Modern Healthcare Systems amid War and Epidemics, 1928-1945* (Leiden: Brill, 2014).

"cultural imperialism."[72] Further, I aim to account for the diversified and unintended effects of philanthropic and government public health programs, with a particular focus on their relationship to Chinese feminisms.

Women's History, Gender History, and Histories of Feminism

This dissertation rests on an expansive body of scholarship, within and outside Chinese studies, which has used gender analytically to transform our understanding of a wide range of historical questions. A rich historiography within Chinese studies has dismantled any notion of Chinese women as mere objects of Confucian patriarchy to establish women as important actors shaping major developments of Chinese history. Scholars have further demonstrated the critical place of gender, as an analytical category structuring conceptions of and struggles over Chinese modernity.[73] My aim is to add to a recent spate of works that bring these insights, most clearly established in works focused on treaty-ports of the late-Qing and early Republican period, into the middle third of the twentieth century and into the interior.[74] Thus, among this dissertation's contributions is a continuation of the project to fill the gap between a robust gender history on the early twentieth century and the body of interdisciplinary feminist scholarship on the PRC.[75]

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[72] For an overview of this literature, see Steven Palmer, *Launching Global Health: The Caribbean Odyssey of the Rockefeller Foundation* (Ann Arbor: University of Michigan Press, 2010), 3-5; see also Mary Brown Bullock, *The Oil Prince's Legacy: Rockefeller Philanthropy in China* (Washington: Woodrow Wilson Center, 2011), 3-4.

[73] For surveys of this large body of literature, see Gail Hershatter, *Women in China's Long Twentieth Century* (Berkeley and Los Angeles: University of California Press, 2007); Gail Hershatter and Wang Zheng, "Chinese History: A Useful Category of Gender Analysis," *American Historical Review* 113, no. 5 (December 2008); Joan Judge, "Chinese Women's History."

[74] See, for example, Danke Li, *Echoes of Chongqing: Women in Wartime China* (Urbana and Chicago: University of Illinois Press, 2010); Nicole Barnes, "Protecting the National Body;" Chen Yan 陈雁, Xingbie yu zhanzheng: Shanghai, 1932-1945 《性别与战争：上海，1932-1945》 (Beijing: Shehui kexue wenxian chubanshe 社会科学文献出版社, 2014).

[75] For examples on feminist scholarship on the PRC across disciplines, see Tyrene White, *China's Longest Campaign: Birth Planning in the People's Republic, 1949-2005* (Ithaca: Cornell University Press, 2006); Susan

Further, by focusing on gender categories and women as state actors, this dissertation reconceptualizes dominant modes of periodizing twentieth-century Chinese history, highlighting projects to expand access to reproductive healthcare that spanned the divide of the 1949 Revolution.

But I am also guided by tensions developing within gender history, which have called into question the very categories on which the field rests. Many historians have long emphasized the contingent and variable constitution of the category "woman," noting its fragmentation by intersecting vectors of difference. Tani Barlow produced among the most significant critiques of the category within Chinese studies, based not on an intersectional approach but rather on the dispersed, historical subject positions in Chinese that have been imperfectly collapsed under the English moniker "woman" in modernity. Further, as Barlow noted, Chinese feminism, as a movement by and on behalf of "women", entailed a protracted process of conceptualizing its subject and scope. Barlow emphasized eugenics as foundational to the "woman" of "Chinese progressive feminism." I expand on these insights to probe the broader field of MIH, profoundly shaped by eugenicist ideals of racial futurity but also concerned with the implications of pregnancy, childbirth, and motherhood for women's overall wellbeing. I find a collective woman envisioned not only through eugenic formulations of the Victorian sex binary, but also through shared witnessing and bodily experiences of pregnancy, labor, and childbirth.[76]

Greenhalgh, *Just One Child: Science and Policy in Deng's China* (Berkeley and Los Angeles: University of California Press, 2008); Gail Hershatter, *The Gender of Memory.*

[76] Tani E. Barlow, *The Question of Women in Chinese Feminism* (Durham: Duke University Press, 2004), 53-51, 355, *passim*. Yung-chen Chiang has similarly argued that the eugenicist dynamics noted by Barlow remained situated within a larger discourse on motherhood during the 1910s and 1920s. See Yung-chen Chiang, "Womanhood, Motherhood, and Biology: The Early Phases of *The Ladies' Journal,* 1915-1925," *Gender & History* 18, no. 3 (November 2006): 519-545, 520.

Gender historians outside of Chinese studies have also begun interrogating both the category of 'woman' and the very notion of gender as a universal system structuring social relations. In this move, gender historians have engaged the historiography of sexuality, noting both sexuality's role in producing categories of social difference and the recent origins of the categories "homosexuality" and "heterosexuality."[77] In a provocative essay reflecting on her earlier monograph, Afsaneh Najmabadi asked if the substitution of a more historicist "same-sex love" for the modern notion of "homosexuality" might also ahistorically read back into the distant past and around the world categories of sex and gender derived from the modern West. Based on her own archival research, Najmabadi concluded that in pre-nineteenth-century Iran, a more complex arrangement of social categories, in which "man" and "woman" were constituted in relation not to each other, but rather in relation to *amrad* (male adolescence).[78] Similarly, in a monograph published in the same year as Najmabadi's essay, Mrinalini Sinha demonstrated the constitution of a universalized political category of "woman" in late colonial India in relation to sectarian communities rather than in relation to "man."[79] In a more recent essay, Gail Hershatter pointed to a similar "disquiet" within Chinese studies, suggesting the inadequacy of the categories and methods championed by gender historians.[80]

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[77] A classic work addressing this question is David M. Halperin, *One Hundred Years of Homosexuality: And Other Essays on Greek Love* (New York: Routledge, 1990).

[78] Afsaneh Najmabadi, "Beyond the West: Are Gender and Sexuality Useful Categories of Analysis?" *Journal of Women's History* 18, no. 1 (Spring 2006): 11-21; see also Najmabadi, *Women with Mustaches and Men without Beards.*

[79] Mrinalini Sinha, *Specters of Mother India*; see also Mrinalini Sinha, "A Global Perspective on Gender: What's South Asia Got to Do with It?" *South Asian Feminisms* (Durham: Duke University Press, 2012), 356-71.

[80] Gail Hershatter, "Disquiet in the House of Gender," *Journal of Asian Studies* 71, no. 4 (November 2012): 873-94.

In light of these critiques, I maintain a critical relationship to "woman" in primary sources examined throughout this dissertation, noting discrepancies between the varied deployment of the category by the host of actors invested in MIH. In each case I find tension between universalizing moves that refer to women's shared and unique reproductive capacities and metrics that sort women based on their varied efficacy in mothering. In the public health discourses surveyed here, biomedical notions of reproduction thus become a vector that at once bounds and fragments "woman." As I outline, this tension produced multiple political effects. The simultaneously held assumptions that bound women to reproduction and divided women based on their reproductive capacity structured the power relations that animated foreign interventions in China and the Nationalist government's colonization of the Chinese interior. Yet these notions also produced political solidarities in Chinese feminisms that were, at once, rooted in shared reproductive capacity and the structural factors that produced differing levels of access to the prerequisites of republican, scientific mothercraft. As I note in the later chapters of the dissertation, this development within Chinese feminisms occurred through mutual exchanges between feminists in other countries and global institutions. Thus, I differ somewhat from Najmabadi here, in seeing the constitution of "woman" in the Chinese case as integral to a global event, rather than the export of a category with nineteenth-century, Western provenance.[81]

My focus on Chinese feminist engagement with public health within China and on a global scale brings to the fore Chinese feminisms that have hitherto received limited attention. Scholars have identified the anarcho-feminist writers of the late-Qing period, the 'new women' of the May Fourth Era, feminist engagement with the Nationalist and Communist Revolutions,

[81] I draw here from Tani Barlow, "Event, Abyss, Excess: The Event of Women in Chinese Commercial Advertisement, 1910s-1930s," *Differences: A Journal of Feminist Cultural Studies* 24, no. 2 (2015): 51-92; see also Najmabadi, "Beyond the West."

women's contributions to the war against Japan, the pursuit of suffrage across the Republican decades, and feminist operations within and through the organs of the socialist state.[82] Scholars have further noted feminist engagement with nationalistic doctrines of eugenics in the Republican era,[83] but less attention has been paid to feminist campaigns to shape national public health policy, especially before 1949. By highlighting what I call "maternalist feminist praxis," I show how certain Chinese feminisms remained integral to and shaped by global movements to redress the suffering and exploitation of a reproductively defined constituency of women. To be sure, scholars have noted the transnational discourses shaping gender and feminism within China,[84] but few have engaged the imagining of feminist solidarities beyond Chinese borders or the critical role of Chinese actors to the development of transnational feminisms and global organizations in the middle third of the twentieth century.

Finally, this dissertation's periodization enriches our understanding of Chinese feminisms by tracing the activism of certain women across the rupture of 1949. This move juxtaposes texts written by a single author on both sides of this temporal divide to highlight strategic deference to radically different political ideologies that overlay a consistent commitment to expanding women's access to reproductive healthcare. This dissertation thus builds on Wang Zheng's

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[82] Some notable works in this field include Lydia H. Liu, Rebecca E. Karl, and Dorothy Ko, eds., *The Birth of Chinese Feminism: Essential Texts in Transnational Theory* (New York: Columbia University Press, 2013); Christina Gilmartin, *Engendering the Chinese Revolution: Radical Women, Communist Politics, and Mass Movements in the 1920s* (Berkeley and Los Angeles: University of California Press, 1995); Wang Zheng, *Women in the Chinese Enlightenment: Oral and Textual Histories* (Berkeley and Los Angeles: University of California Press, 1999); Louise Edwards, *Gender, Politics, and Democracy: Women's Suffrage in China* (Stanford: Stanford University Press, 2008); Wang Zheng, *Finding Women in the State.*

[83] See Yuehtsen Juliette Chung, *Struggle for National Survival: Eugenics in Sino-Japanese Contexts, 1896-1945* (New York: Routledge, 2002); Barlow, *The Question of Women in Chinese* Feminism; Mirela Violeta David, "Free Love, Marriage, and Eugenics: Global and Local Debates on Sex, Birth Control, Venereal Disease and Population in 1920s-1930s China" (PhD diss., New York University, 2014).

[84] See, for example, Judge, *The Precious Raft of History*; see also Judge, "Chinese Women's History."

recent insights regarding a Chinese feminist "politics of concealment" in the PRC to caution against a face-value reading of Nationalist-era writers who demonstrably shifted their rhetoric to claim a strategic position amid differing political conditions.[85]

Chapter Outline

The dissertation proceeds chronologically from the later 1920s to the early 1960s, with chapters organized around a particular actor or case study surrounding the development of MIH in China. After this introduction (Chapter One), Chapter Two places the advent of biomedical MIH in China within the context of the interwar world. Reconstructing correspondence between actors in Geneva, New York, Manila, and Beijing, this chapter demonstrates the key role that Chinese MIH programs played in binding new modes of imperialism and international health to the state-building aims of the Chinese Nationalists. This chapter argues that MIH provided a vocabulary of difference that connected the woman question and new metrics for managing population to an expanding, hierarchical system of nation-states. This remained particularly true in China, a putatively autonomous yet subjugated state believed to harbor both the world's largest population and its highest rates of mortality. Given this context, biomedical reforms to midwifery and motherhood became a point of convergence for the diversified political interests of the U.S. government, the Rockefeller Foundation, the League of Nations, and the newly founded Chinese Nationalist government by the late 1920s.

The next two chapters bring together public health reports and surveys from archives in Geneva, New York, Taipei, Shanghai, Kunming, and Lanzhou to demonstrate how local and provincial MIH programs in China remained intertwined with national and global projects in

[85] Wang Zheng, *Finding Women in the State,* 17-18.

public health, even as local actors adapted (inter-)national programs. These chapters examine the extension of biomedical MIH programs into contested regions of western China from the early 1930s to the later 1940s through case studies focused on the provinces of Yunnan (Chapter Three) and Gansu (Chapter Four). In both cases, Chinese-government policy and propaganda relied on demographic and biomedical categories of difference rooted in MIH to legitimate state and philanthropic intervention. Provincial public health officials adapted national models to local conditions, drawing from the precedent, expertise, and funding of international health organizations. Thus, these chapters show the multi-scalar dimensions of MIH with local specificity, highlighting the local manifestations of macropolitical dynamics and transnational discourses that produced a far-reaching if uneven reproductive landscape prior to 1949.

The dissertation then turns to the feminist utility of MIH in China, as a transnationally circulated body of knowledge that conditioned the rise of certain Chinese feminist physicians (Chapter Five) as well as their lobbying for health and welfare programs (Chapter Six). Chapter Five examines the national and transnational investments in MIH that informed a particular mode of feminist praxis in China. Unlike the growing male-dominance of obstetrics and gynecology in the United States, childbirth and infant care in China remained a primarily feminine domain of female doctors, nurses, and midwives. For many of these women, medical careers in the sciences of childbirth and mothering provided state-sanctioned sites for confronting the gendered, bodily suffering wrought by economic exploitation and imperialist violence. Expertise in mothercraft undergirded the technocratic positions of upper- and middle-class practitioners, differentiating them from the rural and lower-class women they served. However, these differences produced through the knowledge of MIH shaped a reevaluation of the subject and aims of the Chinese women's movement. Chapter Six draws from women's

periodicals and government petitions to examine feminist lobbying for a public medical system and public welfare programs in the later 1940s. These campaigns reframed high rates of maternal and infant mortality as evidence of the state's failure to address compounding, structural inequities between women. In petitions to legislative and advisory bodies of the Nationalist state, feminist physicians drew from transnationally circulated maternalist ideals to intervene in policies that disregarded differing levels of access to scientific mothercraft's prerequisite education, economic means, and healthcare. Highlighting locally salient differences of urbanity, region, health, and class, these lobbying efforts secured legal protections for healthcare and welfare in the 1947 Constitution of the Republic of China.

Chapter Seven outlines the diverging legacies of interwar precedents after the founding of the PRC in 1949. In Taiwan, cooperative endeavors between the Nationalist state, the World Health Organization, UNICEF, and U.S.-government agencies drew from the honed strategy of deploying rural midwives to reduce maternal/infant mortality while shoring up the Nationalist state's status among nations. In Taiwan, these projects became integral to emerging conceptual tripartite divisions of the world, with Taiwan serving as an exemplar of the "modernization theory" informing U.S. interventions globally. In socialist China, many of the institutions and actors critical to Nationalist-era developments partnered with organs of the newly founded PRC government to reduce maternal and infant mortality further. As I show by tracing the post-revolutionary careers of select feminist physicians, these continued efforts in MIH depended on the negation of pre-revolutionary histories of reproductive health. Further, this chapter points to a shift in global reproductive health beginning in the later 1950s from an emphasis on reducing mortality to an emphasis on managing fertility that occurred contemporaneously on both sides of the Taiwan Strait. These later, more familiar campaigns to manage fertility counterintuitively

rested on the very infrastructures and strategies that had been used to reduce mortality from the 1920s to the 1950s. Finally, a brief conclusion provides a summary of key arguments and the significance of this project.

Chapter 2: Converging Investments:

Chinese Maternal and Infant Health (MIH) in the Interwar World

In 1925, John Black Grant proposed a new biomedical midwifery-training center in Beijing to his colleagues within the Rockefeller Foundation. After more than a decade of philanthropy in China, the Foundation had little to show for its efforts aside from the sometimes controversial Peking Union Medical College (PUMC), which the Rockefeller China Medical Board had purchased from medical missionaries in 1915.[86] Through his work with local populations in Beijing and throughout China, Grant had identified unhygienic childbirth as a leading cause of mortality, which produced a recognized and urgent health concern for the local population. He proposed that this widespread problem could be easily remedied by providing biomedical training to the midwives upon whom much of the Chinese population already relied. Thus, Grant argued, local norms that sustained female midwives combined with high rates of puerperal fever and neonatal tetanus (resulting from the unhygienic cutting of umbilical cords) presented a unique opportunity to extend the reach of an international public health operation into China, where Rockefeller philanthropies had hitherto had limited impact. In conversations with Henry Houghton and Victor Heiser of the Foundation, China Medical Board Resident Director Roger S. Greene endorsed Grant's proposal on the basis that, given the particularities of the Chinese case,

[86] This institution would later become celebrated as the Johns Hopkins of China. See Mary Brown Bullock, *An American Transplant: The Rockefeller Foundation and Peking Union Medical College* (Berekely and Los Angeles: University of California Press, 1980), 4-5, 24-47, *passim.*

maternal and infant health (MIH) would provide "the ideal entering wedge for public health enterprises in China just as hookworm work had been used in other countries."[87]

The "hookworm work" to which Greene referred had been the focused initiative to extend Rockefeller health philanthropy outward from the American South and around the world in the early decades of the twentieth century. Heiser, who became Far East Director of the Rockefeller International Health Board (IHB) after overseeing anti-hookworm and other public health campaigns in the U.S.-administered Philippines, made explicit the connections between Rockefeller health philanthropy, U.S. strategic interests, and corporate capitalism amid the shifting dynamics of the interwar world. In opposition to older, European modes of subjugating less powerful states through violence, Heiser argued that U.S. commercial and strategic interests would be better served by a more benevolent approach that promoted health and wellbeing. In response to "the constant reiteration of the British, the French, and the Dutch that it was waste of time and money to sanitate Orientals, who wanted to be left to their ancient unsavory habits,"[88] Heiser argued, "disease never stays at home in its natural breeding places of filth, but is ever and again breaking in the precincts of its more cleanly neighbors. As long as the Oriental was allowed to remain disease-ridden, he was a constant threat to the Occidental…"[89] Heiser at once emphasized a hierarchy of nations and the economic impact of U.S. public health philanthropy, arguing, "human life had a direct monetary value, even though it might be difficult to estimate and might vary greatly with age and race."[90] In Heiser's own estimation, "health should be

[87] Roger S. Greene to Henry Houghton, October 29, 1926 (RAC, Rockefeller Foundation Archives, RG 1.1 Series 601 Box 268 Folder 3398).

[88] Victor Heiser, *An American Doctor's Odyssey: Adventures in Forty-five Countries* (New York: W.W. Norton & Co., 1936), 37-38.

[89] Ibid., 37-38.

[90] Ibid., 37-38.

regarded from the economic as well as from the humanitarian viewpoint,"[91] given that public health work promised to increase the productivity of workers and foster conditions amenable to Western corporations and states. According to Heiser, many in the Rockefeller Foundation shared this opinion and had promoted public health globally based on the belief that "education and health…rather than indiscriminate charity, would make philanthropy produce dividends."[92]

Scholarship on South Asia, Southeast Asia, and Latin America has largely affirmed ties between U.S-based corporate philanthropy and the multifaceted operations of U.S. imperialism.[93] Despite their varied, individual motives and allegiances, many representatives of the Rockefeller Foundation, including many of those overseeing its health operations, maintained regular correspondence with U.S. military leaders and diplomats and moved between positions in government, business, and philanthropy. In the formal colonies of the U.S. after the Spanish American War, the Rockefeller IHB worked with the U.S. military to transform the societies of Guam, Puerto Rico, and the Philippines through public health. Further, as U.S. commercial and strategic interests expanded globally, the Rockefeller Foundation worked in concert with the U.S. military to ensure a safe and disease-free arena for trade.[94] In the colonies of European

[91] Ibid., 37-38.

[92] Ibid., 267.

[93] For example, see see E. Richard Brown, "Public Health in Imperialism: Early Rockefeller Programs at Home and Abroad," *American Journal of Public Health* 66, no. 9 (1976): 897-903; Brian Smith, *More than Altruism: the Politics of Private Aid* (Princeton, NJ: Princeton University Press, 1992); Paul Weindling, "Public Health and Political Stabilisation: The Rockefeller Foundation in Central and Eastern Europe between the Two World Wars," *Minerva* 31 (1993): 253-67; Laura Briggs, *Reproducing Empire: Race, Sex, Science, and U.S. Imperialism in Puerto Rico* (Berkeley and Los Angeles: University of California Press, 2002); Warwick Anderson, *Colonial Pathologies: American Tropical Medicine, Race, and Hygiene in the Philippines* (Durham, NC: Duke University Press, 2006); Terence H. Hull, "Conflict and Collaboration in Public Health: The Rockefeller Foundation and the Dutch Colonial Government in Indonesia," in Milton J. Lewis and Kerrie L. Macpherson, eds., *Public Health in Asia and the Pacific: Historical and Comparative Perspectives* (New York: Routledge, 2008), 139-152.

[94] Nicholas B. King, "Security, Disease, Commerce: Ideologies of Postcolonial Global Health," *Social Studies of Science* 32, no. 5/6 (Oct.-Dec., 2002): 763-789.

powers, Rockefeller leaders also used biomedicine to demonstrate the superiority of Western civilization, affirming a broadly conceived "white man/white woman's burden" that also shored up a U.S. challenge to European power.[95]

However, in the historiography on China, the connections between Rockefeller philanthropy and U.S. imperialism—however defined—have largely been minimized. Scholars have noted Rockefeller philanthropists' efforts to aid "national reconstruction" and "modernization" in China, without adequately attending to the historical conditions and macropolitical dynamics that shaped foreign interventions in Chinese public health. Some have explicitly argued against a framing of Rockefeller philanthropy as "cultural imperialism," pointing to the cooperation of indigenous actors and the willingness of foreigners to adapt global models to local conditions.[96]

Implicit in these assessments is a false choice between imperialism as either formal, foreign rule in the mode of European empires or "cultural imperialism," narrowly defined as the forced imposition of a foreign culture without the participation of native subjects or adaptation to local conditions. The Chinese case fits neither of these models. Yet, archival sources demonstrate the extent to which Rockefeller investments in Chinese public health remained intertwined with a broader project to extend U.S. influence around the world and protect U.S. strategic and commercial investments in the Pacific. As Prasenjit Duara has noted, this exercise of influence

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[95] Mrinalini Sinha, *Specters of Mother India: The Global Restructuring of an Empire* (Durham, NC: Duke University Press, 2006). 73-74*;* see also E. Richard Brown, "Public Health in Imperialism."

[96] See Mary Brown Bullock, *The Oil Prince's Legacy: Rockefeller Philanthropy in China* (Washington: Woodrow Wilson Center, 2011), 3-4; Tina Phillips Johnson, "Yang Chongrui and the First National Midwifery School: Childbirth Reform in Early Twentieth-Century China," *Asian Medicine* 4 (2008):280-302, 290-91; see also Tina Phillips-Johnson, *Childbirth in Republican China: Delivering Modernity* (Lanham, MD: Lexington Books, 2011); John R. Watt, *Saving Lives in Wartime China: How Medical Reformers Built Modern Healthcare Systems amid War and Epidemics* (Leiden: Brill, 2014).

within and through nation-states became a defining characteristic of the "new imperialism" or "the imperialism of 'free nations'" that characterized the U.S.S.R., Japan, and the U.S. during the interwar period.[97] This extension of U.S. power depended upon a universalized and unequal system of putatively autonomous states and disavowed earlier modes of European power, even as it drew from the U.S.'s own colonial precedents in Puerto Rico, Guam, and the Philippines.[98] The efforts of Chinese nationalists to forge and defend an autonomous state legible to international organizations and an emerging global system of nation-states thus proved compatible—in fact, integral—to the triangulated aims of business, philanthropic, and government entities to foster conditions amenable to U.S. commercial and diplomatic interests in the Pacific.

Both international and national projects depended on the articulation of difference, through which clear distinctions could be made between those fit to intervene and those in dire need. Though, unlike earlier European empires, the "imperialism of 'free nations'" tended to emphasize inclusion over exclusion, clearly delineated hierarchies remained critical for justifying linked, external interventions at both national and international scales.[99] In the early twentieth century, science and medicine provided a primary idiom for articulating these hierarchies, in tandem with a global "woman question" that sorted nations based on the relative status of women. In women's reproductive health, these two vectors of difference intersected, while also connecting demographic measures of populations (eg: maternal and infant mortality) to the

[97] Prasenjit Duara, "The Imperialism of 'Free Nations': Japan, Manchukuo, and the History of the Present," *The Global and Regional in China's Nation-Formation* (New York: Routledge, 2009), 40-58.

[98] Other empires also used this strategy. See Julian Go, *Patterns of Empire: The British and American Empires 1688 to the Present* (New York: Cambridge University Press, 2011), 108-111.

[99] I differ here somewhat from Duara's articulation of "the imperialism of 'free nations.'" Duara minimized the articulation of difference in this new mode of imperialism. See Duara, "The Imperialism of 'Free Nations'," 43-45.

quotidian tasks associated with childbirth and mothering. As Laura Briggs has shown in the case of U.S.-administered Puerto Rico, quantified data on infant mortality made women's reproductive health—and the issue of sexuality more broadly—a primary grounding for the power relations between U.S-based civilizers and the objects of their missions.[100]

Despite the absence of the colonial context seen in Puerto Rico, many U.S.-based philanthropists conceived of their work in China in a similar biomedical idiom of childbirth and motherhood, even as they debated the best methods and timing for intervening in Chinese public health. Depending on the source, Chinese women gave birth to either too few or too many children, too many of whom had defects and/or diseases, and thus, they required immediate and extensive aid. The construction and reiteration of these empirical (if inconsistent) facts connecting Chinese women's reproduction to the health of the population as a whole also served the interests of Chinese state-building, legitimizing its authority to manage women's reproduction as a benevolent civilizing mission in the interior. Originally conceived by U.S.-based philanthropists, the project to revolutionize childbirth and motherhood along biomedical models ultimately found allies in the Chinese Nationalist state and the League of Nations Health Organization. Unhygienic childbirth and mothering among Chinese, problems identified by Rockefeller representatives as among the most urgent public health needs, proved central to both nationalistic anxieties and global concerns about the quality and quantity of Chinese bodies. Thus, shaped by conditions particular to the interwar world, the projects of state-building, international health, and U.S. imperialism converged on the issue of MIH, making Chinese women's reproductive health a site of dense political significance by the early 1930s.

[100] Laura Briggs, *Reproducing Empire: Race, Sex, Science, and U.S. Imperialism in Puerto Rico*, 14-20.

The Pre-History of Chinese Public Health

The earliest endeavors to develop a national public health system in China entered a pluralistic field of medical knowledge, shaped by competing schools of indigenous medicines and roughly a century of medical practice by missionaries and treaty-port authorities. The skilled practice of medicine by Chinese *literati* had developed over centuries from a set of cosmological and Daoist modes for "sustaining life" to the late imperial search for corporeal knowledge from classic texts. Replete with drug therapies and health manuals, these prescriptive systems for treating disease gained ground with the growth of print culture and commerce from the Song (960-1279) through the Qing (1644-1912) dynasties. By the late imperial period, the codified medical knowledge of male *literati* coexisted and often competed with widespread vernacular medicines. This remained especially true for medicines surrounding reproduction, given the economic circumstances and norms of gender segregation that led many parturient women to rely on lay midwives. Much to the scorn of *literati* doctors, these midwives gained popularity with the broader circulation of *literati*-authored medical texts. As Gail Hershatter has noted in her ethnographic study of rural Shaanxi women, these vernacular medicines surrounding childbirth remained prevalent in some locales into the latter half of the twentieth century, making reproduction a thickly layered domain of medical practice.[101]

The introduction of Western medicines by missionaries and treaty-port doctors in the nineteenth century further fueled tensions among competing medicines in China. In an act that

[101] Ruth Rogaski, *Hygienic Modernity: Meanings of Health and Disease in Treaty-Port China* (Berkeley and Los Angeles: University of California Press, 2004), 24-6; Charlotte Furth, *A Flourishing Yin: Gender in China's Medical History, 960-1665* (Berkeley and Los Angeles: University of California Press, 1999), *passim*; Yi-li Wu, *Reproducing Women: Medicine, Metaphor, and Childbirth in Late Imperial China* (Berkeley and Los Angeles: University of California Press, 2010), 15-53; Gail Hershatter, *The Gender of Memory: Rural Women and China's Collective Past* (Berkeley and Los Angeles: University of California Press, 2011), 154-81; I also draw here from Nancy Rose Hunt, *A Colonial Lexicon: Of Birth Ritual, Medicalization, and Mobility in the Congo* (Durham: Duke University Press, 1999), 323.

would be widely cited as the arrival of "modern medicine" in China, an American missionary named Peter Parker opened an ophthalmologic hospital in Guangzhou in 1835. Missionaries often lacked adequate training in preventive medicine and the material resources necessary for large-scale public health operations. The skepticism of many Chinese and the Qing state regarding both missionaries' presence in China and their surgical methods placed further limits on the practice of missionary medicine in the nineteenth and early twentieth centuries. In fact, the Qing dynasty's Imperial Medical College banned all invasive therapies (including surgery and acupuncture).[102]

Late-Qing literati doctors responded to the challenge of foreign medicines in a variety of ways, and "Chinese" and "Western" medicines evolved coevally into the twentieth century. Some asserted the compatibility of indigenous and biomedical methods. For example, Tang Zonghai 唐宗海 of the School of Converging Chinese and Western Medicine (*Zhongxi huitong xuepai*) proposed syncretism. According to Tang, Chinese medicine offered sensitivity to the forces of *yin, yang,* and *qi* to supplement biomedical modes rooted in experimentation and a thorough knowledge of anatomy. Others such as Yu Yunxiu 余云岫 advocated for a complete rejection of Chinese medicine and an embrace of science. A particularly devastating outbreak of Manchurian plague in 1911 swayed many Chinese doctors and political leaders toward an embrace of scientific methods for containing contagion and treating disease, while also connecting public health and the practice of Western medicine in China to state concerns

[102] Yan Yiwei 颜宜葳 and Zhang Daqing 张大庆,"*Jibing pu yu zhiliao guan—zaoqi jiaohui yiyuan de anli fenxi* 疾病谱与治疗观——早期教会医院的案例分析," in Yu Xinzhong 余新忠，ed., Qing yilai de jibing, yiliao he weisheng: yi shehui wenhuashi wei shijiao de tansuo《清以来的疾病，医疗和卫生：以社会文化史为视角的探索》(Beijing: SDX Joint Publishing Co., 2009):109-125,110-11; see also Sean Hsiang-lin Lei, *Neither Donkey nor Horse: Medicine in the Struggle over China's Modernity* (Chicago: University of Chicago Press, 2014), 45-47.

regarding governance and sovereignty. Amid the iconoclasm of the 1910-20s, growing numbers of prominent intellectuals came to advocate for the exclusive practice of biomedicine. However, many continued to resist biomedical hegemony into the middle decades of the twentieth century.[103]

The lack of a stable government in China to regulate and oversee medicine in the early decades of the twentieth century allowed for continued diversity of practice, while also preventing the development of a coordinated and coherent system of public health. Some administrators in treaty-ports attempted to improve structural and environmental conditions to foster healthy and hygienic urbanites within their concessions, but missionary medicine remained focused on the treating of individual maladies. Even as educated, urban elites developed an affinity for the methods and tenets of biomedicine, the varied forms of indigenous medical knowledge remained dominant throughout much of the interior. Elites with biomedical educations had obtained them primarily from Japanese institutions and aligned themselves with the work of like-minded German missionaries. Amid such diversity, American doctors remained marginalized prior to the 1920s.[104]

Yet, *fin-de-siècle* changes in U.S. medical practice had profound implications for the development of public health systems in China and throughout the world. U.S. physicians embraced scientific knowledge in the late nineteenth century to elevate medicine into a highly skilled and respected profession. The accompanying need for technological instruments and

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[103] Lei, *Neither Donkey nor Horse,* 44-45, 69-73, 98-99; see also David Luesink, "The *History of Chinese Medicine*: Empires, Transnationalism, and Medicine in China, 1908-1937," in Iris Borowy, ed., *Uneasy Encounters: The Politics of Medicine and Health in China, 1900-1937* (Frankfurt am Main: Peter Lang, 2009), 149-176, 152.

[104] Ibid., 122-125; Japanese public health borrowed heavily from German models, which emphasized compulsory hygiene and relied, to some degree, on police departments. L.W. Hackett, Interview with Raymond B. Fosdick, May 1951 (RAC, Rockefeller Foundation Archives, RG3 Series 908 Box 6 Folder 58); see also Bridie Andrews, *The Making of Modern Chinese Medicine, 1850-1960* (Vancouver: UBC Press, 2014), 41-42.

facilities presented physicians with costs that far exceeded their modest means. To secure the financial resources necessary for biomedical practice, U.S. doctors turned to those who had benefitted most from the rise of industrial capitalism. Capitalists held both the means and interests to support a more professionalized and scientific medicine. In dialogue with physicians, philanthropic foundations backed by private wealth came to see the misery associated with the lower classes as a technical problem solvable through emerging technologies of scientific medicine. The capitalist backing of medical practice also promised to foster good will for wealthy families and their enterprises, both from the medical professionals they supported directly and the lower classes who stood to benefit from medical advances.[105]

The Rockefeller Foundation quickly became a primary player in the development of public health in the U.S. and around the world. In the later nineteenth-century, the Rockefeller-founded Standard Oil Company had become what Alfred Chandler described as "the first of the great industrial consolidations," due to its "extensive managerial hierarchy" that coordinated a "global industrial empire."[106] However, at the turn of the twentieth century, the corporation encountered scathing critiques from labor organizations and muckraking journalists. Many opposed Standard Oil's exploitative and negligent practices toward workers. In what proved highly controversial endeavors, John D. Rockefeller, Sr. and his associates founded charitable

[105] E. Richard Brown, *Rockefeller Medicine Men: Medicine and Capitalism in America* (Berkeley and Los Angeles: University of California Press, 1979).

[106] Alfred D. Chandler, Jr., *The Visible Hand: The Managerial Revolution in American Business* (Cambridge, MA: Harvard University Press, 1987), 422; see also Sherman Cochran, *Encountering Chinese Networks: Western, Japanese, and Chinese Corporations in China, 1880-1937* (Berkeley and Los Angeles: University of California Press, 2000), 12.

organizations for the promotion of education and scientific research, widely seen as a transparent attempt to rebrand the family and its businesses.[107]

Many observers at the turn of the twentieth century and since have viewed these efforts as thinly veiled attempts to "whitewash the sins of Standard Oil."[108] The U.S. government initially denied the Rockefeller Foundation a federal charter in 1910 amid public distrust of monopolistic capitalism and the vocal opposition of labor leaders. The Rockefeller family in particular, it was argued, had contributed to the deaths of workers through negligent and exploitative practices, including the deaths of coal miners and more than a dozen of their wives and children during the infamous Ludlow Massacre. Attorney Frank Walsh, appointed to lead a Commission on Industrial Relations from 1913 to 1918, asserted that the Rockefeller Foundation constituted an attempt to take money "from the toil of thousands of poorly nourished, socially submerged men, women, and children….to exact a tribute of loyalty from the whole profession of scientists, social workers, and economists."[109] Amid such opposition to both their business and philanthropy, the Rockefeller family and its associates redirected charitable funds to a short list of less controversial issues (primarily medicine and public health), based on the belief that labor, business, the U.S. government, and the public at large would readily welcome these projects.[110]

The public health philanthropy of the Rockefeller family began in the American South in the first decade of the twentieth century. Rockefeller leaders saw the southern states as ripe for

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[107] See Victoria Cain, "'An Indirect Influence upon Industry': Rockefeller Philanthropies and the Development of Educational Film in the United States, 1935-1953," in Devin Orgeron, Marsha Orgeron, and Dan Strebile, eds., *Learning with the Lights Off: Educational Film in the United States* (New York: Oxford University Press, 2012), 230-248, 232-3; see also David C. Hammack, "American Debates on the Legitimacy of Foundations," in Kenneth Prewitt, Mattei Dogan, Steven Heydemann, and Stefan Toepler, eds., *The Legitimacy of Philanthropic Foundations: United States and European Perspectives* (New York: Russel Sage Foundation, 2006), 49-98, 67-70.

[108] Cain, "'An Indirect Influence upon Industry'," 232.

[109] Hammack, "American Debates on the Legitimacy of Foundations," 67-70.

[110] Ibid.

industrialization and public health as a valuable tool for integrating the region into the more industrialized economy of the North. Frederick T. Gates, an early pioneer in Rockefeller philanthropy, found inspiration in the research of Dr. Bailey K. Ashford and Dr. Charles Wardell Stiles. Ashford, a lieutenant in the U.S. Army Medical Corps, published reports on the destruction wrought by *uncinariasis* or hookworm disease, which caused anemia among laborers in the recently acquired U.S. colony Puerto Rico. Building upon Ashford's work, Stiles identified hookworm as a primary threat to the productivity of cotton-mill workers in the American South. Popularly known as the "germ of laziness," hookworm disease resulted from a parasite that entered the bare feet of laborers to produce symptoms of paleness and fatigue. Stiles noted that the disease could be prevented by simple improvements in the construction of latrines, leading Gates to seize the opportunity to address this nuisance to both public health and productivity. The Rockefeller Sanitary Commission for the Eradication of Hookworm treated nearly 700,000 individuals in the American South by 1914. Within the Foundation, these projects were seen as achieving their intended objective of combatting both a particular malady and spurring the broader development of sanitation and public health departments throughout the region.[111]

The Sanitary Commission's successes within the U.S. fostered a perception that anti-hookworm campaigns provided a model that could be replicated to produce similar results around the world. In 1913, the Rockefellers founded the International Health Commission [later, International Health Board (1916-1927) and then International Health Division (1927-1951) (hereafter, IHC, IHB, or IHD)] aiming first to survey and target hookworm and thereby develop

[111] F. T. Gates to J. D. Rockefeller, Dec. 12, 1910 (RAC RG 2) quoted in E. Richard Brown, "Public Health in Imperialism: Early Rockefeller Programs at Home and Abroad," *American Journal of Public Health* 66, no. 9 (Sept. 1976): 897-903; Victor Heiser, *An American Doctor's Odyssey*, 266-269; see also Warwick Anderson, *Colonial Pathologies.*

public health infrastructures throughout Asia, Africa, and Latin America. However, Rockefeller anti-hookworm campaigns entered an existing field known as "tropical medicine," which connected the research agendas of primarily European doctors to research sites and subjects in colonies throughout Africa and Asia. Sanitary conferences in Europe in the later nineteenth century and the founding of the *Office International d'Hygiene Publique* (OIHP) in 1907 helped to make early endeavors in tropical medicine a site of collaboration among British, German, and French doctors, each conducting medical research in their respective colonies.[112]

Mirroring the actions of European doctors, U.S. doctors affiliated with the Rockefeller IHC affirmed their partnership with U.S. colonial authorities, helping to construct public health programs in the U.S. territories acquired through the Spanish-American War. In these tropical regions, hookworm again proved a prevalent and preventable problem. In 1914, the director of health in the U.S.-administered Philippines, Victor Heiser, joined with the Rockefeller IHC, becoming regional director of its operations in the East. Under Heiser's leadership and with Rockefeller aid, public health in the Philippines prioritized hookworm along with malaria and leprosy while also devoting specific attention to medical education. In a now infamous quote, then president of the Rockefeller Foundation George Vincent lauded these endeavors, explicitly connecting them to a broader vision of U.S. power in the world. In Vincent's own words, Rockefeller work in the Philippines had demonstrated that "for purposes of placating primitive and suspicious peoples medicine has some advantages over machine guns."[113] At the urging of the Surgeon General of the U.S. Navy, the Rockefeller IHB also began work to combat

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[112] Susan Gross Solomon, Lion Murard, and Patric Zylberman, "Introduction," *Shifting Boundaries of Public Health: Europe in the Twentieth Century* (New York: Rochester University Press, 2008), 9-10; Deborah J. Neill, *Networks in Tropical Medicine: Internationalism, Colonialism, and the Rise of a Medical Specialty, 1890-1930* (Stanford, CA: Stanford University Press, 2012), 165-181.

[113] George Vincent quoted in *The Nation,* June 8, 1918. See also Edward H. Berman, *The Ideology of Philanthropy*, 26; Anderson, *Colonial Pathologies*, 196-199.

hookworm disease in U.S.-administered Guam in 1918 while contuing to work in the Philippines. The surveyors, which included Dr. John Black Grant, found seventy-one percent of a sample of 857 Guamanians infected with hookworm. The IHB argued that this menace to public health could be easily resolved with local resources by constructing inexpensive latrines, based on the precedent of U.S. officials and health workers elsewhere in the world.[114]

Given the now apparent utility of anti-hookworm campaigns to spur public health and aid U.S. strategic interests, the Rockefeller Foundation further expanded operations around the world, though an altered political landscape soon reshaped the nature and scope of IHB/D endeavors. In the aftermath of the First World War, tropical medicine shifted from a cooperative endeavor between doctors across European empires to a competitive and exclusionary operation of threatened imperial power. The 1919 Treaty of Versailles redistributed Germany's territories in Africa and the Pacific among the victors of World War I or placed them under British and French administration as mandates of the League of Nations. Separated from its colonies, German tropical medicine floundered, while U.S. and Japanese influence, broadly construed, grew in Asia and the Pacific. In the U.S. case, this influence often proceeded, in part, through public health philanthropy that operated in cooperation with the U.S. military and State Department as well as the League of Nations.[115]

Rockefeller Ventures in China

[114] Rockefeller International Health Board, *Fifth Annual Report, January 1, 1918-December 31,* 1918 (New York, 1919), 87; see also Necrology File: John Black Grant (Bentley Historical Library, University of Michigan, Ann Arbor).

[115] Neill, *Networks in Tropical Medicine*, 182-185.

Rockefeller interest in China began long before the founding of the Rockefeller Foundation. John D. Rockefeller, Sr. reportedly sold his first kerosene lamp to a Chinese customer in 1867, and Standard Oil gradually increased the sale of its goods through Chinese agents into the 1880s until it accounted for nearly all of U.S. oil exports to China. In the final years of the nineteenth century, American market shares reduced dramatically due to increased imports from Russia and Dutch Sumatra.[116] U.S. diplomats perceived the threat to Standard Oil within a broader, European threat to U.S. trade in China and the Pacific, as multiple European powers sought to increase their economic clout in the region. The U.S. minister to China, Charles Denby, wrote in 1898 that European powers…

> …recognize the fact that trade follows the flag. Where their ships go and where they make their national influence felt, there trade springs up to meet them. They recognize that the present is a critical period in the history of China…The people of the United States must not be content to see their neighbors to the West, with their boundless potentialities of trade, handed over, an uncontested prize, to the ambitions of Europe.[117]

The threat to growing U.S. trade in the Pacific fueled a dramatic expansion of U.S. naval and diplomatic power beginning in the 1880s. As President William McKinley himself admitted, U.S. presence in the Pacific served, in part, to thwart "commercial rivals in the Orient."[118] Following the Japanese victory over the Qing in the First Sino-Japanese War of 1894-95, the threat of China's dissolution into foreign concessions posed a further threat to U.S. interests in the continuation of unfettered trade. With a stronger naval presence in the region, the U.S. adopted the "Open Door" policy in 1899, aimed at protecting the exercise of free trade in

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[116] Cochran, *Encountering Chinese Networks,* 12-27, 30-33; see also Bullock, *The Oil Prince's Legacy*.

[117] Charles Denby, "America's Opportunity in Asia," *North American Review* 166, no. 494 (1898): 32-40; see also Julian Go, *Patterns of Empire,* 222-3.

[118] William McKinley to Paris Peace Commission, September 26, 1898 in Charles Sumner Olcott, ed. *The Life of William McKinley*, vol. 2 (New York: Houghton Mifflin, 1916), 111.

Chinese markets. In the following decades, as Julian Go has noted, "The door not only had to be thrust open through force, but kept open as rivals tried to close it."[119]

Defended by the U.S. military and State Department, the U.S. corporation with the largest trade operation in China sought to protect and enhance its business. Standard Oil founded its Chinese affiliate *Meifoo* 美孚 in 1903, signaling a more direct and expansive investment in China. Executives devoted twenty million U.S. dollars to China alone, more than the total spent in the rest of Asia combined. Working through Chinese staff, Standard Oil circumvented laws that isolated foreign land ownership to treaty ports and reclaimed its dominance of the market by extending its ventures deep into the Chinese interior. Further, Standard Oil and its successor companies recruited Westerners seen to have deep knowledge of China, including the missionary V. G. Lyman who ultimately became a manage in the North China Department of the Standard Oil Company. In the decade from 1895 to 1905, U.S. exports of kerosene to China (excluding Hong Kong)—nearly 100 percent of which were carried out by Standard Oil—increased from 18.02 million to 89.47 million gallons per annum. In 1919, roughly eighty-percent of all Chinese oil imports came from U.S. corporations.[120]

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[119] Go, *Patterns of Empire,* 223; see also Bruce A. Elleman, *International Competition in China, 1899-1991: The Rise, Fall, and Restoration of the Open Door Policy* (New York: Routledge, 2015).

[120] U.S. courts ruled the original Standard Oil an illegal monopoly in 1911, and it was broked up into several smaller companies. Ironically, this fragmentation enhanced the wealth of John D. Rockefeller, Sr., who held a quarter of the shares in each subsidiary company. In China, the "Standard Oil Company of New York" or SOCONY continued to hold much of the market into the 1930s, when it merged with Vacuum Oil, another former subsidiary of Standard Oil. This new company became the Mobil Oil Coproration in 1966, before merging with yet another successor corporation of Standard Oil, Exxon, in 1999. Standard-Vacuum Oil Company (or Stanvac) also operated in China during the Republican period as a jointly held supsidiary of Standard Oil Company of New Jersey (later Exxon) and Socony-Vacuum (later Mobil). See Cochran, *Encountering Chinese Networks,* 12-27, 30-34; see also Irvine H. Anderson, Jr., *The Standard-Vacuum Oil Company and United States East Asian Policy 1933-1941* (Princeton: Princeton University Press, 1975), 204; Patrick A. Gaughan, *Mergers, Acquisitions, and Corporate* Restructurings, Fourth Edition (Hoboken: John Wiley & Sons, 2007), 146.

This broad effort to enhance U.S. strategic and commercial interests in China further relied on Roger Sherman Greene. Greene worked for the U.S. State Department throughout the early twentieth-century, holding several consular positions including posts in Russia, Manchuria, and China proper. From this position, Greene maintained regular correspondence with U.S. officials, U.S. businessmen, and his brother, Jerome Greene, who played a key role in early philanthropic ventures of the Rockefeller family. As Standard Oil and its successor companies aimed to thwart Russian competition in the early twentieth century, Greene proved a valuable asset. He regularly corresponded with V.G. Lyman, who explicitly thanked Greene specifically for his aid in supporting the business interests of Standard Oil and its successor companies. When Greene transferred from Vladivostok to Harbin in 1909, Lyman wrote, "It is proper that I should express the very full appreciation which I feel in respect to all that you have done both for the Company and myself personally, and I am only sorry that you are not remaining to see the inception and completion of the first American enterprise in Dairen."[121] From his consular post in Harbin, Greene continued to advise Lyman, writing in March 1909 as to how Standard Oil might thwart Russian competition. Greene wrote, "You know yourself how much American oil will be sold in this good country [China] if the Russians have their way, and it seems to me that it will be worth your while to spend a considerable amount of trouble and money if necessary to win and keep a footing here."[122] Further Greene offered, "You amy depend upon it that I will do everything in my power to get fair treatment for American interests, and I believe the present is a favorable moment to press our rights. Our government at home is very much interested in the

[121] V.G. Lyman to Roger Greene, February 8, 1909 (Roger Sherman Greene, hereafter RSG, Papers, Houghton Library, Harvard University, Item #20).

[122] Roger Greene to V.G. Lyman, March 20, 1909 (RSG Papers, Item #22).

matter…"[123] As Greene made clear here and in much of his correspondence, the business aims of Standard Oil in China aligned with those of U.S. foreign policy to maintain the "Open Door." The perpetuation of Chinese sovereignty aided both the commercial and strategic interests of U.S. actors in the face of competing powers which might seek to gain a formal colony. This alignment between the interests of the U.S. government and U.S. corporations developed, to some degree, through deliberate coordination. For Greene and his interlocutors, the collaboration between the State Department, Standard Oil, and ultimately, Rockefeller philanthropies, remained a little-examined, common-sense relationship serving the interests of all parties, including the Chinese government and people.[124]

Through his work in the consular service, Greene came to the attention of John D. Rockefeller, Sr. as a possible figure who might aid the family's philanthropic endeavors in China. In 1914, an offer came through Greene's brother, Jerome, for Roger Greene to assume a position with the Peabody Commission of the Rockefeller Foundation and survey conditions for public health philanthropy. Jerome asserted that he had "never done anything to push [Roger] forward in this connection," but that "Mr. Rockefeller" himself had mentioned Roger by name regularly throughout the prior two years.[125] Simultaneously, officials at the State Department were eyeing Greene for advancement in the consular service. In his correspondence with Jerome, Roger Greene offered the various motives shaping his difficult decision as to whether or not he should leave his diplomatic career. He had grown tired of the bureaucratic "red tape" of his

[123] Ibid.

[124] These connections are also made explicit in Greene's correspondence with U.S. diplomats. See American Legation to Roger Greene, March 15, 1911 (RSG Papers, Item #40).

[125] Jerome Greene to Roger Greene, February 16, 1914 (RSG Papers, Item #84).

work, yet he remained "very much interested in the problem of the relationship between the nations of the east and west[sic.]…"[126] Further, Greene offered,

> If your proposition [with Rockefeller philanthropy] would enable me to work along the same lines, only in a more direct and practical way than at present, there would not be the break in the continuity of my life that I want to avoid. I take it that the kind of experience that I have is what your commission wants, and that nearly all of it would be useful.[127]

Yet, Greene qualified this comment somewhat later in his letter, conceding that "…I do not speak Chinese…my knowledge of Chinese manners and customs is very rudimentary."[128] Unlike his brother, Jerome, Roger Greene also had no medical training. Yet, as he himself noted, he remained "pretty well aquainted with business conditions, and with business men, as well as with the missionary element."[129] This initial ambivalence regarding his suitability for the work shaped his decision to join the Rockefeller's commission initially by taking a leave of absence from his position in the consular service.[130]

Greene joined Rockefeller philanthropies after an earlier commission had surveyed China and held a "China Conference" to present their findings in New York. This earlier commission had expressed concerns about a precarious political environment, but advocated for Rockefeller intervention in the form of medical education. As Greene joined these endeavors, John D. Rockefeller, Jr. and Frederick T. Gates along with three other American philanthropists founded the China Medical Board of the Rockefeller Foundation in 1914, increasing the broad investment of the Rockefeller family in China by an additional twelve million dollars.[131]

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[126] Roger Greene to Jerome Greene, March 1, 1914 (RSG Papers, Item #82).

[127] Ibid.

[128] Ibid.

[129] Ibid.

[130] Roger Greene to Jerome Greene, April 2, 1914 (RSG Papers, Item #82).

As Jerome Greene outlined in his correspondence with Roger Greene, the U.S. administration of the Philippines provided a model for the envisioned mission of the China Medical Board. Here, the longheld connections between U.S. colonial administrations and Rockefeller philanthropists provided channels through which to pursue this model. Jerome Green wrote, "The Commission should become thoroughly acquainted with what has been done in the Philippine Islands and to this end I have suggested to President Judson [of the China Medical Board] that he get in touch with Dr. Victor G. Heiser, Director of Public Health in Manila."[132] A representative of the Rockefeller International Health Commission, Jerome reported, was already en route to Manila to court Heiser.[133]

Meanwhile, in Beijing, the China Medical Board prioritized the issue of medical education. In 1915, the China Medical Board purchased the missionary-founded Peking Union Medical College (PUMC) from the London Missionary Society,[134] and began a program to make it the premier institution for medical education in China. The dominance of Rockefeller companies in Chinese markets caused some conflict over whether or not PUMC should bear the name of the Foundation. Wallace Buttrick, who had played a critical role in the anti-hookworm campaigns in the American South before becoming the first Director of the China Medical

[131] John D. Rockefeller, Jr. to Dr. Harry Pratt Judson, January 31, 1914 (RAC, digitized document) http://rockefeller100.org/files/original/e0261ce17360ad9389f93f4f9fae8afd.pdf (accessed March 28, 2017); Certificate of Incorporation of the China Medical Board of the Rockefeller Foundation, July 7, 1915 (RAC, digitized document) http://rockefeller100.org/files/original/0614f1e224b1c133bcaf6031dadb0d1f.pdf (accessed March 28, 2017).

[132] Jerome Greene to Roger Greene, March 4, 1914 (RSG Papers, Item #85).

[133] Ibid.

[134] Certificate of Incorporation of the China Medical Board of the Rockefeller Foundation. Westerners usually referred to the current and former northern capital of China as Peking until the later twentieth century. After the founding of the Nationalist capital in Nanjing, Beijing became known as Beiping until 1949, when the city's name reverted to Beijing. When quoting or paraphrasing from primary sources, I attempt to use the name used in the source, retaining Beijing as a default when in doubt. Thus, the name of the city shifts throughout this chapter, as it did across time and linguistic barriers in the period discussed.

Board, advocated for the inclusion of the Rockefeller name to make clear who supported the endeavor. Greene strongly disagreed based on what he perceived to be the strong association of the Rockefeller family with imperialism in China. In a letter hand-delivered to Buttrick via Henry Houghton, Greene wrote,

> I cannot help feeling that it would be preferable to leave the name of Rockefeller off. As far as assigning credit where credit is due is concerned, every one knows to whose beneficence the work is due, and the repeated emphasizing of it will, I fear produce exactly the opposite impression from that which we all wish. Also, although the Standard Oil Company has an excellent standing here, it seems to me that we do not want to emphasize a name which is inseparably associated with the commercial interests of our country in China, and particularly with the recent attempt to secure farreaching concessions in this country.[135]

Thus, at least some CMB members acknowledged their work as implicated in a broader project to advance U.S. strategic and commercial interests, even as they sought to conceal what might be unwelcome associations in China.

Though many foreign and Chinese practitioners of Western medicine questioned the timing and efficacy of large-scale public health programs, Rockefeller philanthropies in China emerged alongside growing interest in public health within China.[136] Though PUMC initially met skepticism from both locals and foreign missionaries in China, it did begin to train figures who would prove critical to Rockefeller philanthropy and the broader development of public health. One PUMC doctor, J. Heng Liu (Liu Ruiheng 劉瑞恆), would become among the most influential of Chinese public health advocates. A graduate of Harvard College (1909) and Harvard Medical School (1913), Liu exemplified the aspirations of the Rockefeller Foundation as the very embodiment of American-oriented cosmopolitanism. After completing surgical training at Boston City Hospital, Liu returned to China in 1915 and joined the staff of PUMC in

[135] Roger Greene to Buttrick, March 17, 1917 (RSG Papers, Item #147).

[136] Lei, *Neither Donkey nor Horse,* 55.

1918. Liu spent the early 1920s in the U.S., where, with the support of the Rockefeller Foundation, he studied at the Rockefeller Institute in New York and Johns Hopkins. By 1924, Liu had returned to China with biomedical expertise and a commitment to public health. Liu's interest in public health also led him to participate in early, abortive attempts to develop a public health scheme in China with the missionary-founded National Medical Association in Shanghai. In addition to these outside activities, Liu retained his position at PUMC throughout the mid-1920s.[137]

Chinese Dr. Marion Yang (Yang Chongrui 楊崇瑞), also worked at PUMC during the 1920s. In a 1949 autobiographical essay, Yang portrayed her affiliation with the Rockefeller Foundation as presenting the opportunity to pursue her personal ambitions to use medicine for social uplift. According to Yang's own account, her interest in philanthropic medicine first manifested when she contributed to an effort to aid those displaced by a late 1910s flooding of the Yellow River in Shandong. She wrote, "…I was moved and felt great happiness. It was because I felt that I had contributed a great deal to aid those most in need of my help."[138] Yang first met John Grant as a resident in gynecology and obstetrics at PUMC following an earlier missionary medical education. Her encounters with local parturient women led her to seek out

[137] "Liu Ruiheng 劉瑞恆, "*Shengzhiqi zhi bing yu weisheng* 生殖器之病與衛生," Qinghua Zhoukan 《清華周刊》306 （1924）:48-52; Liu Ruiheng, 劉瑞恆, "*Benhui gengkuan anyuan baogao* 本會庚款委員報告," Zhonghua yixue zazhi《中華醫學雜誌》12, no. 4 (1926):424-33; see also "Liu Jui-heng 劉瑞恆" in Howard L. Boorman, ed., *Biographical Dictionary of Republican China*, vol. 2 (New York: Columbia University Press, 1968), 402-403.

[138] Yang Chongrui 杨崇瑞, "*Wo de zizhuan* 我的自传 (Oct. 1949)," in Yan Renying 严人英, ed., Yang Chongrui boshi: danchen bainian jinian 《杨崇瑞博士: 诞辰百年纪念》(Beijing: Beijing yike daxue/ Zhongguo xiehe yike daxue 北京医科大学/中国自额和医科大学, 1990), 144; see also Marion Yang, Personal History Record and Application for Fellowship, December 6, 1924; Marion Yang to M. K. Eggleston, January 9, 1926 (RAC, CMB Records, Box 76 Folder 538); Greene to Heiser, September 20, 1926 (RAC, Rockefeller Foundation Archives, RG 1 Series 601 Box 268 Folder 3398).

knowledge about public health, a department of the college then supervised by John Grant. According to Yang, few in Beijing showed interest in Grant's attempts to promote public health in the early 1920s; few attended lectures, and the department was understaffed. In 1924, Yang worked closely with Grant in an experimental maternal and infant health campaign targeting rural counties surrounding Beijing. Given her experience in treating women at PUMC and interest in public health, Yang became a critical and eager participant in these early endeavors.[139]

In 1925, the China Medical Board awarded Yang a fellowship to study in the West. According to Yang, Grant urged her to extend her time abroad to visit countries throughout North American and Europe and observe maternal and infant health work. Looking back twenty-four years later, Yang wrote, "Naturally, I was very happy to have such an opportunity." Yang's travels had a profound impact on her professional life and fostered an enduring commitment to public health and maternal and infant health in particular. Describing her time in North America and Europe, Yang wrote, "the things I saw and heard made me suddenly understand that public health work truly is a shortcut for ensuring the wellbeing of the people." [140]

Even with Chinese allies interested in public health (like Liu and Yang), early Rockefeller philanthropies in Beijing remained fraught with challenges. The prevalence of conflict in North China during the late 1910s and 1920s presented logistical and safety challenges for PUMC and its affiliated hospital. Conflicts between warlords in the power vacuum left in the wake of Yuan Shikai's 袁世凯 death interrupted classes at the college, with students and teachers leaving educational work to treat wounded soldiers and civilians in the area around Beijing. The college continued operation through the Zhili-Fengtian wars of the early

[139] Ibid., 144-146.

[140] Ibid., 145-146.

1920s. However, PUMC suspended classes in June 1925 and again in the winter of that year when armed conflict reignited between northern warlords Feng Yuxiang 馮玉祥 and Li Jinglin 李景林 in December. During December 1925 and January 1926, Feng recruited physicians serving as instructors at PUMC and many of their students to treat his soldiers in the army hospital at Nanyuan, just south of Beijing.[141]

The limited impact of PUMC given these challenges frustrated some Rockefeller leaders in the 1920s. In addition to political instability, PUMC endured criticism from missionaries skeptical of the school's affiliation with the Rockefeller family. Ironically, many Chinese distrusted PUMC due to its perceived associations with missionaries. As a result of these many challenges, PUMC's efforts remained confined to greater Beijing through the 1920s, with limited efficacy in cultivating allies for American interests or further Rockefeller involvement elsewhere in China. With little to show for the work of the China Medical Board at PUMC, the Rockefeller Foundation sought to increase the efforts of its IHB in China by the 1920s in addition to those of the China Medical Board in Beijing, which would ultimately become a separate corporation in 1928.[142]

The IHB chose Grant to conduct survey work throughout China, first in 1917 and then again in the 1920s, given his ability to speak Mandarin and experience growing up in China as the son of medical missionaries. A graduate of the University of Michigan, Grant too maintained

[141] Barchet to Roger Greene, June 15, 1923; John Grant, "Surgical Work of the Peking Union Medical College at the Nanyuan Army Hospital, December 1925 to January 1926;" Grover Clark to Henry Houghton, June 15, 1925; W. S. Carter to Henry Houghton, December 28, 1925; Archibald Chien, "War Relief Work at Nanyuan December, 1925 – January, 1926," December 21, 1926 (RAC, CMB Records, Box 124 Folder 900).

[142] China Medical Board, RF Confidential Monthly Report No. 173, March 1, 1956 (RAC, Rockefeller Foundation Archives, RG 3 Series 908 Box 6 Folder 58); see also Selskar M. Gunn, "China and the Rockefeller Foundation," (1934); L. W. Hackett, "The China Program," Greer Williams notes (RAC, Rockefeller Foundation Archives, RG 3, Series 908, Box 6, Folder 58).

connections within the U.S. government and military as he aided the public health work throughout the world with a particular focus on Asia. Grant had collaborated with Rockefeller philanthropists and U.S. colonial administrators earlier in a hookworm survey of Guam. In 1926, Colonel J. F. Siler arranged for John Grant to receive the rank of major in the Army Medical Corps reserves in preparation for a possible U.S. military venture in China at some undetermined point in the future. Siler wrote, "…should it ever become necessary to send any military personnel into China, [Grant] could be called into active service as adviser to the Chief Surgeon, which position he is peculiarly well fitted to hold."[143] In an interview in the early 1950s, Dr. Goodrich Schauffler of Stanford Medical School recalled Grant's unique qualifications for Rockefeller initiatives in China. According to Schauffler, "The Chinese race have a very difficult psychology which involves the matter of 'face.' Understanding was difficult; only someone born and brought up there like [Grant] could penetrate the crust and achieve a strategic approach to the problem of teaching and organizing in that country."[144] Under the auspices of the IHB, Grant began traveling widely in China in 1921 and reported his findings regularly to Rockefeller representatives in Beijing, Manila, Singapore, and New York.

By the mid-1920s, Grant had identified smallpox and neonatal tetanus as "the two outstanding, and fortunately easily controllable, causes of mortality" in the hinterland surrounding greater Beijing.[145] In multiple letters, Grant advocated for the founding of a

[143] J. F. Siler to F. F. Russell, October 20, 1926. (RAC, Rockefeller Foundation Archives, RG 2 Series 601 Box 268 Folder 3399); Obituary for John Black Grant, *New York Times*, October 18, 1962 (Bentley Historical Library, Necrology Files, John Black Grant).

[144] L. W. Hackett, Interview with G. C. Schauffler, n.d. (RAC, Rockefeller Foundation Archives, RG 3 Series 908 Box 6 Folder 58).

[145] Grant to Heiser, September 20, 1926 (RAC, Rockefeller Foundation Archives, Box 45 Folder 371); see also J.B. Grant and N. G. Gee, "Midwifery Training," December 22, 1927 (RAC, Rockefeller Foundation Archives, Series 601, Box 45, Folder 371).

midwifery training center to address the latter cause, arguing that the core problem of unhygienic childbirth could be easily addressed through projects that would have significant impact both in Beijing and throughout China. Unlike in the U.S., where the medicalization of childbirth had made it increasingly the purview of male surgeons, Chinese social and medical practices dating to the late imperial period sustained the popularity of female midwives. Both foreign and Chinese physicians saw midwives as ignorant and dangerous. But, midwives facilitated the observance of gender segregation among elite Chinese, while serving locales with few doctors of any kind.[146] For Grant, these conditions presented an opportunity to advance IHB aims through the training of midwives in scientific and hygienic methods.

Grant harbored great ambitions for both this project and Dr. Marion Yang Chongrui. Having sent Yang abroad for preparation, Grant crafted a proposal that connected Yang's talents and passion, the particular medical needs of China, and the broad aims of the Rockefeller IHB. In 1926, Grant wrote to Heiser urging the IHB to develop an institution for promoting scientific midwifery in Beijing. Grant cited his IHB survey work to highlight the severity of infant mortality in the area, pointing to unhygienic midwives as the primary culprits.

> One village of some 1200 population, visited last year by us, had had 80 per cent mortality over a ten year period of all infants born. This was an extreme case and, as with other villages where mortality is high, due solely to the peculiarly dirty habits of the single midwife of the village. A small merchant from this village sat in my office with tears in his eyes—an unusual thing for Chinese men—and stated he had lost all of his six consecutive sons within the first week of life from 'wind' disease.[147]

Here, the suffering of women and children gave affective force to Grant's calls for intervention. Further, the state of women and children rendered self-evident the deficiencies of China and the

[146] Wu, *Reproducing Women*, 227-229.

[147] Grant to Heiser, September 20, 1926; see also John B. Grant to Victor Heiser, September 20, 1926 (RAC, Rockefeller Foundation Archives, RG 1.1 Series 601 Box 268 Folder 3398).

imperative of Rockefeller aid. A subsequent report from Grant affirmed these notions with statistical data and more explicit language to present Chinese childbirth as a crisis worthy of response. He wrote,

> The midwifery question in China forms an important part of the whole medical problem of the country considered either from the standpoint of lack of teaching facilities or of inadequate standards in practice. Its relative importance is indicated when one recalls there are 12,000,000 births per annum and that, even in a center as well provided with medical care as Peking, statistics show the deplorable state where fifty per cent of deliveries are by untrained midwives and an additional twenty-five per cent by relatives or the parturient woman herself. This condition is reflected in turn by the high infant mortality rate in China and by tetanus neonatorum being one of the two chief causes of what is termed "excess" infant mortality.[148]

Grant presented a strong humanitarian case for midwifery reform, articulating the depravity of the situation in China by pointing to demographic measures of mortality and connecting them to the practices of local midwives. But, other concerns figured more prominently in the IHB's consideration of Grant's proposals. In correspondence between Beijing, Manila, and New York, men with ties to the Rockefeller Foundation spoke candidly about the motives and potential of a proposed midwifery training program. Roughly a year after defending midwifery reform as an "entering wedge" in China, Greene again emphasized the potential of midwifery training for advancing Rockefeller interests in a letter to Foundation President George Vincent. The purported facts (based largely on anecdotal observations surrounding Beijing) of China's high rates of infant mortality made the need for foreign aid indisputable. After alluding to the "importance of midwifery training from the public health point of view," about which, Greene argued, "there can be little difference of opinion," he explicitly connected the proposed endeavor to train midwives to IHB programs throughout the world and the original impetus behind the philanthropy's programs. "Furthermore," he wrote, "[midwifery] is a field in which great interest

[148] John B. Grant, "Midwifery Training", December 22, 1927 (RAC, Rockefeller Foundation Archives, RG 1.1 Series 601 Folder 371).

can be aroused locally with correspondingly hopeful prospects for securing local support. In fact it is not unlikely this will prove one of the most effective ways of interesting the public in public health as a whole, just as the hookworm campaigns have served that purpose in other countries."[149]

Throughout the 1920s, Grant's calls for increased intervention in public health broadly had met opposition from figures within the Rockefeller Foundation.[150] Grant's proposal for a midwifery training program continued to meet resistance from Houghton and Heiser into the mid-1920s. The opposition came not from doubts about the efficacy or need of midwifery training, but rather from China's volatile political situation, which threatened the efficacy of investments in public health.[151] Unlike in Guam and the Philippines where the U.S. military aided the entry and operation of the IHC/B, China in the early to mid-1920s lacked a stable government, with many areas plagued by persistent civil war among regional militarists. PUMC staff had witnessed these interruptions first-hand. IHB officials remained hesitant to invest heavily in new operations unless political stability could be reasonably assured.

IHB leaders harbored concerns not only with safety, but also the difficulties of operating without the formal cooperation of a national government. In accordance with shifting interwar norms governing imperialism and rights of self-determination, cooperative nation-states came to be seen as ideal fields for the operation of Rockefeller philanthropy around the world. In regard

[149] Roger S. Greene to George E. Vincent, December 27, 1927 (RAC, Rockefeller Foundation Archives, RG 1.1 Series 601 Folder 371).

[150] Lei, *Neither Donkey nor Horse,* 58-59.

[151] Many Chinese practitioners of Western medicine shared similar concerns regarding the weakness of the Chinese state as an obstacle to the promotion of biomedicine and public health. See Lei, 57.

to the Chinese case, unnamed members of the IHB expressed concerns that operations in China accepted "responsibility without authority" given the uncertain political situation.[152]

Grant's proposals for a program of midwifery training followed a series of challenges and failures for the IHB elsewhere in Asia. In Indonesia, competing approaches to public health between the IHB and the Dutch colonial government hampered efforts to address hookworm and promote medical education.[153] IHB efforts to prevent hookworm infection among colonial plantation workers in India and Ceylon also ended abruptly with minimal results in the early 1920s. The IHB had attempted to forge a cooperative effort with colonial officials, yet poor sanitation in workers' villages ensured repeated reinfection with hookworm even with IHB work on plantations. These failures brought about a shift in IHB methods. Rather than using campaigns (like those against hookworm) to spur the development of public health around the world, the IHB/D would provide aid and expertise to pre-existing public health ministries of national governments, upon whom it could exercise the necessary influence and supervision.[154]

Here, the modes of Rockefeller philanthropy further aligned with those of the U.S. State Department, which had grown increasingly defensive of "the sovereignty, independence, and the territorial and administrative integrity of China" since the late nineteenth century.[155] As Akira Iriye has noted, the U.S. government's preservation of an autonomous, territorially intact Chinese state served as a tactic against the economic threat of European powers and the encroaching influence of Japan in the Pacific. At the Washington Conference of 1921-22 and

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[152] LW Hackett, Interview with Fosdick.

[153] Terence H. Hull, "Conflict and Collaboration in Public Health."

[154] John Farley, *To Cast Out Disease: A History of the International Health Division of the Rockefeller Foundation (1913-1951)* (New York: Oxford University Press, 2004), 66-68; 75-76.

[155] Henry L. Stimson, Speech on Hoover's Foreign Policies, Philadelphia, October 1, 1932; see also Secretary Stimson to Senator Borah, February 23, 1932 in *The China White Paper* (Stanford: Stanford University Press, 1967), 447-448.

again in 1931, the U.S. government reiterated its defense of China from both European influence and Japanese expansion, thereby ensuring the continuation of the "Open Door" policy for trade in the Pacific.[156] In correspondence with IHB/D leadership, Grant conceded the critical role of a stable, national government by connecting Rockefeller business and philanthropic ventures. In a 1927 report, Grant wrote, "The interests of foreigners in China is essentially one of finding a market for the goods they wish to sell, whether cigarettes, religion, medicine or kerosene oil. The most important factor in determining the market is the type and stability of government."[157]

Amid the concerns of the IHB/D regarding a stable government and existing public health operations, Grant turned his attention from Beijing to Canton (Guangzhou) in the far south, where a rebel nationalist movement descending from Sun Yat-sen had begun experimenting with public health on a local level. "Realizing…the dependence for the eventual success of health plans on the condition of government as a whole," Grant reported on the Chinese political landscape to address the concerns of IHD members.[158] If the persistent conflicts among warlords in the North hurt the prospects of midwifery reform, perhaps, Grant argued, the IHD could cooperate with a group that Rockefeller philanthropists referred to as "the Cantonese" before adopting a transliteration of the group's Chinese name, "the Kuomintang." Rockefeller officials had envisioned a new midwifery program in Beijing if the political situation ever allowed. Grant's report on efforts of "the Cantonese" in the South proposed Canton as "the strategical

[156] This policy would be defended once again in the U.S. response to the 1931 founding of Manchukuo. See "Colonel Stimson on Far Eastern Policy", October 1, 1932, Meiguo dui Manzhou wenti zhi zhengce 《美國對滿洲問題之政策》1931-1935 (Academia Historica); see also Akira Iriye, *After Imperialism: The Search for a New Order in the Far East, 1921-31* (New York: Atheneum, 1978) 13-15.

[157] John Black Grant, "Central Trends in the Nationalist Movement," July 1927 (Rockefeller Archive Center (hereafter, RAC), Rockefeller Foundation Archives, RG 5 Series 1 Box 309 Folder 3922).

[158] John Grant to Victor Heiser, July 11, 1927. (RAC, Rockefeller Foundation Archives, RG 1.1 Box 309, Folder 3921).

[sic.] point for influencing a really large area that would be reached only with difficulty from demonstration in Peking or even as far south as Shanghai due to the distances in China." Citing officials and medical professionals with Western educations like the University of Syracuse-educated Dr. H. C. Szeto who served as Commissioner of Health, Grant argued, "Canton now presents the situation where initiative in medical affairs has passed definitely from the foreigner to the native." Grant argued that the Nationalist movement presented the IHD with an opportunity to gain greater influence through the funding of fellowships and the expansion of public health institutions into southern China.[159]

Grant's advocacy for the Nationalist Party in Canton fostered favorable views of the party within the Rockefeller Foundation, even as they remained skeptical regarding the possibility of political stability for trade and philanthropy in China. By 1927, as the right wing of the Nationalist Party under Chiang Kai-shek began consolidating its power, Heiser and IHD Director Russell continued to resist committing to a new program of midwifery education, opting instead to wait for a clearer sense of political conditions. Greene conceded that "…no harm will be done by waiting to see what the political situation actually is…"[160] While the position of Rockefeller philanthropies in China, like the political topography of the region, remained uncertain, new players in public health continued to gain influence in China.

The League of Nations Health Organization

[159] Grant, "A Tentative Proposal for Public Health Cooperation with Canton." July 1927 (RAC, Rockefeller Foundation Archives, RG 1.1 Box 309, Folder 3921).

[160] Roger S. Greene to Henry Houghton, January 27, 1927 (RAC, CMB Records, RG 4 Box 94, Folder 669).

The advent of the League of Nations in 1920 would contribute further to the development of international health and new modes of imperialism in the interwar period. Founded with the purported intent of resolving disputes, in many cases, the League of Nations furthered the interests of imperial powers victorious in World War I. The League's mandate system secured the efforts of the British and French in much of the world, protecting markets and resources from rising U.S. power.[161]

However, the consequences of the 1919 Treaty of Versailles and the founding of the League of Nations also aided U.S. and Japanese imperialism in a number of ways, some counterintuitive. The League contributed to the universalizing of a system of nation-states around the world, first to areas like Siam and China, neither of which had been formal colonies. If democratizing and equalizing at face value, the League's promotion of peace through a system of nation-states fostered conditions ideal for the modes of U.S. influence in much of the world, especially China. Based on a study of the League's Mandate System, Antony Anghie has argued that "the new technologies of the interwar period" enabled a transformation of the "classical positivist criteria for statehood—government, population, and territory" from mere criteria to be satisfied to "projects to be undertaken" by the League and its partners.[162] These projects, among which public health featured prominently through the efforts of the League of Nations Health Organization (LNHO), served the interests of nation-building *and* new forms of imperial power that depended upon the stability and cover afforded by national structures. As Paul Weindling has shown, despite the officially isolationist policy of the U.S. in the 1920s and its absence in the

[161] Antony Anghie, "Colonialism and the Birth of International Institutions: Sovereignty, Economy, and the Mandate System of the League of Nations," *NYU Journal of International Law and Politics* 34, no. 3 (spring 2002): 513-633.

[162] Ibid.; 620.

League of Nations, U.S. foundations were "exerting pressure for the development of public health policies and institutions" around the world, often operating within national structures and in concert with the League of Nations.[163]

After an initial focus on Europe and its mandate territories in Africa and the Middle East, the LNHO established a Far Eastern Bureau in 1925 in Singapore, then a British colony. From Singapore, the LNHO served the commercial interests of imperial powers in the Pacific through efforts to prevent the spread of cholera, smallpox, yellow fever, and other infectious diseases via ships. In 1926, the LNHO's offices in Singapore and Geneva began to coordinate with Dr. Wu Lienteh (Wu Liande 伍連德) and Dr. Shisan Fang (Fang Shishan 方石珊) who worked under the auspices of the crumbling Beiyang government to address public health concerns in North China.[164] In accordance with the desire to protect trade in the Pacific from disease and contagion, the LNHO's efforts included surveys of quarantine procedures in China's port-cities.[165]

Correspondence between doctors in China and Geneva reveal opposition to the LNHO from various parties with investments in the region, including new imperial powers and the Beiyang government. Dr. Wu Lienteh, a key liaison for the LNHO to Beijing, wrote to LNHO director Dr. Ludwik Rajchman in November 1926 about difficulties in securing approval for a survey of

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[163] Paul Weindling, "American Foundations and the Internationalizing of Public Health," in Gross Solomon, Murard, and Zylberman, eds., *Shifting Boundaries of Public Health*, 65-66.

[164] The Beiyang government was a loose and unstable confederation of warlords in northern China that ended with the rise of the Nationalist Party in 1927. Wu Lien-teh, an ethnic Chinese born in Penang, had been critical to efforts to control an outbreak of plague in Manchuria in 1910-1911. See William C. Summers, *The Great Manchurian Plague of 1910-1911: The Geopolitics of an Epidemic Disease* (New Haven: Yale University Press, 2012), 63-65.

[165] Iris Borowy, "Thinking Big – League of Nations Efforts towards a Reformed National Health System in China," in Iris Borowy, ed., *Uneasy Encounters: The Politics of Medicine and Health in China, 1900-1937* (Frankfurt am Main: Peter Lang, 2009).

plague in Manchuria. The official letter merely pointed to the necessity to secure the cooperation of Russians in the endeavor. A confidential addendum to the letter confided that no Japanese should be permitted to participate given conflicts between the Soviet Union and Japan over the issue of Manchuria. Wu wrote "[Japanese] presence will seriously affect the success of the expedition, for the Russians of all grades will not tolerate them…From my private conversations with Russian savants and politicians, they will rather not have the expedition than allow Japanese to spy out their land."[166]

Regarding the proposed quarantine survey in ports, Wu wrote that he had been working to convince the Beiyang Ministry of the Interior that a formal invitation to the LNHO should not be delayed further, but, as Rajchman had expressed in earlier correspondence, no such invitation had been sent. Wu explained that the Chinese Inspectorate of Customs had blocked the request. Lobbying continued on behalf of the LNHO to the Ministry of Foreign Affairs, but Wu remained less than optimistic about the Ministry of Interior's influence over the Ministry of Foreign Affairs or the Customs Inspectorate, given the factionalism and armed conflict that plagued the loose Beiyang confederation. Wu wrote, "…the Ministry of Interior could not pay for even ink and paper and the officials desert their offices in order to snatch a living outside. It is all very sad."[167]

These early efforts soon brought the LNHO into regular communication with the Rockefeller Foundation and its affiliated public health organizations, which, by this time, maintained a significant presence in the Pacific and had operated in China for more than a decade.

[166] Wu Lienteh to Ludwik Rajchman, November 12, 1926 (United Nations Archives, hereafter UNA Box R966 Classement 12B Dossier 45658).

[167] Ibid; see also Wu Lienteh to Ludwik Rajchman, October 26, 1926 (United Nations Archives, hereafter UNA Box R966 Classement 12B Dossier 45658).

Foreshadowing a cooperative relationship that would have a profound impact on the political landscape of East Asia, the LNHO, the Rockefeller IHB/D, and doctors affiliated with the Beiyang government worked together to lobby Great Britain to allot funds from the Boxer Indemnity to support public health in China. In early 1926, Rajchman of the LNHO and Heiser of the IHB discussed the matter in Singapore before corresponding with Grant in Beijing. The three men coordinated a lobbying scheme that would target British diplomats on various fronts. While an open letter was sent to the British government and a summary cabled to London newspapers, Grant urged British Dr. Douglas Gray to garner support for the endeavor in Britain. Under advisement of Rajchman in Geneva, Chinese Dr. Tsefang Huang (Huang Zifang 黃子方) wrote to Sir Francis Algen, the British Inspector-General of the Chinese Maritime Customs Service, to explain the potential use of a requested 100,000 pounds per annum of Boxer Indemnity funds. Huang argued that the funds would be used in large part to support an LNHO "review of the existing health provisions in the various ports" to ascertain "expert recommendations regarding what may or should be done (under the present national and international conditions) to lessen the danger of these ports as a fearful menace to the world's health." Pointing to the shared investments of Chinese elites, the LNHO, and imperial powers in global health, Huang argued that the survey would help to "raise [the ports'] status out of the condemned "Third Class"—a matter of great commercial significance and—it must be—of great interest to the Customs Administration." By mid-1926, a number of British diplomats supported using the Boxer Indemnity to fund a cooperative public health effort orchestrated by the LNHO, the IHD, and the Beiyang government.[168]

[168] Tsefang Huang to Sir Francis Algen, April 1926 (UNA Box R966 Classement 12B Dossier 45658). The "Customs Administration" referred to in Huang's descended from the Imperial Maritime Customs Service established by British and American powers in Shanghai's International Settlement, in consultation with the Qing imperial government, for regulating and securing trade. See Pär Kristoffer Cassel, *Grounds of Judgment:*

Intensified conflicts within and between the regimes of Chinese warlords thwarted these earliest attempts to promote public health on a national scale. Like Rockefeller-funded philanthropists, LNHO representatives and their Chinese contacts repeatedly lamented the impediments to public health work posed by China's political climate. Wu Lienteh put indefinite delays on proposed surveys in coastal ports and Manchuria with hopes that stability would return once Zhang Zuolin 張作霖 took the Beiyang presidency. But, like the Rockefeller public health workers in Beijing, Wu noted a growing insurgency in the South that would likely perpetuate fighting in the short term but ultimately foster an environment amenable to LNHO initiatives. In November 1926 he wrote, "You will have seen from the papers that the Cantonese are forging ahead and have now occupied Kiukiang…Lots of lives are being lost, but perhaps a new era will now blossom forth for the good of all."[169] Determined to work through established governments, both the LNHO and the Rockefeller Foundation delayed any further expansion of their efforts in China, with a hopeful eye on the rising "Cantonese," also known as the Nationalist Party.

The Nationalist Revolution and an Alignment of Interests

The Rockefeller Foundation and the LNHO found a willing partner for their efforts by 1928 in the newly founded Nationalist government in Nanjing. After uniting much of eastern China proper, a short-lived Nationalist-Communist alliance collapsed in 1927 when the right-wing of the Nationalist Party surrounding Chiang Kai-shek purged both real and suspected communists from its ranks. The survival of this new state depended on its recognition by the

Extraterritoriality and Imperial Power in Nineteenth-Century China and Japan (New York: Oxford University Press, 2012), 65; see also John King Fairbank, *Trade and Diplomacy on the China Coast.*

[169] Wu Lienteh to Ludwik Rajchman, November 18, 1926 (UNA Box R966 Classement 12B Dossier 45658).

global community as a legitimate member of a newly universalized order of nation-states. The developing strategies of U.S. power and the growing competition with Japan in the Pacific produced a context in which accommodating U.S. interests—in addition to forging cooperation with the LNHO—helped to win international recognition and, thereby, allies against the threat of Japanese aggression. Further, the development of public health infrastructures promised to shore up Nationalist legitimacy and authority in contested regions beyond its nucleus of power. With an established government and circumscribed territorial base, the Nanjing government, in close consultation with the LNHO and the Rockefeller IHD, began work to manage the population subject to its rule. The Nationalist-led project of state-building accorded with the aims of many foreigners to maintain Chinese sovereignty and thereby free trade in the Pacific. Thus, the three entities forged an enduring if unequal partnership that reflected the historical imperatives of the interwar moment.

Though Grant became a key early advocate for the establishment of a Ministry of Health,[170] Chinese documents surrounding the initial founding of a Ministry of Health reflected Nanjing's primary concerns regarding its fragile hold on power. Laws and guidelines asserted the sovereignty of the Nanjing-based Ministry over local and provincial governments, as well as the various medical institutions that predated the founding of the Nanjing government. The Republic's Central Political Congress officially adopted the Republican Government Ministry of Health Organization Law in early 1928. The Nanjing ministry asserted the hegemony of biomedicine even more strongly than Rockefeller philanthropists had, with the explicit aim of eradicating "vulgar customs" and "shamans."[171] In addition to outlining the administrative

[170] Lei, *Neither Donkey nor Horse,* 62-64.

[171] Richard M. Pearce to George E. Vincent, December 17, 1920 (RAC, CMB, Inc. Records, Box 25, Folder 175); see also *Weisheng Xingzheng*, Weisheng Gongbao*,* v. 2 (Nanjing: 1929).

structure of the new ministry, the law affirmed its broad jurisdiction through provisions such as, "The Ministry of Health shall administer matters of health administration for the entire country" and "The Ministry of Health shall have the responsibility of directing and supervising the highest-ranking chief executives of each region." The Ministry's authority remained restrained, at least in theory, only by the Executive Yuan's powers of oversight, to which local governments could appeal if they saw the ministry as violating the law or reaching beyond the scope of its authority.[172] Soon, however, the Ministry of the Interior intervened to restrict the purview of the Ministry of Health slightly, arguing that its primary focus should be the health of "the masses." Based on British models, the health of soldiers fell to the military itself and government oversight of medical training became coordinated in partnership with the Ministry of Education under its management of all institutes of higher learning.[173]

Top posts in the new government often went to Nanjing's political and military rivals, in an effort to curry loyalty amid a fragile political union. Xue Dubi 薛篤避, an ally of warlord turned short-lived vice premier Feng Yuxiang, became Nanjing's first Minister of Health. Xue had no medical education or expertise, but he had overseen limited public health measures during his prior term as governor of Beijing.[174] Feng Yuxiang's faction also gained entry into the early Ministry through Feng's wife, Li Dequan 李德全, who reportedly expressed specific

[172] Items 1-3, Guomin zhengfu weishengbu zuzhifa 國民政府衛生部組織法, November 14, 1928 (Academia Historica).

[173] Tan Yankai 譚延闓 and Feng Yuxiang 馮玉祥 to Xue Dubi 薛篤避, n.d. Weishengbu zuzhifa 衛生部組織法 (Academia Historica); see also Weishengbu 衛生部, Weisheng gongbao 《衛生公報》Vol. 1 (Nanjing: Zongwusi 1929).

[174] Watt, *Saving Lives in Wartime China*, 35-6; Bullock, *An American Transplant,* 145-6; Ka-che Yip, *Health and National Reconstruction in Nationalist China*, 45-46.

interest in biomedical reforms to childbirth and motherhood to both Rockefeller representatives and Chinese-government authorities.[175]

Nanjing required that provinces and municipalities establish and maintain their own health administrations under the oversight of the central Ministry of Health, envisioning a network of institutions that bound provinces to the central government. In January 1929, the Ministry of Health published *Early Steps for Local Health Administrations,* a twenty-six-page booklet intended to help standardize public health throughout Nationalist territory. Like the founding law of the Ministry, the guidelines firmly established biomedicine as the hegemonic mode of medical practice and emphasized the imperative to promote hygienic habits. The guidelines began with a list of "Rules for Personal Hygiene," consisting of a twelve-item regimen including prescriptions for daily handwashing, dental care, sleeping, defecation, exercise, laundering, and food preparation. A foreword by Minister Xue Dubi followed that articulated Nanjing's views regarding the nationalistic implications of public health. Xue argued that China's lack of development in this area hindered the advancement of medical knowledge, the quality of medicines, the strength of the race, and the size of the population. The publication in many ways modeled the type of public health propaganda it urged local governments to put forth, as Xue called upon "all his fellow countrymen" to "join together in a great effort" to support the "work of public health." Thus, through emphases on individual acts as integral to the survival of the nation-state and the Chinese race, the Nationalist minister's foreword reflected the perceived relationship between individual bodies and the health of the population that bound

[175] Grant to Heiser, November 16, 1928. (RAC, Rockefeller Foundation Archives, RG 2 Series 601 Box 11 Folder 93). After 1949, Li Dequan would later become the first minister of public health of the People's Republic of China. See Funü cidian bian xie zu 妇女词典编写组, ed., *Funü cidian* 妇女词典 (Beijing: Qiushi chubanshe 求实出版社, 1990), 100.

public health to China's position in an international hierarchy, a notion that served the aims of both foreign and Chinese actors.[176]

The government's *Early Steps* also emphasized the need for locales to collect statistics on populations subject to their administration and to allocate provincial funds for the building of public health infrastructures. These two issues remained closely linked, as local governments were instructed to allocate a minimum of two *jiao* (a measure of currency) per person per year for public health. Nanjing's guidelines also directed local governments to collect statistics on morbidity and mortality to ensure effective medical practice. Further, local governments, under the direction of the national Ministry of Health, were to ensure that medical practitioners, including midwives, doctors, nurses, and dentists, complied with the provisions of the 1928 founding law that emphasized the methods of modern biomedicine and the imperative of formally registering with the government.[177]

Given the geographic limits of Nationalist power in 1928, compliance with these requirements varied. By the end of 1928, local authorities in Anhui, Beiping, Guangdong, Guangxi, Hebei, Henan, Hubei, Jiangsu, Shandong, and Shaanxi formally recognized the founding law and expressed intent to comply. Correspondence from distant Xinjiang initially conveyed a desire to fulfill the Ministry's requirements in June 1929. Shanxi came to supply the central ministry with data and information on its plans only in the 1930s after the defeat of warlord Yan Xishan 閻錫山 in the Central Plains War of 1930. As outlined further in Chapters

[176] *Guomin zhengfu weisheng bu* 國民政府衛生部, Difang weisheng xingzheng chuqi shishi fang'an《地方衛生行政初期實施方案》 (Nanjing: January 1, 1929); Foucault framed the relationship between individual acts and the management of the population as the interrelated "anatomopolitics of the human body" and "biopolitics of population." See Michel Foucault, *"Society Must Be Defended" Lectures at the Collège de France, 1975-76,* Mauro Bertani and Alessandro Fontana, eds., David Macey, trans. (New York: Picador, 1997), 243, 278.

[177] *Guomin zhengfu weisheng bu* 國民政府衛生部, Difang weisheng xingzheng chuqi shishi fang'an 地方衛生行政初期實施方案."

Three and Four, most distant regions in the West, despite their initial acknowledgement of Nanjing's requirements in the late 1920s, became integrated into the Nationalist public health system only during the mid- to late-1930s.[178]

Even in areas firmly under Nanjing's control, China's pluralistic medical landscape presented administrative challenges. In addition to indigenous practitioners, a variety of biomedical institutions were variably supported by local governments, private philanthropists, and foreign organizations. In one of its first official acts of asserting its authority, the Ministry of Health published a letter addressed to all agencies engaged in "philanthropic, medical, and emergency relief work," requesting that they formally register with the Nanjing government. The list of petitioned agencies included chapters of the Red Cross, Christian hospitals, and the Buddhist/Daoist philanthropic organization known as the Red Swastika Society (*hong wanzi hui*). Specifically, the Ministry requested that the organizations provide information about leadership, location, activities, and average monthly expenditures.[179]

In 1929, the Ministry of Health announced further regulations to facilitate government oversight of philanthropic agencies and emergency medical providers operating within territory claimed by the Nationalist government. The provisions of the "Law to Supervise Humanitarian Groups" set standards for the leadership of approved societies and established channels through which exemplary philanthropists would receive special recognition from the Nanjing government.[180] As the Ministry asserted its oversight, many Chinese and foreign organizations gradually became incorporated into the Ministry's network of offices and agencies. These

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[178] *Guomin zhengfu weishenbu zuzhifa* 國民政府衛生部組織法; Weisheng tongji 《卫生统计》 (Chongqing: Weisheng shu 衛生署, 1938).

[179] Weisheng bu, Weisheng gongbao Vol. 1.

[180] Weisheng bu 衛生部, Weisheng gongbao 《衛生公報》Vol. 2 (Nanjing: *Zongwusi,* 1930).

measures, along with an extensive campaign to register doctors and regulate medical practice that would gain momentum in the later 1930s and 1940s,[181] constituted an attempt to impose a standardized, secular notion of biomedical public health over the pluralistic network of medical institutions in China. As outlined in later chapters, the success of this attempt varied, and national regulations often gave way to local pragmatism.

The Nationalists' early moves to found a Ministry of Health met a mixed response from foreign philanthropists vested in Chinese public health. Rockefeller representatives remained optimistic about the founding of a stable government, seen as critical for their aims. Grant reported to Heiser in mid-1928 that, despite the fact that civil war could erupt again at any moment, "as far as public health is concerned, one thing stands out for which 1927-28 will go down in history. This is the inauguration of nation-wide municipal administration and with it an entirely new position and conception of public health in local government."[182] Further, Grant remained particularly interested in the expressed interest of Li Dequan in a future campaign to promote hygienic childbirth.[183]

However, IHD correspondence circulated negative opinions and suspicion regarding Xue Dubi, then Minister of Health, whom John Grant had encountered earlier in his travels throughout China. In an early report to New York on the Chinese Ministry of Health in February 1929, Grant wrote of Xue,

> His general knowledge would not equal that of an ordinary high school graduate. However, he is honest, a hard worker and very sincere in his desire to discharge his responsibilities. These characteristics make him one of those persons who does not

[181] Weisheng yishi fagui 《衛生醫師法規》(May 1934); Weisheng renyuan renyong fa 《衛生人員任用法》1941-1945 (Academia Historica).

[182] Grant to Heiser, July 16, 1928 (RAC, Rockefeller Foundation Archives, RG 2 Series Box 12 Folder 95).

[183] Grant to Heiser, November 16, 1928 (RAC, Rockefeller Foundation Archives, RG 2 Series 601 Box 11 Folder 93).

> realize that he cannot do everything at once. This type of individual constitutes a danger not only to the Ministry but to other places in China possessing general administrators of a similar nature, who by their well-intentioned desire for quick results not only accomplish nothing of permanent value but prevent much from being done that otherwise might be.[184]

Grant further recounted a visit paid to Xue by "a quack physician" who "recommended a prescription that would cure *trachoma* in one treatment at the cost of one-tenth of a cent."[185] According to Grant, Xue demonstrated both his impetuousness and ignorance by immediately advocating widespread use of the treatment. Grant expressed further dissatisfaction with the hastiness of the Nationalist government's efforts.[186]

By late 1928, the situation looked more promising for IHD projects, including Grant's proposed midwifery school. J. Heng Liu, who had worked and studied in close affiliation with Rockefeller philanthropy, had assumed the position of technical vice-minister within the Ministry of Health by November 1928. Along with Grant's official advisory position, Liu became a key figure in connecting IHD and LNHO aims and expertise to the operations of the Nanjing ministry. In November 1928, Grant reported to Heiser, "One of the first questions which [Liu] hopes to deal with is the midwifery question."[187]

Roughly one month after Liu's appointment, the Nanjing government announced plans that placed midwifery training as a priority for both public health and the broader state-building aims of the Nationalist government. As Chinese publications outlined, the initial surveys of the Ministry of Health to oversee medical personnel had quickly identified a dearth of trained

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[184] Grant to Heiser, February 1929 (RAC, Rockefeller Foundation Archives, RG 2 Series 601 Box 28 Folder 232).

[185] Ibid.

[186] Ibid.

[187] Grant to Heiser, November 16, 1928.

midwives. Throughout Chinese media, various publications began to highlight maternal and infant mortality as a chief issue separating China from the modern world. According to a publication of the Beijing municipal health station, Chinese rates of infant mortality placed the country in a ranking lower than India in terms of development, staggeringly far behind the position of major world powers like the British who ruled India. In addition to affirming the health of women and children as a marker of difference between nations and states, this fact also affirmed connections between the quotidian tasks of childbirth and mothering on the one hand and the management of the population as a whole on the other. The demographic measures of maternal and infant mortality served to justify the central government's developing plans for large-scale midwifery education programs.[188]

Yang Chongrui, who had been critical to Rockefeller plans for midwifery training in China, also outlined for Chinese audiences how the promotion of standardized, biomedical midwifery training aided national interests. Though, as outlined further in later chapters, Yang harbored her own investments in MIH, she helped to bind skilled midwifery to China's relative status on the world stage. In one Chinese publication from the early 1930s, she wrote, "The high rates of maternal and infant mortality seen in China at present are truly lamentable when compared to those of other countries. The primary reason is the unhygienic cutting of umbilical cords."[189] The later 1930s turn toward a fascistic investment in putatively indigenous gender norms of the "good wife, wise mother" only affirmed the critical place of biomedically sound reproduction and nurturing in nationalistic ideology.[190]

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[188] "*Zhuchanshi ying gankuai peizhi* 助產士趕快培植," Weisheng yuekan 《衛生月刊》no. 2 (1928): 23-25.

[189] Yang Chongrui 楊崇瑞, "*Zhuchanshi zhi guanli fa* 助產士管理法," Zhonghua yixue zazhi《中華醫學雜誌》16, no. 4 (1930): 262-265, 263.

The urgency of midwifery training gained greater traction in the Nationalist government through a reorganization of the Ministry of Health that occurred during 1929 and 1930. Mere months after Liu's appointment to the post of vice minister, Xue Dubi sent a letter to Geneva requesting that Rajchman, Heiser, and British public health expert Sir Arthur Newsholme form an International Advisory Council to advise the Ministry on the continued development of a national public health system.[191] However, an alliance of scorned Nationalist leader Wang Jingwei 汪精衛 with warlords Yan Xishan and Xue's close ally Feng Yuxiang led Xue to leave his post as Minister of Health amid the Central Plains War of 1930. These events, combined with what some have seen as a lackluster commitment to public health among many within the government, led Nanjing to reduce the total number of ministries. Amid this reorganization, the Ministry of Health became the National Health Administration (NHA) of the Ministry of the Interior. J. Heng Liu became the head of this reorganized administration. Liu held this post for eight years, directing the NHA while also serving as Vice-Chairman of the Advisory Committee of the LNHO in the early 1930s.[192]

Both the IHD and the LNHO emphasized the need for gathering data before (re)forming institutions. On the eve of the Nanjing Decade in March 1927, Rajchman and Grant had endorsed a careful and deliberate approach. Both men agreed that a "thorough study of the needs of the country" should be carried out "before proceeding to the elaboration of a definite plan…"[193] The reorganization of the NHA presented the opportunity to conduct major surveys of

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[190] See Johnson, *Childbirth in Republican China,* 155.

[191] Xue Dubi (Hsueh Tu-pi) to Rajchman, January 31, 1929 (UNA, Box R5905 Series 10183, 10595)

[192] Weishengshu zuzhifa 衛生署組織法, 1930 (Academia Historica); see also Watt, *Saving Lives in Wartime China,* 36-37; Yip, *Health and National Reconstruction in Nationalist China,* 44; Lei, *Neither Donkey nor Horse,* 67-68.

[193] Rajchman to Grant, March 15, 1927 (UNA Box R966 Series 4600 Classement 12 B Dossier 45658).

Chinese doctors, ports, and the population. Rajchman himself completed three survey tours of China from 1929 to 1931, with several other European doctors conducting focused assessments of issues such as maritime quarantine and medical education. These data would be supplemented by the continual collection of medical facts by Rockefeller-funded medical personnel and the Nanjing government's NHA throughout the 1930s and 1940s.[194]

Medical Education and Maternal and Infant Health

Though the NHA and its foreign partners would attempt to address a host of public health concerns in the following decades, two interrelated issues proved especially important for the construction of a large-scale public health system in China during the Nationalist period: medical education and maternal and infant health. Regarding medical education, LNHO surveys identified the lack of medical personnel as the greatest threat to public health, affirming the Rockefeller Foundation's established focus on training practitioners in biomedical methods.

The LNHO sent Danish Dr. Knud Faber, professor of medicine at Copenhagen University, to conduct a survey of medical education in China from September to December 1930. Faber's report found less than 5,000 biomedical doctors serving a population of 400 million. The result was a ratio of one doctor per 100,000 people, compared to one doctor per 800 people in the U.S. in 1927. Faber proposed an ambitious goal of increasing the number of doctors by 50,000, with a target ratio of one doctor per 8,000 Chinese.[195]

[194] See, for example, "Chinese Public Health Reorganisation. Quarantine Service. Completion of Survey of Chinese Ports and Report on the Reorganisation of the Port Health Services." (UNA, R5920 Series 22752, 23393).

[195] Knud Faber, "Survey of Medical Education in China by Professor Knud Faber, 1930" (UNA, Box R5907, Series 10595).

Faber also noted the diversity of medical practice in China and the problems it posed for a centralized public health system. The number of doctors per person increased significantly when practitioners of indigenous medicine were accounted for. Citing figures from the Chinese Doctors' and Druggists' Federated Association, he estimated a total of 1.2 million practitioners of "so-called 'Chinese medicine'" and approximately seven million Chinese druggists. However, Faber offered these figures as further evidence of China's lack of medical expertise, lamenting that only Eastern urbanites had access to "modern medicine." The remaining patchwork of medical institutions consisted of missionary hospitals and schools; some well-equipped private hospitals run by English, Americans, Japanese, or Germans in urban areas; and "well-run private Chinese hospitals for well-to-do Chinese." These institutions differed in funding, method, and focus, representing few exceptions to a general trend of a diseased population without access to biomedical care.[196]

Faber ultimately argued that increasing the number of hospitals in China would fail without first increasing the number of biomedical doctors. Existing hospitals, he argued, "have the greatest difficulty in obtaining experienced physicians as well as younger assistants," to say nothing of the "great demand for doctors in all public medical work, in the army, in the customs service, as well as in the health service." "Every attempt to provide medical treatment as well as health service for the general public," Faber continued, was "hampered by the lack of doctors." Of all existing medical schools in China established by missionaries, philanthropists, and foreign-trained Chinese over the preceding century, Faber found only thirteen that could be "counted on" to produce adequately trained doctors. With small classes, these schools remained unable to supply enough graduates to address China's dire need for biomedical personnel.[197]

[196]Ibid.

Faber proposed a highly centralized public health system that prioritized medical education and high standards of treatment. These suggestions accorded with the Rockefeller Foundation's primary goals to garner favor from a stable, cooperative government staffed by Western-trained elites as well as the Nanjing government's demonstrated objectives of maintaining close oversight. An extensive fellowship program began following a model initiated earlier by the Rockefeller Foundation but now expanded and facilitated by the LNHO, through which hundreds of Chinese medical personnel obtained training in Europe and the U.S. from the 1920s to the 1940s. To serve the interests of the NHA, many of these fellowships included the condition that graduates return to China to staff the national public health system.[198]

In addition to the continuation of Rockefeller fellowships now arranged in coordination with the LNHO, Faber and Rockefeller representatives desired a central role for PUMC in the training of public health workers. In a January 1931 letter, Greene recounted a discussion in which Faber hinted at his recommendations to the LNHO regarding PUMC. Faber harbored concerns that sending large numbers of Chinese to study abroad would foster factionalism within the public health system, especially if individuals were sent to a number of different countries. Further, Faber argued that "in the clinical branches particularly the men need experience in dealing with Chinese conditions, which can be obtained only through actual service in their own country until they are fairly mature." Based on this perspective, Faber reportedly planned to lobby the NHA via the LNHO to give primacy to PUMC for the training of clinicians, a recommendation welcomed by Greene. Though Greene remained unsure of the attitudes of the LNHO and NHA given "existing chauvinist feeling" in the Chinese government, PUMC

[197]Ibid.

[198] Roger Greene, PUMC Memorandum Re: Interview with Dr. L. Rajchman, December 21, 1930 (RAC CMB Records, Box 22 Folder 155).

remained a premier training center for Chinese medical professionals into the later 1930s. Greene saw the PUMC as presenting "a possibility of conducting an experiment that may be of great value to the world" by developing centers for the biomedical training of local personnel globally, "suggesting new methods of dealing with the medical and health problems of society."[199]

With a relatively stable and cooperative government in place, the Rockefeller IHD gained greater confidence in the organs of the Nationalist government as it worked in close cooperation with the LNHO into the 1930s. In December 1929, Grant, who had been serving as IHD advisor to the reorganization of the NHA, sent a positive update to Heiser in New York. According to Grant, Rajchman of the LNHO had done much to increase the prestige of the NHA and to secure additional funding for its work from the Nanjing government. Though Rajchman, like Heiser, had insisted that the Nationalist government assume primary responsibility for its public health work, he also recommended that the IHD maintain a representative in China to work closely with the NHA when a series of new initiatives began the following year.[200]

Amid the growing faith in Nationalist institutions and the partnership with the LNHO, the IHD initiated a large-scale program to reform midwifery under the leadership of Yang Chongrui. In consultation with Grant, J. Heng Liu, now director of the NHA, endorsed maternal and infant health work as a top priority. A list of twelve primary aims published by the NHA in 1929 reflected a commitment to the health of women and children as central to its public health mission.[201] The NHA and the Ministry of Education jointly formed a National Midwifery Board to oversee a new First National Midwifery School (FNMS), funded and staffed, in part, by the

[199] Greene to Max Mason, January 1, 1931 (RAC, CMB Records, Box 22 Folder 155).

[200] Grant to Heiser, December 28, 1929 (RAC, Rockefeller Foundation Archives, RG 2 Series 601 Box 28 Folder 232).

[201] *Weisheng Xingzheng,* Weisheng Gongbao, v. 2 (1929).

Rockefeller Foundation. When the FNMS obtained a permanent location in Beiping in 1930, Grant's years of lobbying finally produced the desired result with the blessing of Nanjing as well as Heiser, Greene, and Vincent.[202]

Expectations that Nanjing would maintain responsibility for its own programs minimized direct financial investment from the Rockefeller Foundation in FNMS, even if the Foundation would ultimately devote large sums of money to public health work in China. Rajchman of the LNHO confided to Greene in late 1930 that, though he hoped the China Medical Board would continue to support PUMC, it was essential that the Nanjing government quickly become otherwise fully financially responsible for its public health system. The Rockefeller Foundation and its affiliated philanthropies were eager to comply with Rajchman's wishes. The initial budget for the first year of the FNMS' operation called for a contribution of $20,900 (USD) from the Rockefeller Foundation, but contributions lessened in subsequent years. In the school's second year, less than twenty-percent of its total funding came from the Rockefeller Foundation. By fiscal year 1934-35, despite continued Rockefeller oversight, Nanjing supplied one hundred percent of the school's budget.[203]

Given these resources and Yang Chongrui's personal commitment to MIH, the work of FNMS and the NHA's Maternal and Child Health Division expanded dramatically under her leadership. The curriculum of FNMS diversified to meet the demands of the developing public health apparatus, providing courses for new midwives, retraining for old-style midwives, and

[202] Grant to Heiser, November 16, 1928 (RAC, Rockefeller Foundation Archives, RG 2 Series 601 Box 11 Folder 93); Marion Yang 楊崇瑞, First Annual Report – First National Midwifery School, Peiping, 1929-31 (1932) (RAC, Rockefeller Foundation Archives RG 5 Series 3 Box 221 Folder 2763).

[203] Marion Yang 楊崇瑞, First Annual Report – First National Midwifery School; Second Annual Report – First National Midwifery School, Peiping, July 1, 1930-June 30, 1931; Fifth Annual Report – First National Midwifery School, Peiping, July 1, 1933-June 30, 1934 (RAC, Rockefeller Foundation Archives RG 5 Series 3 Box 221 Folder 2763).

"refresher courses" for missionary-trained midwives seeking licenses from the Nanjing government. Midwifery training schools founded on FNMS' model appeared throughout the country, while midwives trained at FNMS traveled widely to promote hygienic childbirth. The number of patients seen at the maternity hospital affiliated with FNMS grew rapidly also, quadrupling in its second year of operation to a total of more than 4500.[204]

Yang's work in Beiping also sought to improve statistical data on infant and maternal mortality in China, which only served to affirm the primacy of MIH to public health policy and China's position in an international order. Foreshadowing the later work of other midwives elsewhere in the country, FNMS personnel recorded the sex and size of infants as well as location and time of birth. Despite the constant reiteration of facts regarding China's abysmal rates of infant mortality as stemming from unhygienic childbirth, Yang expressed frustration at the wide variation in estimates of infant mortality in China and their purported causes. Thus, she also implemented a detailed survey method through which all midwives, nurses, and doctors collected information on their patients. Yang's methods drew heavily from those of the LNHO elsewhere in the world. Based on her findings primarily in and around Beijing, Yang concluded that earlier figures of Chinese infant mortality served as "conservative estimates" of a critical public health crisis that warranted the continued investments of the Nationalist government and its foreign partners.[205]

Here, Yang's collection of new data supplemented earlier findings by Grant and the LNHO on abysmal maternal and infant mortality to provide an empirical justification for the continuation and expansion of MIH programs, even while the link between the practices of

[204] Yang, Second Annual Report – First National Midwifery School.

[205] Ibid.

midwives and mortality rates received little scrutiny. In her annual reports to the IHD, Yang reiterated the great need for her work even as she highlighted moderate successes. To emphasize the severity of China's public health emergency and the central role of maternal and infant health, she wrote, "China possesses a high morbidity rate and about 24,000,000 people are ill every day together with annual excess of deaths of 6,000,000. The main groups of the excess deaths are infants and women during the child bearing period." In accordance with her own training and the Nanjing government's initial war on "vulgar customs," Yang wrote in 1932 that more than eight hundred years of unregulated and unscientific midwifery in China had resulted in this widespread crisis, but that recent "appreciation of modern medicine" had brought about more hospital deliveries and a reliance on trained personnel that had "saved many lives of both mothers and babies."[206]

The avalanche of data on maternal and infant mortality compiled by local hospitals and schools (like the FNMS), the NHA, the IHD, and the LNHO, circulated widely in Europe, the U.S., and China from the 1920s to the 1940s. This resulted in a pervasive rhetoric of a reproductive health crisis in China that would collect growing investments of foreign philanthropists, national and local governments, and international health organizations. Reading across the records of these varied institutions reveals an alignment of interests in public health in general and maternal and infant health in particular including but exceeding the nationalistic rhetoric of those within the Chinese state. Most public health endeavors were carried out under the auspices of the NHA from 1928. Yet, the building of a large-scale, public health system in China during the Nationalist decades remained a project initiated and sustained by the

[206] Yang, First Annual Report – First National Midwifery School.

Rockefeller foundation, which, along with the LNHO, gained a significant degree of influence within the Nationalist government.

Conclusion

By 1933, the Rockefeller Foundation had spent roughly thirty-seven million dollars on medicine and public health in China alone, representing more than one-third of its total expenditures in "medical sciences" globally. Some in the Rockefeller Foundation harbored concerns that the results of its efforts paled in comparison to the amount of money invested. In a 1934 treatise, IHD doctor Selskar M. Gunn argued for a continued commitment to China. Rockefeller influence in cooperation with the diplomatic efforts of the U.S. government promised great rewards for the future, he argued, given China's large population and territory. After quoting former Secretary of State John Hay's assessment of China that "whoever understands that mighty empire…has a key to world politics for the next five centuries," Gunn argued,

> China is bound to play an ever-increasing role in world affairs in the years to come. The relationship of the United States to China today is, on the whole, very favorable and our Government has done much to improve our position. I am convinced that the opportunities in China are vastly more significant than those presented in any of the many countries where I have worked for the Foundation in Europe…I do believe that the Foundation is singularly well adapted as demonstrated by its history of accomplishment, to take a significant part in helping China in its struggle for stability and progress.[207]

A foothold in China, Gunn argued, would be essential to succeeding in the twentieth-century world. Citing the IHD's successes as evidence of the influence to be gained in Chinese institutions through philanthropy, Gunn advocated for new Rockefeller programs to promote rural health as well as the social and natural sciences. These initiatives would strengthen the

[207] S. W. Gunn, "China and the Rockefeller Foundation," 1934.

Rockefeller Foundation's relations with both the LNHO, who inaugurated global rural health programs, and the U.S. Department of State, who increasingly sought to foster intellectual and cultural exchanges. The State Department's Cultural Relations Division, a descendent of Nelson Rockefeller's endeavors in Latin America, would play an increasingly centralized role in coordinating the diverse efforts of U.S. philanthropists and experts in China in the 1940s.[208]

In light of such foreign interest and investment in Chinese public health, the history of medicine in China enters into a broader history of medicine in the modern, non-Western world, which has been largely focused on the dynamics of (post)colonial states. Rogaski's *Hygienic Modernity* tied the development of Chinese public health to the nineteenth-century treaty ports of the "semi-colonial" era.[209] The scalar intervention made here demonstrates that even in the twentieth century and the rural interior, China's public health system remained imbricated within global power struggles shaped by shifting modes of imperialism and capitalism. Within an emerging system of unequal realtions between putatively autonomous nation-states, U.S.-based philanthropy (often in dialogue with the U.S. government) came to see nation-states as prime sites for the extension of power and influence in contradistinction to the waning empires of Europe. The League of Nation's terms of recognition and desire to secure global health, peace, and trade aided these U.S. modes of power, even as the U.S. remained outside the League's membership. The contemporaneous intersection of biomedicine with the "woman question" linked demographic measures of mortality to the quotidian tasks of childbirth and mothering, and provided measure for differentiating between those in need of intervention and those fit to

[208] Ibid.; see also Raymond Fosdick to Charles Thomson (U.S. Dept. of State), February 7, 1942; Greg Barnhisel, *Cold War Modernists: Art, Literature, and American Cultural Diplomacy* (New York: Columbia University Press, 2015), 14-16.

[209] Rogaski, *Hygienic Modernity*, 8-17.

provide aid. These factors ultimately furthered the broad interests of U.S. power and philanthropy in the Pacific, as revealed in the candor of Rockefeller representatives operating in close association with the LNHO and both Chinese and U.S. governments.

Within this context, China became the primary experimental site for new modes of U.S. influence, broadly construed. In the Rockefeller Foundation and the U.S. government, the Nationalist Party found allies that asserted the territorial and administrative sovereignty of Nanjing against the threat of Japanese aggression, while providing capital and expertise to reduce mortality and shore up Nationalist authority. The further cooperation between the Nationalist Party and the LNHO, forged in large part through association with U.S. philanthropists, aided international recognition of the Nationalist state and the acquisition of foreign aid for many of its projects.

The macropolitical perspective adopted here not only enhances our understanding of the Chinese case, but also the reciprocal impact of Chinese maternal and infant health on the broader power dynamics of the interwar world. In the Chinese case, U.S. interventions diverged in key ways from earlier, formal colonialism in Puerto Rico, Guam, and the Philippines. Many within the U.S. government, like some representatives of the Rockefeller Foundation, perceived the continued territorial integrity and legitimacy of the Chinese nation-state as best serving their interests. This differed starkly from the perceived aims of European powers and Japan, who threatened to colonize China or carve the country into concessions. While the U.S. government thwarted the ambitions of other powers to subjugate China, certain U.S. philanthropists imbedded themselves within the structures of the Nationalist state, justified by a pervasive humanitarian crisis figured at once in gendered and biomedical terms.

Chapter 3: Local Adaptations:

The Geography of MIH and Pre-revolutionary Yunnan

As outlined in the previous chapter, maternal and infant health (MIH) provided a field for adapting international health programs to Chinese conditions, tethering international health organizations and the "imperialism of free nations" to Chinese social dynamics and newly founded organs of the Chinese Nationalist government. But beyond the discursive and ideological dimensions linking state-building to global health and new imperialisms, MIH produced material effects that aided the Nationalist Republic's legibility to an emerging international order. The productive dynamics of biopower's operation in both foreign philanthropy and state-building, evident in the expansion ever deeper into the interior and into rural areas, aided Nanjing's accumulation of a territoriality, which, as many scholars have noted, remained a prerequisite criterion for modern nation-states.[210] Amid the emerging order of the interwar world, MIH linked the particular needs and customs of Chinese society to the broad projects of new imperialism, while also linking metrics of mortality that sorted populations to the management of women's reproduction. These developments further helped provide a path

[210] See Thongchai Winichakul, *Siam Mapped: A History of the Geo-Body of a Nation* (Honolulu: University of Hawaii Press, 1994), 16-17; Antony Anghie, "Colonialism and the Birth of International Institutions: Sovereignty, Economy, and the Mandate System of the League of Nations," *NYU Journal of International Law and Politics* 34, no. 3 (spring 2002): 513-633, 620.

through which the Nationalist state might obtain the population and territory necessary to gain equal footing with great powers on the world stage.[211]

The last chapter demonstrated how both foreign and Chinese actors framed maternal and infant mortality rates as the product of unhygienic childbirth and as quantifiable evidence of China's relative backwardness. This chapter and the next demonstrate that MIH proved critical not only for the aims of Rockefeller philanthropies in China, but also for Nationalist colonization of the interior during the 1930s and 1940s. The biomedical "facts" of women's varied capacity to reproduce and nurture effectively separated China from great powers, but also rural and Western regions of China from more cosmopolitan and urban areas of the coastal East. MIH thus provided an idiom of difference that underwrote Nationalist interventions in distant provinces, often carried out in partnership with foreign actors, as benevolent civilizing missions to rescue suffering women and children in contested regions and thereby affirm both the population and territory subject to Nationalist governance.

However, the move to rapidly expand MIH institutions and personnel produced unexpected effects. In addition to the implications for Chinese feminisms discussed in Chapters Five and Six, international and national investments in a rapidly expanding MIH network had a decentralizing impact on the Nationalist health system. Reporting on a tour of China during 1942, John Grant of the Rockefeller International Health Division (IHD) noted, "The quantitative expansion in the provinces of 'health units' is almost incredible, particularly under war circumstances. The concept of State Medicine may almost be said to be over-sold to the

[211] I draw here from the insights of world systems theorists, who have pointed to a fusion of capitalist and territorial logics as integral to the rise of the modern world system. See Giovanni Arrighi, *The Long Twentieth Century: Money, Power, and the Origins of Our Times,* 31-34; see also Prasenjit Duara, "Introduction," in Duara, *The Global and Regional in China's Nation Formation* (New York: Routledge, 2009), 4-5.

public."[212] As one of the original architects of midwifery reform outlined for the Rockefeller Foundation, China's primary problem no longer lay in a dearth of medical institutions by 1942. Rather, the vast network of institutions had now exceeded what the Nationalist health administration could adequately oversee.[213]

Thus, from local cases, we see both the vast reach of Nationalist-era MIH programs and the unevenness of central-government oversight. In some cases, the extension of state and philanthropic projects relied on ever-growing numbers of local practitioners and health officials, many of whom remained flexible when not indifferent to national policies. With a primary focus on the province of Yunnan, this chapter argues that an expanding network of reproductive health practitioners and institutions connected the aims and resources of international and national health organizations to individual households in rural and remote regions of China prior to the PRC. Rather than emphasizing this development as a straightforward triumph of the Nationalist state, I show how this network of institutions proceeded unevenly, often dependent on local pragmatists who took advantage of state and foreign investments while operating at the margins of state authority.

The Geographic Expansion of MIH Programs

From its original imagining by Yang Chongrui and John Grant, Beiping's First National Midwifery School (FNMS) had been intended as an initial step toward a much broader program to promote hygienic childbirth and mothercraft throughout China. As these large-scale reforms to

[212] John Black Grant, "Report on Trip to China: July 16 – August 6, 1942" (RAC, Rockefeller Foundation Archives, Sleepy Hollow, NY, RG 2, Series 601, Box 240, Folder 1662).

[213] Ibid. I also draw here from the insights of two recent dissertations. See Mary Augusta Brazelton, "Vaccinating the Nation: Public Health and Mass Immunization in Modern China, 1900-60," (PhD diss., Yale University, 2015); Nicole Barnes, "Protecting the National Body: Gender and Public Health in Southwest China during the War with Japan, 1937-1945," (PhD diss., UC Irvine, 2012).

childbirth and mothering came to fruition through the policies and offices of the Nationalist government, they proceeded in accord with the Nationalist-state's territorial expansion. In tandem with military campaigns to vanquish rival militarists, public health, often spearheaded by midwifery reform, extended Nationalist influence well beyond the eastern nucleus of Nanjing's power to reach such distant locales as Yunnan and Gansu by the mid-1930s.

Three years after the founding of FNMS and the National Midwifery Board, national authorities began to realize the goal of expanding the nascent MIH program that operated under the auspices of the NHA. Due to the flagship status of the Rockefeller-affiliated FNMS and Yang Chongrui's simultaneously held post as Director of the NHA's Maternal and Child Health Division, FNMS became central to midwifery reform throughout the Nationalist realm. Staff at FNMS helped to determine licensing standards for midwives while supplying staff for newly organized hospitals and midwifery schools throughout the country. Although, in some cases, midwifery training schools and maternal health centers became departments within larger institutions of public health, the issue of childbirth often served as the "entering wedge" for the National Health Administration (NHA) in a given locale, much as it had for the IHD in the years prior to the Nanjing Decade. In many provinces, the founding of a midwifery training school preceded the later establishment of provincial hospitals and health bureaus, intentionally built around the pioneering efforts of midwives and obstetricians.[214]

Yang Chongrui's annual reports to the Rockefeller Foundation attest to the central role of FNMS in the dramatic and rapid expansion of state-sanctioned MIH institutions during the 1930s, and the compatibility between Rockefeller and Nationalist Party aims. In 1932, FNMS staff founded officially recognized midwifery schools in the provinces of Shaanxi in the West

[214] Marion Yang (Yang Chongrui), FNMS Fourth Annual Report, 1932-3 (RAC, Sleepy Hollow, NY, Rockefeller Foundation Archives, RG 5 Series 3, Box 222, Folder 2771).

and Jiangxi in the South. In the same year, FNMS graduates and staff founded additional "rural midwifery homes" in remote areas of these provinces in a move to combat the geographic obstacles that separated many in rural regions from hospitals of provincial capitals.[215]

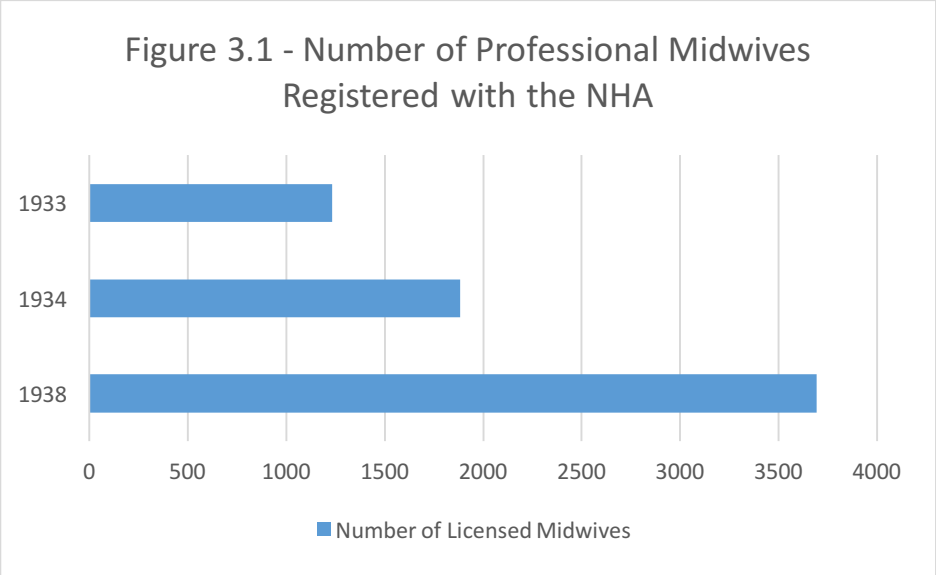
Soon thereafter in fall 1933, the effort to expand the reach of the NHA's MIH program brought about a second national midwifery school, the Central Midwifery School, in the capital city of Nanjing. This school operated in close association with the Central Field Health Station of Nanjing, founded in 1931, which many pointed to as evidence of the legitimacy and effectiveness of the NHA. Though planned through cooperative efforts of the League of Nations Health Organization (LNHO), the Rockefeller IHD, and the NHA, the Nanjing Central Field Health Station maintained financial independence from its outset in accordance with the demands of LNHO advisor Ludwik Rajchman and Rockefeller IHD Far East Director Victor Heiser. Midwives trained at the affiliated Central Midwifery School featured prominently in reports sent to New York and Geneva that asserted the Nationalist state's rightful position among the modern member states of international organizations. These widely circulated reports came replete with photographic evidence of vaccinations and medical training classes, demonstrating Nationalist China's active participation in the international project to advance public health within and beyond Chinese borders.[216]

The rapidly expanding network of MIH institutions placed a considerable strain on the staff and resources of FNMS. When the Central Midwifery School of Nanjing opened in 1933, Yang Chongrui took a three-month leave of absence from FNMS to serve as the new school's interim director, while a steady stream of recent graduates left Beiping to work for new training

[215] Ibid.

[216] First Report of the Central Field Health Station (April 1931-December 1933) (RAC, Rockefeller Foundation Archives, RG 2, Series 601, Box 89, Folder 712); see also Chapter Two of this dissertation.

centers and hospitals throughout the Nationalist Republic. In fact, most midwifery schools and maternity hospitals founded by the NHA and its provincial subsidiaries in the 1930s were staffed by graduates, teachers, midwives, and doctors from FNMS in Beiping. By mid-1934, just five years after the founding of FNMS, there were ten provincial schools, three municipal schools, and fifty-four registered private schools overseen by the NHA, in addition to the two national schools in Beiping and Nanjing. Together, these schools constituted a multidirectional network through which rural women who had received basic training in local or provincial schools went on to pursue advanced study at national-level schools in Beiping and Nanjing. These educational pilgrimages between core and periphery aided the integration of provinces into the Nationalist republic, as reports circulated both within and outside China asserted the links between the national program and its localized iterations.[217]



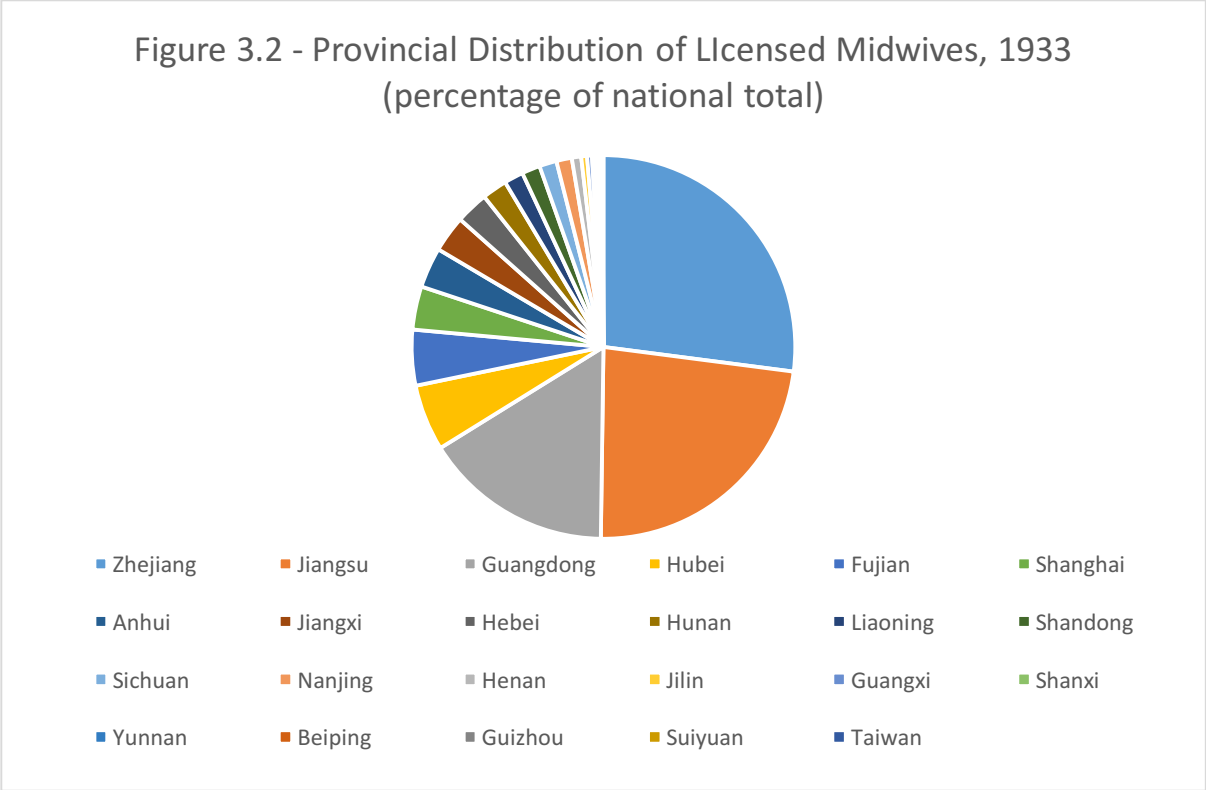
Sources: "*Quanguo zhuchanshi dengji tongji zhaiyao* 全國助產士登記統計摘要," Neizheng diaocha tongji biao 《內政調查統計表》4, no. 15 (1933): 14; Marion Yang (Yang Chongrui), FNMS Fifth Annual Report, 1933-34

[217] Marion Yang (Yang Chongrui), FNMS Fifth Annual Report, 1933-34 (RAC, Rockefeller Foundation Archives, RG 5 Series 3, Box 222, Folder 2774); This report provides only the English names used by these Chinese graduates of FNMS. Where possible, I have provided Chinese names by matching transliterations with the names provided in Chinese-language sources.

(RAC, Rockefeller Foundation Archives, RG 5 Series 3, Box 222, Folder 2774); Weisheng tongji 《衛生統計》 (Chongqing: *Neizhengbu* 內政部, 1938), 34-35.

As shown in Figure 3.1, the founding of new training programs significantly increased the total number of biomedically trained midwives registered with the NHA during the Nanjing Decade. A total of 1,234 midwives had received licenses from the NHA and its subsidiaries by 1933, a figure which grew to 1,883 one year later. Four years later in 1938, the NHA reported that the total number of licensed midwives had nearly doubled to 3,694.[218] Though this total number remained proportionately modest given China's vast territory and population, the figure remains significant given the then short life of the NHA and the geographic limits of Nationalist power, which had only begun to reach to distant Western provinces when these statistics were collected. The growth reported in 1938 preceded the wartime expansion of MIH and public health in western provinces outlined in the following case studies of Yunnan and Gansu. Further, the data in Figure 3.1 only reflect practitioners who had formally registered with the NHA. The dispersed, multifaceted nature of MIH programs with varied ties to the Nationalist state produced a more diverse and capacious landscape of practitioners than can be seen from these data alone.

[218] Ibid; Weisheng tongji 《衛生統計》 (Chongqing: *Neizhengbu* 內政部, 1938), 34-35.



Provinces are listed in descending order of percentage of midwives (left to right) starting with Zhejiang. One midwife is listed here from Taiwan, though Taiwan was a Japanese colony in 1933. Source: "*Quanguo zhuchanshi dengji tongji zhaiyao* 全國助產士登記統計摘要," Neizheng diaocha tongji biao 《內政調查統計表》4, no. 15 (1933): 14

The significant increase in the number of licensed, biomedical midwives coincided with a widened geographic distribution of official, biomedical midwifery practice. As shown in Figure 3.2, roughly half of all licensed midwives registered in the provinces of Zhejiang and Jiangsu in 1933. These bordering provinces along the Yangzi Delta constituted the locus of Nationalist power and one of the most economically developed regions of the country. Nonetheless, Figure 3.2 also shows that official registration and licensing procedures had stretched, to a limited extent, across a wide geographic area as early as 1933, merely four years after the founding of FNMS, thereby aiding the integration of distant and contested regions into the Nationalist polity. Figure 3.3 (below) provides more detail on the geographic distribution of registered midwives by highlighting the reach of FNMS graduates specifically. By 1935, FNMS graduates had reached

as far west as Sichuan (Szechuan) and Gansu (Kansu), though most remained concentrated in eastern provinces.

The following case of Yunnan and the next chapter's discussion of Gansu show an accelerating trend toward expansion in numbers and distribution of MIH personnel and institutions from the mid-1930s to the later 1940s. As seen in these cases, the intertwined efforts of foreign philanthropists and national authorities to reform Chinese childbirth reached to rural areas of distant provinces by the later 1940s. This expansion aided and depended on Nationalist accumulation of territory, even as it produced decentralizing effects that allowed for adaptations of national policies to local conditions.

Figure 3.3 - "Distribution of Graduates of the First National Midwifery School" (1934-35)

Souce: Marion Yang, Sixth Annual Report, First National Midwifery School, July 1, 1934 – June 30, 1935 (RAC, Rockefeller Foundation Archives, RG 5, Series 3, Folder 2775).

Yunnan in Late Qing and Early Republican China

Yunnan remained on the periphery of Chinese states before the mid-1930s. The Yuan and Ming dynasties maintained little control over the region, and most aspects of governance fell to local chieftains. In the eighteenth and nineteenth centuries, Han immigration to Yunnan expanded along with the Qing empire, fueling conflicts between local powers, Han immigrants, and the Qing state. In addition to cultural diversity, a tropical climate, and untamed terrain, disease thwarted Yunnan's penetration by outside powers. Malaria in particular posed a significant challenge to the administration of Yunnan by the Qing state and Han governors. Susceptibility to malaria helped to materialize the ill-defined borders between ethnic categories that became integral to the hierarchical relations of Qing administration in the region. But, malaria also restrained Qing expansion into Yunnan, particularly in the southwestern frontier. In much of the region, the Qing state was forced to rely on allegiances with local chieftains, with the prevalence of infectious disease shoring up Yunnan's position as an untamed land at the periphery of the empire.[219]

This mode of governance became difficult to maintain amid an influx of migrants fleeing famine and economic crisis in southern and central China during the mid-nineteenth century. Increasingly, tensions between locals, immigrants, and the Qing state erupted into violence, including a three-day massacre of ethnic Hui by Qing forces in 1845. After a later massacre of an additional 3,000 Hui in 1856, Du Wenxiu, a Muslim convert of Han ancestry, founded an

[219] David Bello, "To Go Where No Han Could Go for Long: Malaria and the Construction of Ethnic Administrative Space in Frontier Yunnan," *Modern China* 31, no. 3 (July 2005): 283-317.

independent sultanate in Yunnan, in a movement later referred to as the Panthay Rebellion of 1856-73. The Qing state responded with brutal force, and as many as five million people died during the prolonged conflict. Many of varied ethnic groups supported the Dali Sultanate, and Du himself called for multiethnic unity against Qing forces. Some Hui in the region were spared when they joined with the Qing to suppress the rebellion. Many others fled across ill-defined borders into British Burma, Laos, and Thailand. In the wake of the rebellion, the Qing state asserted firmer control over Yunnan, but many continued to contest Qing authority until the empire's collapse in the early twentieth century.[220]

Following the Xinhai Revolution of 1911, Yunnan remained largely autonomous throughout the early Republican period. After a brief alliance with the Beiyang Republic, the provincial Yunnan Army split from the Beiyang Army in resistance to Yuan Shikai's attempt to reinstate the monarchy in 1916. For the next two decades, local military leaders ruled Yunnan with little outside intervention. Yunnanese militarists entered into a fragile union with Sun Yat-sen's Nationalist Party from its base in Guangdong in the 1920s. However, the Yunnan army fragmented shortly thereafter as a result of internal factionalism and the power struggles within the Nationalist party after Sun's death in 1925. In 1927, Long Yun, an ethnic Yi general, became the dominant military and political leader in Yunnan. Long served as provincial governor nominally loyal to the Nanjing-based Nationalist government from the late 1920s until 1945, though the central Nationalist government had limited authority in the province before the mid-1930s.[221]

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[220] It should be noted that ethnic divisions were very much in flux during this period. Joseph Francis Ford, *The Local Histories of Yün-nan* (London: China Society Occasional Papers, no. 19, 1974), 20-25; see also David G. Atwill, *The Chinese Sultanate: Islam, Ethnicity, and the Panthay Rebellion in Southwest China, 1856-73* (Stanford, CA: Stanford University Press, 2005), 185-94, passim.

[221] Donald S. Sutton, *Provincial Militarism and the Chinese Republic: The Yunnan Army, 1905-25* (Ann Arbor: University of Michigan Press, 1980), 254-56.

As in most matters, Nanjing exercised little influence over public health in Yunnan during this period. According to several reports, a small office in the Kunming police station oversaw all matters pertaining to public health in the province in the early decades of the twentieth century. The response of political leaders in Yunnan to the early dictates of the central Ministry of Health (before its reorganization as the NHA) affirms what scholars have written regarding Nationalist governance during the Nanjing Decade. Local leaders expressed deference to the Nationalists, who had little if any control over the province. In 1928, political leaders in Yunnan acknowledged the national law that ordered the founding of provincial health bureaus. In accordance with these laws, provincial leaders announced the founding of a new provincial health administration in August 1930. This early bureau took up the task of improving water quality and treating infectious diseases. The provincial administration also founded the Kunhua provincial hospital in Kunming, which remained one of its few lasting achievements. Like other largely autonomous provincial authorities throughout China during this period, Yunnanese leaders also announced a plan to comply with the 1929 national law requiring government oversight of doctors and midwives. However, archives bear little evidence that local authorities took actual steps to implement these plans, aside from a brief expression of intent to comply with national regulations. According to several different reports, these efforts lacked funding and the militarist government maintained other priorities.[222]

Yunnan, Nationalist Sovereignty, and Global Health

[222] Yunnan sheng minzhengting wunian weisheng gongzuo baogao 《雲南省民政廳五年衛生工作報告》 (Historical Documents, Yunnan Provincial Library); see also "*Yunnan zhibian duban gong shu zhixing zhangcheng* 雲南殖邊督辦公署暫行章程"; *Yunnan sheng zuzhi fa ling'an,* no. 2《雲南省組織法令案　（二）》(Nanjing, 1930-44) (Academia Historica, Taipei).

Yunnan's integration into the Nationalist state came about through coordinated acts of the Nationalist state, its foreign partners, and its local representatives beginning in the mid-1930s. Since the late nineteenth century, commercial interests in India had sought to foster trade with China through the British colony of Burma. Britons such as A. R. Colquhoun came to harbor hopes that an overland route through Yunnan could connect the Qing Empire to the Indian Ocean. These plans met a number of familiar challenges, including political instability, local resistance, tropical disease, and mountainous terrain. In the late nineteenth century, Britain extended its formal control of Burma northward to combat encroaching French interests from Indochina, as Yunnan became a border zone between competing colonialisms in the region.[223]

In the interwar period, these distinct pursuits of territory in the region brought Britain's aims for trade into alignment with Najing's aim of international recognition. Recognition of Nanjing's territorial claims to Yunnan at once brought stability to British areas of northern Burma while pulling Kunming toward Nanjing and away from the orbit of French influence. At the urging of Great Britain, a "neutral chairman" appointed by the President of the Council of the League of Nations presided over a joint boundary commission that began negotiations in late 1934 to update an 1897 convention with the Qing Empire. The joint commission met in both Nanjing and in Yunnan to demarcate a fixed border that avoided the bisection of villages or blocked local access to waterways, bringing relations between Yunnan and British Burma into the territorial frameworks of diplomacy.[224]

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[223] Stephen L. Keck, *British Burma in the New Century, 1895-1918* (New York: Palgrave Macmillan, 2015), 33-4; see also John L. Christian, "Anglo-French Rivalry," in Paul H. Kratoska, ed., *Southeast Asia, Colonial History: Empire-Building in the Nineteenth Century* (New York: Routledge, 2001), 80-91.

[224] "*Dianmian bianjing nanduan weiding jie wenti* 滇緬邊境南段未定界問題," (Nanjing, 1934) (Academia Historica). I draw here from Winichakul, *Siam Mapped, passim.*

The negotiations served the aims of both parties. The League helped to affirm and protect British commercial interests in Burma, while recognizing Nanjing's sovereignty over contested regions of Yunnan. Further, the treaty advanced an ongoing process to make the Nationalist Republic legible to an international order of nation-states, codifying the limits of its territoriality even as they remained contested on the ground. Through these negotiations over Yunnan, an international community had affirmed Nationalist China as a nation-state capable of engaging in "mutual compromise" with Western powers.[225] With a clearly defined border and international affirmation of Nationalist rule, Nanjing moved to shore up its influence in Yunnan.

As in a number of other provinces, this strengthening of ties between center and periphery occurred, in part, through the development of provincial public health institutions, in cooperation with international organizations. In late 1934 and 1935, the League of Nations further affirmed Nanjing's claims to Yunnan through the partnership between the Chinese NHA and the LNHO. During this period, Yugoslavian doctor and LNHO representative Andrija Štampar became one of the most significant actors in the westward expansion of the Nationalist state's public health enterprises not only in Yunnan but also in the provinces of Gansu and Sichuan. In the 1920s, Štampar's work with the LNHO and the Rockefeller Foundation brought large sums of money into his native Yugoslavia, funding such endeavors as the School for Public Health in Zagreb and fellowships for Yugoslavian health professionals to study in the West. Both the LNHO and the Rockefeller Foundation subsequently employed Štampar as a researcher and advisor in countries throughout Asia, Europe, and the Americas beginning in the mid-1920s. By 1930, Štampar had become one of twenty-four members on the LNHO's Executive Council.[226]

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[225] Ibid.

[226] M.D. Grmek, "Life and Achievements of Andrija Štampar, Fighter for the Promotion of Public Health," in M.D. Grek, ed., *Selected Papers of Andrija Štampar*, M. Halar, trans. (Zagreb: Andrija Štampar School of Public

In the early 1930s, Štampar became increasingly valuable to the operations of the LNHO around the world, specifically in its efforts to develop rural health programs. Officials in Geneva identified Štampar as a "man of wide experience and unusual competence" in this area.[227] Ludwik Rajchman, who had been integral to the reorganization of the Chinese NHA,[228] invited Štampar to assist with the organization of a European Rural Health Conference in April 1931. This initial conference strengthened the LNHO's ties with both Štampar and the Chinese government, signaling plans for future endeavors in China. In a letter to the Chinese NHA, LNHO officials invited the Chinese government to send observers to the European conference, based on the notion that rural health concerns would remain particularly important for public health in China. It was noted that

> …consideration of rural health problems in [non-European] countries might complicate the discussions by introducing other factors, such as tropical diseases and special conditions, nevertheless the rapporteur thought the Council would wish to invite the Governments of non-European states which had a special interest in rural problems to send observers to attend the Conference and hear the discussion.[229]

This conference was the first in a series on rural health held around the world in the 1930s, with Štampar and the broader LNHO successfully encouraging Chinese participation in their global endeavors.[230]

Health Medical Faculty, 1966): 13-51, 30-31; see also "Collaboration of Dr. Štampar with the Health Section, August-September 1931," (UN Archives, R5933, Series 30182, 30816).

[227] "The Treasurer" (UN Archives, R5933, Series 30182, 30816).

[228] See Chapter Two of this dissertation.

[229] Joseph Avenol to Chinese Minister of Foreign Affairs, n.d. "*Guolian yanjiu nongqu weisheng ouzhou geguo daibiao huiyi* 國聯研究農區衛省歐洲各國代表會議," 1930/12-1931/01 (Academia Sinica, Taipei).

[230] See Štampar to Han Lee Min, March 6, 1934 (UN Archives, R6060 Series 940).

As part of the LNHO's global rural health project, the League commissioned Štampar to survey areas in central China following the devastating floods of 1931. Aside from a detailed report of British Hong Kong, most of Štampar's findings on this initial survey were discussed privately with Rajchman in a meeting in Geneva where minutes were not taken.[231] Whatever his findings, they apparently affirmed the need for further intervention in China and Štampar's integral role in this effort. In 1933, the Secretary General of the League of Nations formally requested that Štampar become "the League expert on health matters to be put at the disposal of the Chinese Government in connection with the plan of technical co-operation with the League of Nations in national reconstruction."[232] From this position as "League expert," Štampar advised the Chinese government on the further extension of public health into its expanding territory in western China, while using observations and connections in China to advance the League's broader endeavors in rural health internationally.

Štampar's particular expertise and value to the LNHO in the area of rural health sent him far from Nanjing into remote regions of western China. As a foreign expert with specialized knowledge, Štampar accompanied Chinese national authorities in surveys of public health in Jiangxi, Sichuan, Shanxi, and Yunnan in 1935. Based on his observations, he produced reports that guided the extension of the NHA and broader Nationalist influence into these contested regions. According to a Chinese translation of Štampar's report on Yunnan, the provincial government formally requested advice from the central NHA on improvements to public health

[231] See Rajchman to Štampar, June 2, 1932 (UN Archives, R5933, Series 30182, 30816).

[232] Grmek, "Life and Achievements of Andrija Štampar," 37.

in September 1934. In 1935, the NHA, under the advisement of Rajchman and Borčić, sent Štampar on a three-week tour of Kunming and its surrounding hinterland.[233]

Štampar's survey of Yunnan, purportedly an initial step toward consulting on public health matters, covered a variety of social and economic issues that linked public health enterprises to broader goals for development. His report outlined the depravity of the region based on a number of standards. As in the case of Gansu outlined in Chapter Four, the NHA and its foreign partners viewed public health in Yunnan as intertwined with issues of economic development and infrastructure that would integrate the province into the Nationalist realm. Štampar provided extensive descriptions of the untamed wilderness of Yunnan noting a general lack of roads, largely ignoring the Kunming-Hai Phong Railway built by the French that connected Kunming to French Indochina. The provincial government had recently constructed a route connecting Kunming to four surrounding counties, he reported, but travel to most parts of Yunnan remained difficult and time-consuming. Thus, his report focused primarily on the provincial capital, where he had spent the majority of his time.[234]

From his unique perspective as a foreign expert well-traveled in the Chinese interior, Štampar pointed to a number of other factors that differentiated Yunnan from both Han-dominated areas of China and the Western world. He sketched out a verbal map of the province's topography, noting mountainous regions in the Northwest and deep basins in the South as well as an exceptionally humid climate. At 150,000 square miles, he reported, the province was second

[233] Ibid., 37-9. Štampar's reports were translated into Chinese. See Si Danba 司丹巴 (Štampar), "Shicha Yunnan baogao 視察雲南報告," 1935 (Academia Historica, Taipei), 1643-5; see also "*Si Danba kaocha dian gan jin chuan baogao* 司丹巴考察滇贛晋川報告," 1936 (Academia Historica, Taipei).

[234] Si Danba 司丹巴 (Štampar), "Shicha Yunnan baogao," 1643; see also W. Langhorne Bond, *Wings for an Embattled China,* James E. Ellis, ed. (Bethlehem, PA: Lehigh University Press, 2001), 178.

only to Sichuan in land area, with vast, rugged landscapes that isolated an estimated 11,000,000 people from each other and the broader world.[235]

Štampar also gave particular attention to ethnic diversity in his characterization of the province, noting that Han Chinese constituted only about 3,000,000 (or about twenty-seven percent) of Yunnan's total population. Only the ethnicities of Tibetans, Miao, and Han were specifically mentioned, but Štampar noted that more than 1,000 distinct ethnic groups inhabited the province. Many of Yunnan's rural inhabitants had little contact with other tribes in the region, much less coastal Chinese or foreigners. This isolation and ethnic difference became key to Štampar's thesis regarding the dire state of Yunnan, as he focused on the peculiarities of local practices. He wrote, "The social customs of this province, even from the perspective of Han Chinese, are quite undesirable."[236] Here, Štampar maintained multilevel hierarchies within and between races to frame Yunnan as a region markedly inferior to both Han and Western sensibilities. These hierarchies served to justify intervention in the province by both the Han-dominated Nationalist government and their Western advisors.[237]

Štampar provided specific details regarding the unsavory habits of Yunnan's tribes, which, despite earlier acknowledgement of their diversity, quickly became a monolithic group constituted through their apparent difference from both eastern, cosmopolitan Chinese and Westerners. Later sections of the report regarding hygiene and health rested on this prior establishment of Yunnanese barbarity in broad terms. Though also particularly horrified by the treatment of workers in mining areas, the state of women and children became a primary idiom

[235] Ibid, 1643-44.

[236] Ibid., 1644.

[237] Ibid., 1644.

for articulating Yunnan's depravity, and thus a key piece of evidence supporting external intervention. Štampar wrote, "In Kunming, the practice of accumulating female slaves has not yet been abolished. Five- or six-year-old girls are bought and sold for between five and fifty *yuan*. In one area of Kunming, there are more than one hundred people who traffic slave girls."[238] Such detail in a report purportedly focused on public health sheds light on the linked notions of morality, ethnic difference, gender, and sexuality that undergirded the perceived urgency of public health for both Štampar and his interlocutors. In a province where ethnic Others routinely bought and sold young girls as slaves, the proposed interventions of the Nationalist state and its advisors became exceptionally urgent.

With prose that suggested self-evident links between undeveloped wilderness, feminine fragility, child slavery, human trafficking, and health, Štampar turned abruptly to the previous annual budget of the provincial government to suggest that a lack of investment in public health had produced these inferior conditions in Yunnan. Unsurprisingly given the recent history of sustained conflict, Štampar reported that sixty-three percent of the 600,000 yuan in tax revenues collected by the provincial government had gone to military expenditures. Štampar reported that a mere six percent of tax revenues supported education or public services. Here, again, the state of children provided compelling evidence. Though roughly 450,000 children lived in Yunnan, only one-fourth of these had received any education. Most Yunnanese remained illiterate and ignorant, with the government spending just forty yuan on any sort of mass education program. As for public health specifically, the provincial government had spent a mere total of 13,000 yuan in 1934. The province thus remained in dire lack of biomedical practitioners and hospitals.

[238] Ibid., 1644-5.

Only a few missionary or government-affiliated clinics had been established in the capital, leaving most of the population without access to biomedical care.[239]

Based on his survey, Štampar provided several recommendations to the Nanjing-based NHA regarding the development of public health in Yunnan. The initial step should be the founding of a centralized Provincial Health Institute, which would coordinate all public health projects in the province. The central Nationalist government provided the province with an initial 10,000 yuan plus a subsequent 20,000 yuan per annum designated specifically for these purposes. Štampar retained a degree of influence and continued to advise both national and provincial public health administrators. When the leadership of the Yunnan institute moved to establish a hospital at the site of a police school near the southern gate of Kunming, Štampar insisted that the space was unsuitable, and local authorities chose a different location.[240]

Despite geographic and economic challenges particular to Yunnan, provincial public health reforms proceeded along the model of other provinces as envisioned by the now well-established collaboration between the LNHO, the Rockefeller International Health Division, and the NHA. The reorganization and strengthening of public health services in Yunnan brought greater Kunming into the growing network of institutions founded by the LNHO, Rockefeller, and NHA coalition. Reports shared between Nanjing, Beiping, Geneva, and New York now framed distant Yunnan within broader efforts to advance public health in China and around the world, primarily in discussions focused on tropical diseases, rural health, and biomedical midwifery. Closer ties to central public health operations also meant the transfer of Rockefeller-

[239] Ibid., 1645.

[240] *Yunnan quansheng weisheng shiyanchu* 雲南全省衛生實驗處, Yunnan quansheng weisheng shiyanchu er nian gongzuo gaikuang《雲南全省衛生實驗處二年工作概況》(Kunming, 1938) (Nationalist Party Archives, Taipei), 1-2.

trained personnel from eastern Chinese cities to Kunming, a migration that gained momentum following the Japanese invasion of Eastern China in 1937.

The initial director of the reorganized Provincial Health Institute, Yao Xunyuan 姚尋源, maintained close ties to both Rockefeller institutions and the central NHA. Yao had studied at the Rockefeller-funded Peking Union Medical College (PUMC) and at Johns Hopkins University through the Rockefeller International Health Division's fellowship program for Chinese medical personnel. Most recently, Yao had overseen the founding of a provincial health ministry and midwifery training school in Ningxia, a remote northwestern province.[241] With this training and experience, Yao's efforts to advance public health attempted to develop public health in Yunnan along national models and thereby integrate the peripheral province into the Nationalist Republic centered on Nanjing.

MIH in Yunnan

The founding of a national midwifery school represented an initial step toward these goals immediately following Štampar's survey tour. Plans for a provincial midwifery school appeared in print even before Štampar's report of his tour of Yunnan, more than a year before the 1936 founding of a provincial health organization. In early 1935, after the commission survey but before Štampar's published report, the Chinese-language publication *Public Health Bimonthly* announced that a provincial midwifery school would soon begin operations within a municipal hospital in Kunming.[242]

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[241] John R. Watt, *Saving Lives in Wartime China*, see also L.C. King to Rockefeller Foundation, March 14, 1949 (RAC, Sleepy Hollow, NY, RG 2 Series 601 Box 464 Folder 3110).

[242] "*Xiaoxi: Yunnan sheng: wu, choushe shenghui zhuchan xuexiao* 消息：雲南省：五，籌設省會助產學校，" Weisheng banyuekan《衛生半月刊》2, no.4 (1935); Weisheng tongji 《衛生統計》 (Chongqing: *Neizhengbu* 內政部, 1938), 9 (Nationalist Party Archives, Taipei).

As in other provinces, the founding of a midwifery school linked Kunming to a growing number of institutions centered on Nationalist power centers. While Rockefeller-trained personnel, like Yao Xunyuan, came to Yunnan, the most promising midwifery students recruited from Kunming and its hinterland received government sponsorship for advanced study at national schools in Beiping and Nanjing. By 1938, more than forty midwifery students from Kunming had received scholarships for advanced study at one of two national-level schools in the East. Thus, Kunming became integrated into a multidirectional network of MIH, with practitioners from the East supporting work in interior provinces and women throughout China embarking on educational pilgrimages to coastal cities.[243]

The particularities of Yunnan, however, gradually produced a provincial public health system that operated in deference to the aims of the central government, while retaining a greater measure of autonomy than that seen in some other provinces. The province's long history of autonomy often resulted in tensions between local authorities and the national leaders to whom they professed allegiance. These tensions appeared in various areas of governance, including military affairs, industry, and commerce. Many in the central government, including Chiang Kai-shek himself, viewed Yunnan as critical for national defense given its positioning along the Burma border. However, the longstanding autonomy of the province combined with the central government's preoccupations elsewhere also made Yunnan a haven for political dissidents of the Nationalist regime during the war with Japan.[244]

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[243] "*Xiaoxi: Yunnan sheng: wu, choushe shenghui zhuchan xuexiao* 消息：雲南省：五，籌設省會助產學校，" Weisheng banyuekan《衛生半月刊》2, no.4 (1935).

[244] See Lloyd Eastman, *Seeds of Destruction: Nationalist China in War and Revolution, 1937-1945* (Stanford: Stanford University Press, 1984), 10-70.

The demonstrable yet tenuous influence of the Nationalist state in Yunnan shaped local authorities' approach to public health. Both provincial and national authorities shared the vision of the provincial midwifery school in particular as a catalyst for the broader development of public health not only in Kunming but also in more rural areas of the province. Provincial health authorities aimed for the midwifery school to provide a steady flow of MIH workers that would extend the reach of the newly founded Provincial Health Institute through the founding of county-level health stations. Yunnan's lack of urbanization and infrastructure necessitated adaptations to the curriculum of the midwifery school, which shifted to focus on providing basic health services beyond midwifery in addition to overseeing childbirth without the readily available assistance of doctors or a hospital. Initially, this scheme had limited impact. In its first two years of operation, the Provincial Health Institute founded local bureaus in only six of Yunnan's counties.[245]

Despite the lackluster results of early years, the 1940s brought significant expansions to MIH in Yunnan, in numerical and geographic terms. This resulted from a number of factors, including the wartime relocation of several eastern medical schools along with their respective experts to the provincial capital of Kunming.[246] However, the specific advancement of MIH particularly in rural areas relied on the positioning and pragmatism of Miao Ancheng 缪安成 or Janeson Miao, who succeeded Yao Xunyuan as Director of the Provincial Health Institute. Miao's path to prominence depended on the international networks of philanthropists and missionaries as well as his own personal connections to political elites in Yunnan. Miao, a native

[245] Today, Yunnan has 129 counties. *Kunming shi zhengfu xingzheng shiweihui* 昆明市政府行政實委會, Yunnan xingzheng jishi 《雲南行政記實》vol. 23 (Weisheng) (Kunming, 1943) (Nationalist Party Archives, Taipei).

[246] H. P. Chu, "Medical Education – Realignment," 1940 (RAC, Sleepy Hollow, NY, China Medical Board, Inc., Box 22, Folder 155).

of the province, had studied at the Catholic Aurora University Medical School in Shanghai. In 1939, he left China with Rockefeller aid to earn a Master's in Public Health from Harvard University. He assumed directorship of the Yunnan Provincial Health Institute in 1940, but soon left the province again first for Chongqing and then the United States with the stated purpose of "investigating and researching matters related to public health."[247] Miao returned to Yunnan in 1941, where he simultaneously served as Provincial Commissioner of Public Health and Professor of Public Health and Bacteriology at National Yunnan University.[248]

Like many in the Nationalist bureaucracy, Miao remained a cosmopolitan figure who served as liaison between the varied parties with investments in Chinese public health. He had spent time in the United States as a child in the charge of his uncle, Miao Yuntai 繆雲台, who was then a student at the University of Minnesota. Miao Ancheng reportedly converted to Catholicism after an epiphany during illness, aided by the nuns who attended him at St. Mary's hospital in Shanghai. These facts were highlighted in foreign publications, along with his Rockefeller ties and American education, to affirm Miao's positioning vis-à-vis the West, as Miao used his varied ties to elevate Yunnan's place in national and global public health projects.[249]

Miao's U.S. ties and cosmopolitan upbringing aided his cultivation of allies and benefactors for local public health campaigns. However, his particular approach to public health met disapproval from some members of the Rockefeller Foundation. Despite published articles

[247] L.C. King to Rockefeller Foundation, March 14, 1949.

[248] Ibid.

[249] N.C.W.C. News Service "Chinese Health Official, Amid Dark Present, Labors for China of Post-War Days," 1941 (Shanghai Municipal Archives).

in the United States that praised Miao's critical contributions to the joint efforts of the U.S. and China to defeat Japan, some U.S. philanthropists voiced criticism of Miao in private. In the late 1940s, the Rockefeller Foundation denied Miao additional funding to study abroad on the stated basis of preference for younger medical practitioners. However, in a copy of a letter denying the fellowship circulated internally, Robert Briggs Watson of the Rockefeller Foundation confided that he had met Miao on a number of occasions and felt that he should not receive further support. According to Watson, Miao stayed in office due solely to his powerful uncle, Miao Yuntai, who held a post in the Department of Agriculture and Mining while also serving as president of Fudian Bank. Without providing great detail, Watson argued that neither Miao nor his uncle had a "very good reputation."[250] Further, the letter suggested that the Miaos exercised considerable autonomy in Yunnan. Thus, Miao Ancheng remained at once critical to the allied projects of foreign philanthropists and the Nationalist state in Yunnan and evidence of their limited ability to determine local dynamics amid a rapidly expanding health system.

As public health minister, Miao continued to capitalize on the investments of foreigners and the Nationalist state in women's reproductive health, even as he remained a pawn of neither project. Early in his tenure as director, a report to national authorities in Chongqing highlighted the Provincial Health Institute's operations in the areas of midwifery training, infant care, pediatrics, health education in schools, and examinations for schoolchildren. Despite the limited progress made in the years preceding his appointment, which Miao labeled a "good foundation," he focused on these aspects of public health to demonstrate a persistent, dire need of additional investment by the National government and foreign philanthropists in Yunnan. Miao lauded a

[250] Robert Briggs Watson to L.C. King (copy), May 2, 1949 (RAC, Sleepy Hollow, NY, RF Records RG 2 Series 601 Box 464 Folder 3110); see also "Miao Yuntai," University of Minnesota Distinguished Alumni https://china.umn.edu/en/alumni/distinguished-alumni/miao-yuntai (accessed January 12, 2017).

recently founded maternity hospital at the Kunhua midwifery school, while pointing to data that showed that the hospital had "not yet achieved outstanding results" in its first three months of operation. Only fifteen women had received prenatal examinations, and only one of these had sought postnatal services in the clinic. Only two of the infants born to these women had been seen by hospital staff. Through outreach efforts to treat women outside the hospital, staff had seen an additional thirty-eight postpartum mothers. Professional midwives had overseen just two births, both of which occurred at the hospital.[251]

Elsewhere in the report, Miao specifically addressed the persistence of "old-style" midwives throughout the province that had thwarted efforts thus far to universalize biomedical childbirth. After lamenting the lack of interest among local women, he concluded, "Regulating old-style midwives remains the most important work of MIH."[252] From Miao's perspective, searching out, regulating, and re-training these lay practitioners remained among the most pressing issues facing the maternity clinic, the midwifery school, and broader public health operations. Further, the differing methods through which women gave birth and nurtured their infants became increasingly critical in shaping the provincial health institute's work in rural areas under Miao's leadership.[253]

With this priority, Miao developed creative approaches to adapt the national model of reforming childbirth to the particular conditions of Yunnan. The few biomedically trained midwives in the province remained clustered around the capital of Kunming, and geographic barriers presented particular challenges to regular contact between these midwives and parturient

[251] Yunnan sheng weisheng chu 雲南省衛生處, *Minguo sanshiyi nian gongzuo baogao* 《民國三十一年工作報告》(Kunming, 1942), 32, 39.

[252] Ibid., 39.

[253] Ibid., 39.

women in rural areas. Given the limited resources of the provincial institute, Miao developed cooperative programs with local "study groups 訓團" to implement small classes for new positions of "nursing assistants 助理護士" and "midwifery assistants 助理助產士." Local groups organized classes based on the approved curriculum of official schools. The ten-month course comprised a three-month study period followed by a seven-month practicum in Kunming hospitals. The provincial institute appointed a single supervisor to oversee courses in a given county. At the completion of the program, students who passed an exam received employment with county-level health offices. From the outset, the program was modestly successful. In the first year of the program (1942), seventy-three people participated. But, more importantly, Miao's program began a process of expanding biomedical methods of childbirth and mothercraft into the rural areas of one of China's most remote provinces.[254]

"Child health 兒童衛生," still understood at this point as a related but distinct field from MIH, had seen better results in Yunnan than midwifery reform, Miao reported. The Provincial Health Institute held several public events framed as localized iterations of the national "child festivals" organized by the central NHA in cooperation with private philanthropic organizations. In Yunnan as elsewhere, these events included health demonstrations, examinations, and healthy child competitions. Parents had enthusiastically participated in the pageantry of these public health programs targeting their young children, even as women reportedly remained indifferent to midwifery reform. According to Miao's 1942 report, more than 29,000 people had participated in a recent three-day event for child health.[255]

[254] Ibid., 35.

[255] Ibid., 32-3.

The successes of these events fostered stronger ties between public health programs targeting childbirth and those emphasizing the health of young children, a development that occurred locally in Yunnan in dialogue with international trends in public health. As Miao reported, new programs in Yunnan capitalized on the interest that local mothers had shown in the treatment of childhood diseases and healthy child competitions to aid the promotion of biomedical midwifery. 'New-style' midwives became the primary orchestrators of both maternal/infant and child health programs. To reflect professional midwives' newly expanded role in promoting both biomedical childbirth and the broader treatment of mothers and young children, the provincial government approved a measure renaming *zhuchanshi* 助產士 (literally 'aiding-birth professional'), discarding the term that had been used widely throughout the Nationalist Republic since the founding of FNMS in Beiping in the late 1920s. In a move that differentiated local MIH professionals further from both midwifery assistants and 'old-style' midwives, these practitioners would be certified under the new title, *fuying weisheng yuan* 婦嬰衛生員 or "MIH Personnel."[256] The choice by Miao and provincial authorities to create new categories of public health workers reflected the extent to which biomedical MIH programs in pre-revolutionary Yunnan expanded due to the local adaptation of national models. Affirming the NHA's commitment to midwifery training and MIH, Miao developed less formal training programs to penetrate rural areas while expanding the scope of midwives' duties to connect childbirth and prenatal examinations to locals' demonstrated enthusiasm for the health and wellbeing of their young children. By the late 1940s, this pragmatism proved effective, as Miao continued to leverage and adapt international and national investments to bring biomedical

[256] "*Wei zunling zhuchanshi gaicheng fuying weisheng yuan cheng minzhengting shi ji minzhengting* 為遵令助產士改稱婦嬰衛生員呈民正廳事及民政廳 , (Kunming, January 6, 1943) (Yunnan Provincial Archives, Kunming).

childbirth and mothercraft to remote villages in Yunnan, penetrating to the level of individual households.

Local Households, State Surveillance, and International Philanthropy

Through his government post, international connections, and accommodation of local conditions, Miao connected global philanthropy and national public health to individual households in the rural areas of a frontier province. Like those before him in other areas of China, Miao had discovered MIH and related childcare programs to be an effective method for fostering public interest in biomedical modes of healing and disease prevention. With a clearer sense of the most relevant aspects of public health for locals, Miao mobilized to use these programs to extend provincial public health operations deeper into rural areas.

A 1944 report by provincial authorities laid out strategies for the expansion of MIH and pediatric care into the rural counties of Yunnan. This report to the national government made use of now hegemonic Nationalist state ideology that linked individual and national bodies to each other and to China's place in an international ranking of nations and states. "Examining the health of the *minzu* is a prerequisite for being a strong country," the report began, before turning to high rates of mortality that necessitated the further development of public health interventions. Here, the report emphasized the particular threat that disease posed to women and children, citing especially high rates of maternal and infant mortality and poor environmental conditions in schools that made children vulnerable to disease.[257]

[257] "*Sanshisan niandu ge xian baojian gongzuo jihua dagang ji shishi buzhou* 三十三年度各縣保健工作計劃大綱及實施步驟," (Kunming, 1944)（Historical Documents, Yunnan Provincial Library）, 1.

In accordance with these stated priorities, the official plan offered a detailed agenda for addressing MIH at the county level. Following national precedent, primacy was afforded to collecting data on the state of childbirth and mothering. Specifically, authorities planned to use midwives as investigators to identify the manner in which women gave birth, rates of maternal and infant mortality, and statistics on the number of "old-style" midwives. Then, the province would move to supervise and retrain "old-style" midwives and promote "new" methods of midwifery through sustained engagement at the level of the household. Efforts would then turn to prenatal and postnatal examinations and education programs in hygienic mothercraft. The plan also mandated that each county establish clinics for obstetrics and gynecology and provide annual reports on MIH work to provincial authorities.[258] At the writing of the report, this project was already well underway. The previous year, the Kunhua hospital in Kunming and its affiliated provincial midwifery school had dispatched biomedically trained midwives to Lancang county in Yunnan's southwest frontier. Provincial authorities had explicitly framed this project as an initial step toward the broader goal of establishing a public health bureau in the county.[259] According to a separate report, by 1943, thirty-two of Yunnan's counties had permanent public health offices. Unsurprisingly given military conflicts with the Japanese along the Burma border to the west, these bureaus remained concentrated in counties in southern and eastern Yunnan.[260]

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[258] Ibid., 1-3.

[259] "*Han qing Yunnan shengli kunhua gaoji yishi zhiye xuexiao banli Lancang weisheng yuan jipin zhuchanshi an*, 函請雲南省立昆華高級醫事職業學校辦理瀾滄衛生院急聘助產士案" (Kunming, 1943) (Yunnan Provincial Archives, Kunming).

[260] *Kunming shi zhengfu xingzheng shiweihui*, Yunnan xingzheng jishi 《雲南行政記實》vol. 23 (Weisheng); see also Asano Toyomi, "Japanese Operations in Yunnan and North Burma," in Mark R. Peattie, Edward J. Drea, Hans J. Van de Ven, eds., *The Battle for China: Essays on the Military History of the Sino-Japanese War of 1937-1945* (Stanford: Stanford University Press, 2011), 361-385.

The provincial government's plans conveyed the cultural assumptions and ideology shaping this particular tack for public health in Yunnan. County-level healthcare workers were given the following guidelines:

> Connect with familial sentiments so that public health work will penetrate the populace. Fully understand the conditions of a household so that personnel can sympathize with people's suffering. Point out common health knowledge to make the masses understand public health's significance and function. Serve the infirm and provide health demonstrations to make the masses understand the individual benefits of a public medical system.[261]

Here, MIH affirmed cultural ideologies of the Nationalist state while connecting them to the particular needs and desires of local people. The emphasis on "familial sentiment" propagated Nationalist state ideologies regarding the family as a microcosm of the broader polity, and the intertwined allegiances to both groups as a key component of individuals' relationships to the state. However, health authorities in Yunnan also viewed these particular emphases as key to arousing local interest in public health.

Provincial plans provided detailed and prescriptive information for examining parturient women and their children at varied stages of development, extending state surveillance into the quotidian aspects of rural women's lives. Married women should be instructed to visit a hospital as soon as they stopped menstruating to determine if they were pregnant or suffering from illness. They should track their menstruation to ensure accurate predictions of birth dates. Guidelines directed pregnant women to undergo prenatal examinations once a month during first and second trimesters, twice a month during the seventh and eighth months of pregnancy, and weekly during the final month. In addition to these recommendations, the guidelines given from the government to the populace through rural midwives and healthcare workers included prescriptions on diet, clothing, and exercise during pregnancy that accommodated emphasized

[261] "*Sanshisan niandu ge xian baojian gongzuo jihua dagang ji shishi buzhou*," 30.

nutrition while accommodating local customs. Pregnant women were to consume primarily fruits, vegetables, tofu, and eggs, while limiting consumption of meat and fish. Smoking and alcohol were prohibited by official guidelines, especially after the sixth month of pregnancy. Warm and hygienic clothing reportedly prevented difficulty in labor, as did daily exercise and fresh air.[262]

Provincial authorities also laid out each step of the birthing process in detail, emphasizing sanitary methods as a clear alternative to 'old-style' midwifery. MIH personnel were to thoroughly sanitize all instruments prior to delivery and make preparations for preventing infection. After delivery, midwives would then flush the infant's eyes with water and cut the umbilical cord with sanitized instruments. All implements used during delivery were to be sanitized once again post-delivery, to prevent future infection.[263]

The nurturing of infants, too, became routinized through detailed prescriptions from public health workers. According to these guidelines drafted by provincial authorities and transmitted through county MIH workers, nursing should begin twelve hours after birth followed by feedings at four-hour intervals. Infants should only be fed after six o'clock in the morning and before ten o'clock at night. Infants reluctant to nurse should be given clean water. Weekly examinations by the midwife, who collected quantifiable measurements on the infant's growth, would ensure that mothers adhered to these directives. After forty days, the infant should undergo additional screening for smallpox. These instructions were followed by detailed tables outlining the precise amounts of milk required by infants at each stage of development. To ensure compliance and the accurate collection of data, the government supplied forms for

[262] Ibid. 15-16.

[263] Ibid., 17.

midwives' recording of quantified measures regarding the methods and frequency of nursing. Thus, through the intermediary of the local MIH worker, biomedical methods of childbirth and childrearing came to shape the quotidian activities of rural women in Yunnan.[264]

As elsewhere in the report, these detailed plans were explicit about the specific role that MIH programs would play in connecting the concerns of local households to provincial goals and the broader projects of the Nationalist state. Interventions at the stage of pregnancy and childbirth became integrated into the more popular projects for addressing the health of young. Provincial authorities intended for these programs targeting children and mothers to legitimate broader public health operations at the local level. The guidelines provided a path for future generations to perpetuate the relationship between the provincial public health apparatus and individual households through health examinations throughout life that began at the time of conception. As public health work expanded, children over the age of five would be routinely examined by public healthcare workers stationed in schools and into adulthood by personnel specializing in the prevention and treatment of infectious diseases. MIH workers' regular inspections of the sanitary conditions of homes advanced the immediate goal of improving health while collecting data that would shape future adaptions of local endeavors. According to the plan, the priority afforded MIH in counties would not only benefit women, infants, and children, but ultimately come to decrease broader rates of mortality and morbidity throughout the province.[265]

These choreographed encounters that connected individuals and households to the projects of the Provincial Institute, the NHA, and international philanthropy were standardized

[264] Ibid., 17-20.

[265] Ibid., 30-35.

by contemporaneous efforts for displacing "old-style" midwifery in the province. Using local adaptations of the national categories of personnel, provincial reports shored up the line between "MIH professionals" and "midwifery assistants" on the one hand, and 'old-style birthing grannies' on the other. Though biomedical training served as a primary factor separating old- and new-style midwives, other requirements that midwives be between the ages of twenty and fifty, with good hearing and eyesight, and of general good health and sound mind also reinforced the contrasts between the desired professionals and the lay practitioners they were to replace. Provincial authorities paid deference to national policies strictly forbidding anyone from aiding childbirth without proper licensing, even as they accommodated the prevalence of 'old-style' midwives by creating crash courses for rural 'midwifery assistants.' To aid the transition from 'old-' to 'new-style midwifery', the 1944 report affirmed that public health workers in counties should establish temporary training programs for re-training local midwives at the expense of local governments. Demonstrating further flexibility with regard to national policies, this provincial report also granted a six-month grace period during which untrained midwives could continue practicing while they studied and obtained licenses.[266]

As public health officials gained oversight of midwives through training and licensing programs, the provincial government relied increasingly on these local practitioners to universalize biomedical modes of childbirth and motherhood. As a condition of their license to practice, the provincial government required county-level midwives to report regularly on their work. In particular, health authorities required MIH personnel and midwifery assistants to report all instances of maternal and infant death or serious health problems to higher-level healthcare workers. Even licensed midwives with biomedical training were expressly forbidden from

[266] Ibid., 40-41.

performing surgeries on women or their offspring. Midwives collected data regarding the number, names, and genders of children in a given family. Similar to schemes observed in the Northwest Communist Border Region government, midwives were further required to report on all the pregnant women in a given county. This reporting, along with detailed accounts of efforts to convince mothers to adopt biomedical modes of childbirth and mothering, were required for MIH personnel to keep their licenses. After childbirth, the midwife would aid the government's monitoring of mothering at the level of individual households, through regular home visits and examinations. To encourage rural women to comply, poor mothers would be provided MIH services free of charge, as they were in both Nationalist- and Communist-administered areas of the Northwest.[267]

This county-level management of mothers and midwives became integral to the development of professional midwifery education programs at provincial and national levels. Local midwives identified by county-level MIH personnel became enfolded in the multi-tiered (re-)training scheme developed by provincial authorities, the NHA, and foreign philanthropists. Provincial guidelines provided a path to professionalization for 'old-style midwives' and inexperienced recruits, who could receive prerequisite training in temporary, county-level courses before attending the provincial school at the Kunhua Hospital in Kunming. Here, new midwives' training would expand beyond practical methods for sterilizing the birth site and cutting the umbilical cord to include broader biomedical knowledge of reproduction, thus

[267] Ibid., 41; "Program for Child Welfare (Shensi-Kansu-Ninghsia Border Region)," January 27, 1941 (UCR Records, Box 2 Folder 5, New York Public Library).

preparing them for advanced education at a national institution or professional practice elsewhere in the province or even the country.[268]

When provincial health officials found national support insufficient for their grand designs, they circumvented the national government to court private philanthropies directly. For example, in October 1947, representatives from the Chinese Medical Association (formerly the China Medical Missionary Association) traveled throughout China to investigate the state of infectious diseases. While in Kunming, the representatives reportedly observed the particular threat posed to infants and children. To combat China's infamously high rates of infant and child mortality, the organization provided funds to provincial authorities directly for MIH and childhood health programs in Yunnan, including a donation specifically for a new MIH hospital. The institution provided a boon to ongoing projects to supervise and train midwives and mothers while also advancing immunological campaigns against smallpox.[269]

Having developed a number of programs to foster interest in MIH and extend access to healthcare, the Provincial Director Miao Ancheng oversaw the removal of remaining economic barriers through these newly arranged philanthropic endeavors in Kunming. In early 1948, the Provincial Health Institute oversaw the founding of a "Children's Healthcare Society 兒童保健會" under the auspices of the newly founded Renmin 仁民 Hospital. Official records of this project minimized local dynamics and philanthropic support, instead pandering to the

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[268] "*Minguo sanshiswu nian Yunnan sheng putong jianding kaoshi zhuchan kaoshi zhengtang fenmian shiti* 民國三十五年雲南省普通檢定考試助產考試正堂分娩試題," (Kunming, May 1946), (Yunnan Provincial Archives, Kunming).

[269] Miao Ancheng 缪安成, "*Wei fa fuying baojianyuan gong shenghuo buzhufei gei Yunnan sheng weisheng chu de zhiling* 為發婦嬰保健院共生活補助費給雲南省衛生處的指令" (Kunming, December 23, 1947) (Yunnan Provincial Archives, Kunming); see also Xiaoqun Xu, *Chinese Professionals and the Republican State: The Rise of Professional Associations in Shanghai, 1912-1937* (New York: Cambridge University Press, 2004), 133-36.

nationalistic discourse of the NHA. The school opened with the stated purpose of turning weak Yunnanese children into "healthy and strong citizens."[270] To aid this goal, the society provided free medical treatments and examinations to local mothers, infants, and children. Newborns could be seen weekly without charge, with free examinations for infants once every ten days and for young children twice monthly. This free program for mothers, infants, and children expanded dramatically a few months later when the provincial government approved plans to provide at-home, biomedical midwifery services free-of-charge to the rural poor and refugees. The national Ministry of Health (a reincarnation of the former NHA) promised an additional 3,000,000 yuan above provincial and philanthropic funds to support this expanded program.[271]

The early results of this free health program reflected the provincial institute's sustained efforts to reduce geographic and economic barriers while adapting to local conditions and needs. After the strategic expansion of MIH to include programs for young children, the dispatching of midwives into rural counties and their engagement with individual households, and, finally, extensive programs to provide a variety of services without charge, the number of women seeking MIH care in the province increased significantly and rapidly during the later 1940s. Reports from this expanded program demonstrate both this increase and the significant barrier that cost had apparently posed for many local women. In the first year of this outpatient program (1948), 614 persons received free treatment through the MIH hospital, a figure roughly ten times the number of paying patients (sixty-eight). More than two-thirds of those receiving free care were new patients. The second year saw similar numbers. The new program treated 606 poor

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[270] "*Yunnan shengli renmin yiyuan ertong baojian hui* 雲南省立仁民醫院兒童保健會簡章" (Kunming, January 1, 1948) (Yunnan Provincial Archives, Kunming).

[271] Ibid.; "*Jubao banli mianfei chuwai jiesheng niju shishi banfa zhixing zhiling di yi fuying baojian yuan* 據報辦理免費出外接生擬具實施辦法暫行指令第一婦嬰保健院," (Kunming, June 29, 1948) (Yunnan Provincial Archives, Kunming).

patients free-of-charge and an additional eighty-three patients paid for treatment as of September 1949. That the number of women receiving free treatment remained roughly ten times greater than the number of paying patients suggests that economic barriers had hitherto been among the most significant obstacles to the state's extension of MIH services and to rural women's access to healthcare. Though proportionally modest in relation to the total number of women in the region, these figures further demonstrate a significant upsurge in the prevalence, popularity, and accessibility of biomedical MIH services in Yunnan one month before the founding of the People's Republic of China.[272]

MIH at the Margins: Xiong Jin and Xizhou

Official sources in Yunnan demonstrate a project coordinated by provincial authorities that leveraged private philanthropy and adapted national policy to reach individuals in remote and rural areas. Though the actors critical to this project clearly harbored various motives, methods, and allies, official sources perpetuate the perception of a multi-tiered yet state-centered program that brought local subjects into intimate contact with national and provincial authorities. But these sources, when read in isolation, oversimplify the complexities of MIH practice and public health in pre-revolutionary China. In addition to the distinct yet converging projects of global, national, and provincial organizations, the story of one family's medical practice at the margins of state networks demonstrates the multifaceted development of MIH in Yunnan and the diversified institutions on which later, socialist-era MIH programs relied. In addition to the Nationalist state's use of foreign aid and expertise, private philanthropists and altruistic medical

[272] "*Yunnan sheng fuying baojian yuan pinbing mianfei tongji biao* 雲南省婦嬰保健院貧病免費統計表, 1948-49," Minguo shiqi xinan bianjiang dang'an ziliao huibian《民国时期西南边疆档案资料汇编》 vol. 43 (Kunming: Yunnan Provincial Archives, 2014), 50-52.

professionals operated outside of state structures to found clinics and training centers for biomedical midwifery and childbirth. Only after provincial public health institutes extended and asserted their authority to regulate did these institutions become incorporated into the network of institutions that stretched from Beiping to Kunming, throughout China and around the world.

The Xiong family remained among the many parties who contributed to the development of MIH in Yunnan as well as their native Jiangxi. The Xiongs came from a long line of medical practitioners. Though many in the family practiced medicine, Xiong Jin 熊懂 (1896/98-1989/90) and her brothers became particularly influential figures in the development of public health. Little of Xiong Jin's voice remains in the historical record, but the institutions she founded persist in some form to this day. Her career connects MIH in Yunnan to the transnational conditions undergirding its development, further demonstrating investments in childbirth and mothering irreducible to nationalism or statist biopolitical projects. The origins of the institutions founded by Xiong and her family lie outside the project envisioned and orchestrated by the Nationalist state and its benefactors. Examining these origins and the ultimate incorporation of Xiong's clinics into a national project sheds light not only on the diversified operations of MIH, but also the varied means through which twentieth-century Chinese states ultimately gained oversight of women's reproduction and childrearing.

Xiong Jin's path bears striking similarity to others among China's "second generation" of female doctors born in the 1890s, a few of which are examined in greater detail in Chapter Five. Xiong was born to a wealthy family renown for expertise in Chinese medicine. Coming of age during the final decades of the Qing dynasty, Xiong took advantage of her family's resources,

transnational investments in China's fate, and expanded educational opportunities for women and entered a missionary school for girls in Jiangxi's capital, Nanchang.[273]

Records of Xiong's career contain contradictory details, with various parties over the past century reframing and appropriating her life to fit the demands of different political contexts. According to a hagiographic report from a school she later founded in Jiangxi, Xiong's commitments to public health broadly and MIH in particular came about as a result of her parents' death. In 1915, her mother reportedly died from a post-natal infection. Xiong's father died soon thereafter. A matter of months later, Xiong and her elder brother Xiong Hui 熊恢 (1894-1970) left Jiangxi for Tokyo with a commitment to combatting disease and mortality through the study and practice of biomedicine. For Xiong Jin, this commitment reportedly remained personal, gendered, and shaped by the particular conditions of her mother's death.[274]

Xiong Jin graduated from the Tokyo Women's Medical School before practicing medicine at the Tokyo Red Cross Hospital. Reports differ on the amount of time that Xiong and her brother remained in Japan, with estimates as high as a decade. In the mid-1920s, the pair returned to China with biomedical expertise and a commitment to public health. Xiong Jin reportedly used money saved from her earnings as a doctor in Japan to purchase medical instruments that she brought with her when she returned to Jiangxi.[275]

In the city of Nanchang, Xiong began a private MIH practice that soon grew to include the training of midwives. In January 1929, before FNMS in Beiping began classes, Xiong

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[273] "*Zhuisi woxiao diyi ren xiaozhang Xiong Jin nüshi 追思我校第一任校长熊懂女士*," Gannan Yixue Yuan 赣南醫學院, http://rwgy.gmu.cn/show.aspx?id=54&cid=4 (accessed Monday, September 19, 2016).

[274] See Xiong Jin 熊懂," *Jiangxi Provincial Gazetteer*; "*Zhuisi woxiao diyi ren xiaozhang Xiong Jin nüshi* 追思我校第一任校长熊懂女士."

[275] "*Zhuisi woxiao diyi ren xiaozhang Xiong Jin nüshi* 追思我校第一任校长熊懂女士."

founded a school for biomedical midwifery that enjoyed the support of provincial authorities. For a few years, Xiong's school remained outside the national project of midwifery reform that emanated from Beiping. The Nanchang school expanded rapidly. In its first decade of operation, the school added a new building that included a maternity hospital with forty beds. The limited influence of the Beiping-based project to reform midwifery is evinced, in part, by the dominance of German-Japanese models of public health at the Jiangxi school, reflecting Xiong's training in Japan. Prior to the mid-1930s, the school remained dominated by doctors trained in German and Japanese models of public health, and even included instruction in German and Japanese languages. These trends persisted even as Rockfeller and LNHO representatives embedded themselves within the Nationalist state and fueled the Anglo-American dominance of public health in Nationalist China.[276]

As the Nationalist state expanded its power base in eastern China during the 1930s, the Jiangxi school ultimately became subject to national requirements and the movement to integrate local operations into the network of midwifery schools and clinics overseen by national authorities.[277] In 1932, Yang Chongrui noted the existence of Xiong's Jiangxi school in her reporting to the Rockefeller Foundation. From FNMS in Beiping, Yang reported plans to investigate and provide recommendations to the Jiangxi school to facilitate bringing it into the formal registration process now required by the Nationalist state. By 1934, the provincial school founded by Xiong had been "reorganized" under the supervision of doctors and midwives

[276] "*Jiangxi shengli zhuchan xuexiao zhiyuan yi lanbiao* 江西省立助產學校職員一覽表," Jiangxi jiaoyu jie《江西教育界》no. 2 (1930): 140-42; For more on German-Japanese vs. Anglo-American factions with regard to medicine and public health, see Bridie Andrews, *The Making of Modern Chinese Medicine, 1850-1960,* (Vancouver: UBC Press, 2014), 145-47

[277] See "*Qi ba yue jian xingjiang fangyang zhi liuxuesheng* 七八月間行將放洋之留學生," Shenbao 申報, June 20, 1936; see also Xiong Jin 熊慬," Jiangxi Provincial Gazetteer; "*Zhuisi woxiao diyi ren xiaozhang Xiong Jin nüshi* 追思我校第一任校长熊慬女士."

formally affiliated with FNMS. By 1936, the school was firmly under the oversight of the National Midwifery Board, which implemented substantial changes to the curriculum. A three-year course emphasizing mothercraft and healthy child competitions replaced the two-year course originally designed by Xiong Jin. Changes in personnel accompanied these changes in curriculum. Thus, the Jiangxi school provides one example of ascendant, Rockefeller-aided American dominance of public health in China during the Nationalist decades. The Jiangxi school became the first in a series of institutions founded independently by Xiong that ultimately became enfolded into state projects.[278]

Amid the reforms imposed on the school she founded, Xiong Jin and her younger brother, Xiong Quan 熊悛 left China. In 1936, the pair traveled to Nazi Germany—then an ally of the Nationalist state—to pursue further training in medicine and public health.[279] When the Xiongs returned to China after the collapse of the Sino-German alliance in 1938, the Japanese invasion prevented them from returning to their native Jiangxi. Instead, the pair relocated to Yunnan, where their personal commitments to public health, specifically MIH, aligned with the wishes of a private philanthropist and the growing operations of the Provincial Health Institute.[280]

By 1938, a provincial midwifery school had already been established on the site of the Kunhua hospital in Kunming. But, a local philanthropist, Yan Zizhen 嚴子珍, harbored a desire

[278] Yang Chongrui, *Third Annual Report*, *First National Midwifery School, July 1, 1931-June 30, 1932* (RAC, Rockefeller Foundation Archives Box 222 Folder 2768); Yang Chongrui, *Fifth Annual Report, First National Midwifery School, July 1, 1933 – June 30, 1934* (RAC, Sleepy Hollow, NY, Rockefeller Foundation Archives Box 222 Folder 2774); see also "*Zhuisi woxiao diyi ren xiaozhang Xiong Jin nüshi* 追思我校第一任校长熊慤女士"; Andrews, *The Making of Modern Chinese Medicine,* 146-47.

[279] "*Qi ba yue jian xingjiang fangyang zhi liuxuesheng* 七八月間行將放洋之留學生," Shenbao 申報, June 20, 1936.

[280] *Yunnan quansheng weisheng shiyan chu*, Yunnan quansheng weisheng shiyan chu er nian gongzuo gaikuang, 65-6.

to promote education and health in his home county of Dali in northwestern Yunnan. The newly founded Provincial Health Institute also aimed to expand its operations into more rural and remote areas of the province. National policy required that all medical institutions in the province become incorporated into the centralized operations of the provincial government. However, the lack of biomedical institutions in the province, particularly in areas outside Kunming, made Yan's support of a private hospital an attractive proposal for provincial authorities. In consultation with Yao Xunyuan, then Director of the Provincial Health Institute, Yan and his son, Yan Xiechen 嚴燮臣, founded several public health institutions in rural Xizhou in Dali county. In 1938, Xiong Quan became director of a privately funded hospital in Xizhou while Xiong Jin came to direct the newly founded Xizhou Private Advanced School for Professional Midwifery.[281]

The actions of the provincial government after the founding of these private institutions suggests both pressure from national authorities to bring greater oversight and Nanjing's limited ability to enforce strict national regulations in Yunnan. In reporting to the central NHA, the provincial institute emphasized both the necessity of these institutions and the steps it had taken to bring these private institutions formally into state networks. The provincial director Yao lobbied Xiong Quan to also take over directorship of the provincial midwifery school in Kunming, a post that he simultaneously held while overseeing the private school in Xizhou. Provincial authorities also moved to ensure that the privately funded ventures followed state regulations. In reports to the central NHA, the provincial institute insisted on the critical importance of keeping the school open despite its status as a private institution. It was argued that "Although the Xizhou hospital and school are private, in all cases they follow government

[281] Ibid., 65-6.

rules regulating public health, medicine, and education. They also contribute a great deal to society."[282] As these reports suggest, provincial health workers saw the institutions operated by the Xiongs in Xizhou as aiding their goals to expand public health, even as they remained conspicuously at the margins of their regulatory power and, to some degree, oppositional to the political aims of national authorities. Thus, further demonstrating the adaptation of national models to local conditions, provincial health officials emphasized compliance with the spirit of national public health laws while recognizing the dissonance between the need to expand government oversight and the permitting of these privately operated institutions.

Archives fall silent on the work of the Xiongs after 1938 until their return to Jiangxi in the early 1940s. By 1941, the stalemate between Chinese and Japanese forces left swaths of territory in Jiangxi unoccupied, though the continual threat of Japanese air raids thwarted many attempts at reconstruction. Fleeing Japanese aggression, many provincial institutions relocated from the provincial capital of Nanchang to a southern region of the province known as Gannan, centered on the city of Ganzhou. Here, Xiong resurfaces in archival records through an encounter with Chiang Ching-kuo, the son of Chiang Kai-shek and later leader of the Nationalist state on Taiwan. Chiang Ching-kuo had returned from Moscow in 1937, harboring loyalties to communist ideology and the Soviet Union even as his father sought to eliminate communism from China. In 1938, Chiang Kai-shek appointed his son deputy director of the Provincial Peace Preservation Corps, which soon thereafter relocated along with other institutions from Nanchang to Ganzhou. Chiang Ching-kuo's roles expanded quickly, as he came to wage reform campaigns that aimed to promote reconstruction, morality, and stability.[283]

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[282] Ibid., 66.

[283] Jay Taylor, *The Generalissimo's Son:* Chiang Ching-kuo and the Revolutions in China and Taiwan (Cambridge: Harvard University Press, 2000), 85-115; see also Dong Weikang 董伟康，He Ruoyuan 贺若渊， and

Many of Chiang's reforms in Gannan bore the influence of his Soviet experiences. In fact, Chiang asked several former Chinese classmates who had studied with him in Moscow to join him in Gannan, and he continued to voice support for the Soviet Union during this time. Chiang soon identified midwifery and MIH care as critical to his efforts to reform the region and aid locals. Through her work in Yunnan, Xiong had come to be seen as a potential asset to the MIH operations of the Nationalist state. When the Gannan administration developed plans to found a new midwifery school and maternity hospital in Ganzhou, Xiong Jin and her brother were summoned by the provincial Jiangxi government to return and lead these endeavors.[284]

From Ganzhou, Chiang Ching-kuo wrote letters to his father and stepmother, Soong May-ling, often noting the inadequacies of the Nationalist government from the perspective of locals. In a report on the aftermath of a Japanese air raid in 1942, Chiang specifically mentioned Xiong Jin, whom he identified as the foremost person aiding local people in the wake of the attack. Chiang's first-hand description of Xiong Jin's commitments and successes in 1942 lends credibility to the laudatory descriptions written in the following decades. As in commemorative portrayals of Xiong, Chiang's observations portray her as a resourceful and skilled practitioner who viewed MIH practice as an aid to those most vulnerable.[285]

Wang Xuqi 王緒圻, eds., Jiang Jingguo zai dalu 《蔣经国在大陆 》(Beijing: *Zhigong jiaoyu chubanshe* 职工教育出版社, 1988), 66-85.

[284] Gannan yixue yuan xiaoshi 《贛南醫學院校史》, vol. 1 1941-1985 (Ganzhou: *Gannan yixue yuan* 贛南醫學院, 2011), 11-12; see also Rana Mitter, *Forgotten Ally: China's World War II, 1937-1945* (Boston and New York: Houghton Mifflin Harcourt, 2013), 21, 264-65.

[285] "*Jiang Jingguo dian Jiang Zhongzheng Song Meiling diji hongzha Ganzhou quancheng qihuo ji banli shanhou qing* 蔣經國電蔣中正宋美齡敵機轟炸贛州全城起火及辦理善後情- 1942/01/05~1945/10/19 (Jiang Jingguo Jiashu, 2 – Jiang Zhongzheng zongtong wenwu 蔣經國家書(二) - 蔣中正總統文物) (Academia Historica, Taipei).

Chiang took no credit for his own role in providing relief to locals, nor did he praise the provincial government. Rather, he framed Xiong Jin as the key orchestrator of projects that had been of most benefit to the people of Ganzhou. According to Chiang, the school and hospital overseen by Xiong had aided more than 300 women in the past year alone. Most of the births overseen by the clinic had been tended by Xiong Jin herself. Chiang pointed to a specific incident in which a woman suffering through difficult labor received life-saving aid from Xiong, who used the medical instruments she had purchased during her time in Germany to give an injection that speeded birth. As a result of Xiong's skill, both mother and child were safe and healthy. "This spirit of service," Chiang asserted, "is more than worthy of great admiration."[286]

The central Nationalist state never regained firm control of Jiangxi, and Xiong continued to operate her Ganzhou school and hospital at the margins of state networks into the later 1940s. As in Yunnan, figures from the Ganzhou school and hospital suggest increasing numbers of rural women seeking out medical treatment after the removal of financial barriers and before the founding of the PRC. Through provincial-funded outpatient programs that provided poor women services free of charge, the number of women receiving MIH services in Ganzhou each year increased by a factor of five in the two years following Chiang Ching-kuo's letter. Between 1942 and 1944, 2495 women received outpatient treatment from this single institution in Ganzhou.[287]

Conclusion

National and international investments in women's reproductive health, along with their underlying historical conditions, spurred the development of a far-reaching landscape of MIH

[286] Ibid.

[287] *Gannan yixue yuan xiaoshi,* 11-12.

institutions and personnel during the Nationalist decades. In many ways, this development aided the aims of state-building and international philanthropy, as it connected these intertwined projects to women in rural and remote regions of China. The proliferation of midwifery schools and maternity clinics produced a multidirectional network that connected midwifery students and patients in Yunnan and Jiangxi to internationally celebrated institutions in Nanjing and Beiping, thereby integrating these regions into the Nationalist Republic and aiding the Nationalist state's recognition by foreign powers.

However, as this chapter has shown, the flourishing of MIH institutions and personnel also had decentralizing effects, leaving many local practitioners to pay deference to national authorities while pursuing localized iterations that often diverged from national policies. In the case of Yunnan, we see a relaxing of rigid standars for "midwifery professionals," a focus on the particular needs and interests of local women, and the toleration of private practitioners operating at the margins of state oversight. The case of the Xiong family, who moved between Yunnan and Jiangxi, shows how certain practitioners operated at the periphery of state projects, even as officials saw them as integral to the broader aims of the Nationalist government and its foreign partners.

In both Yunnan and Jiangxi, these conditions led to significant and growing increases in the numbers of institutions, personnel, and patients prior to 1949. The local cases surveyed here point away from a narrowly conceived comparison of the relative successes of Nationalist and Communist regimes to demonstrate a diversity of actors, with varying relationships and allegiances to organs of the state, that produced institutions and personnel later critical for Communist campaigns to manage both mortality and fertility in the early PRC. I take up these post-revolutionary developments in more detail in Chapter Seven.

In Yunnan, provincial and local actors often operated with limited influence from the central government, even as they reported on their activities to national authorities. However, as outlined in the following chapter, the central Nationalist government and its foreign advisors devoted greater attention and resources to MIH programs in other areas of the Republic, more firmly under Nanjing's control. Thus, taken together both this chapter and the next demonstrate a richly textured and uneven landscape of reproductive health institutions prior to 1949 that included but exceeded the efforts of the central Nationalist government.

Chapter 4: "Developing the Northwest:"

MIH in Pre-revolutionary Gansu

Before the mid-1930s, Gansu, like Yunnan, remained geographically distant and culturally distinct from Nationalist power centers. Gansu's integration into the Nationalist Republic began with the Central Plains War of 1930 and gained momentum after the Japanese invasion of 1937. Gansu and the broader Northwest frontier had long figured as a land of violence and desolation, radically different from Han-dominated areas of China proper. But the province's economic promise and strategic location made it increasingly important to Nationalist state-building in the 1930s and 1940s. Beginning in the mid-1930s, Gansu also became a critical site for the League of Nations Health Organization's (LNHO) global programs in rural health and the Rockefeller International Health Division's (IHD) campaign to use midwifery training to spearhead public health in China. After the Japanese invasion, Gansu came to harbor large numbers of internally displaced people from central and eastern China, further spurring the movement of medical personnel and public health authorities into the province. Both foreigners and Chinese suspected that Gansu held mineral resources and oil, strategically positioned as a gateway to Central Asia and the Soviet Union. After the Communist insurgency fled Nationalist forces on a Long March to the Northwest in 1934-35, Gansu also became a critical front in the ongoing conflicts of the Chinese Civil War. While Nationalist institutions reached westward from the provincial capital of Lanzhou, the Communist government of the Shaan-Gan-Ning Border Region administered territory east of the provincial capital.

The politics of MIH touched all of these diverse actors invested in the fate of Gansu, shaping both their actions and the framing of those actions in demographic metrics of mortality and biomedical measures of women's varied capacity to reproduce and nurture. Like in Yunnan, Nationalist authorities recycled the gendered, medicalized discourses employed by Western philanthropists to legitimize a civilizing mission along the Northwest frontier. As longstanding assumptions about the savagery of Gansu became medicalized in the mid-1930s, gendered discourses of disparate development based on health metrics provided new tools of Han conquest. Based on the perceived links between the health of the population as a whole and the individualized habits of mothers, national authorities framed these endeavors as a rescue mission to save the women and children of Gansu.

As this chapter shows, these public health campaigns remained integral to a broader national project of "developing the Northwest 開發西北" that emphasized infrastructures of transportation, communication, and public health as critical for the higher goal of bringing economic development to the region.[288] But the development of MIH in Gansu cannot be understood solely in terms of the national government's motives or policies. On the ground, local public health officials, well aware of the aims and ideology of national authorities, cited the persistent depravity of Gansu in the idiom of MIH to secure continued support for endeavors they variably perceived as feminist and/or humanitarian, even as their records demonstrated successes and the ever-expanding reach of biomedical midwifery and mothercraft. Foreign philanthropists, also particularly focused on women and children, leveraged capital and expertise

[288] Jeremy Tai has shown how this project in the Northwest remained contested and imbricated within currents of international fascism. See Jeremy Tai, "The Northwest Question: Capitalism in the Sands of Nationalist China," *Twentieth-Century China* 40, no. 3 (2015): 201-219, 215-218.

to secure allies in both Nationalist and Communist camps in the Northwest with an eye on the future of China after the resolution of overlapping intra-national and international conflicts.

This chapter traces the development of MIH in Gansu province throughout the Nationalist decades, noting its intertwined relationship with the broader development of public health at local, national, and global scales. Through newly uncovered sources authored from provincial, national, and international perspectives, I show how the varied political aims of national authorities, local public health workers, and international philanthropists converged on the reproductive functions of Gansu women to make significant if proportionally modest gains in the number of health institutions, medical personnel, and patients before the Communist Revolution. The limited scholarship on MIH has minimized the significance of Nationalist-era MIH programs due to a perceived failure to engage rural women, particularly in central and western China.[289] The case of Nationalist Gansu further challenges this consensus. Whereas in Yunnan local actors often operated with limited interference from the state, the central Nationalist government took particular interest in Gansu, founding national-level hospitals and devoting significant resources to a province seen as particularly important for its strategic interests that had been brought more firmly under the administration of the central government by the mid-1930s. Nationalist investments in MIH in Gansu have been undstated in existing scholarship, but, as this chapter shows, the reproductive health landscape of Gansu emerged from a variety of actors and projects. Through a critical and integrated reading of public health policy, nationalistic rhetoric, international correspondence, and local reporting, the following analysis

[289] Tina Phillips Johnson, *Childbirth in Republican China: Delivering Modernity* (Lanham, MD: Lexington Books, 2011), 126-27; Gail Hershatter, *The Gender of Memory: Rural Women in China's Collective Past* (Berkeley and Los Angeles: University of California Press, 2011), 161-162.

builds on the case of Yunnan to demonstrate the expanding reach and momentum of biomedical MIH in China before 1949.

China's Northwest Frontier

The region surrounding present-day Gansu province has repeatedly been a site of political and economic importance for states emanating from capitals in eastern China. Geographically, Gansu lies along the western border of China proper at a critical contact zone for Hui, Tibetans, Mongols, and Han. Spanning the Yellow River, Gansu connects Xinjiang and Inner Mongolia to the Han-dominant provinces of Shaanxi and Sichuan. The earliest Han cities existed in northwestern regions of present-day China, with the "Gansu Corridor" providing an important trade route for ancient and medieval dynasties.[290] However, from the Song (960-1279 CE) through the later Qing (1644-1912) dynasties, cultural and economic life in the Northwest remained oriented toward Central and Western Asia through the overland *Haj* pilgrimages of its wealthier Muslim inhabitants. Han-dominated empires remained centered on northeastern capitals and/or the Yangzi Delta near the eastern coast. The Qing conquest of Central Asia that extended westward well beyond Gansu began an incremental integration of the region into the Qing Empire. The export of commodities like opium and wool to rapidly developing markets in the East brought Gansu further into the commercial networks of China proper, while nineteenth-century improvements in nautical travel attracted religious pilgrims who sailed to Mecca from Shanghai rather than attempting the treacherous overland journey through western Asia.[291]

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[290] G. William Skinner, "Introduction: Urban Development in Imperial China," *The City in Late Imperial China*, Skinner, ed. (Stanford, CA: Stanford University Press, 1977): 3-31; 9-11.

[291] Jonathan Lipman, "Ethnicity and Politics in Republican China: The Ma Warlords of Gansu," *Modern China* 10, no. 3 (July 1984): 285-316; see also Jonathan Lipman, *Familiar Strangers: A History of Muslims in Northwest China* (Seattle: University of Washington Press, 1998).

However, the Northwest's integration into the political and economic networks of China proper occurred primarily among a select group of political and economic elites before the 1930s.[292] While increased contact made apparent the cultural differences and prejudices between Han and and other ethnicities, the Qing dynasty's restrictions on commerce and interruption of trade networks in the region also fueled tensions among varied ethnic groups in Gansu, often igniting armed conflict in the nineteenth century. Some have interpreted the violence waged through Qing campaigns to suppress Muslim rebellion in Shaanxi as ethnic cleansing (literally referred to as a campaign to "*xi hui*" or "wash away the Muslims"). In the 1860s, this violence contributed to mass migration of Hui from Shaanxi into eastern areas of present-day Gansu, already home to a large Muslim population. During this period of diversified conflict (sometimes mischaracterized as a coherent Dongan or Hui "revolt"), Muslim militias initially organized around ethnic difference from Han split according to their varying loyalty to the Qing, with some Muslim militarists aiding the Qing in its suppression of rival groups. Though armed conflict between Muslim militias reignited at the turn of the twentieth century over differences of religious doctrine, Gansu's administrators remained largely dependent upon and loyal to Qing rule. In fact, these political leaders demonstrated their expressed loyalty through attempts to thwart the Xinhai Revolution of 1911-12 that gave rise to the Republic of China.[293]

Gansu's history of Muslim militias and rebellion, combined with a large Tibetan population in the Western regions of the province, contributed to its place in the Han imagination as intrinsically Other, even if political claims asserted the incorporation of Gansu into the Qing dynasty and, later, the Republic of China. According to Jonathan Lipman's analysis of the

[292] Tien Hung-mao, argues that Gansu's integration into the Chinese state remained superficial throughout the Nanjing Decade, if not longer. See Tien Hung-mao, *Government and Politics in Kuomintang China,* 109-110.

[293] Lipman, *Familiar Strangers,* 118-137.

relations between Gansu and Eastern China, the Han, "like the Europeans, drew on many facets of their culture to confirm their inherent superiority over neighboring peoples." Following G. William Skinner's model of Chinese macroregions that placed Gansu at the periphery of Northwest China, Lipman describes eastern Gansu as the middle zone in a progression from core, to periphery, to steppe. This continuum, he argues, "forms the model for Han cultural perceptions that divide the world into civilized: partially civilized: uncivilized zones. Civilization, of course, is measured by degree of adherence to Han ways." Eastern Gansu, home to the provincial capital of Lanzhou, served as a frontier, contact zone in these schemes for dividing the Chinese world, where Hui maintained their dominance over other ethnic minorities through allegiances to majority-Han states. In Gansu, as in other frontier zones, Lipman argues, "people must define themselves as different, must set consistent criteria for belonging to their group and not to some other. Such a process of self-definition identifies both Us and Them for all participants…"[294]

The displacement and devastation wrought by decades of drought, famine, and continued warfare in the early twentieth century shored up Han perceptions of Gansu as a desolate, underdeveloped, savage wasteland in the Republican period. Even as the Nanjing-based Nationalist government laid political claim to Gansu through the professed loyalty of warlord Feng Yuxiang 冯玉祥 and his vassal generals, these perceptions of difference figured prominently in development narratives of the Nationalist decades. With the Nationalist state's embrace of biomedical public health as an essential tool of governance and state-building,

[294] Lipman, "Ethnicity and Politics in Republican China, 286-87; see also G. William Skinner, "Regional Urbanization in Nineteenth-Century China," *The City in Late Imperial China*: 211-249; 214-16.

longstanding beliefs about the savagery of Gansu became medicalized, now affirmed by scientific fact.

Public Health in Gansu during the early Nanjing Decade

According to various reports, few medical institutions of any kind existed in Gansu before the mid-1930s. The earliest clinics and hospitals remained localized endeavors that predated any public health system even at the local level. In the early years of the Republican period (1911-1949), foreign missionaries established the earliest biomedical clinics that primarily served the capital of Lanzhou. Perhaps most notably, German missionaries founded a clinic in 1929 under the auspices of a Catholic mission dating back to 1911.[295]

Political leaders in Gansu first formally recognized the authority of the Nanjing-based Ministry of Health and the priority it gave to medical education and MIH in the months immediately following the Ministry's founding in late 1928.[296] After national legislation that imposed uniform standards for medical licensure throughout the Nationalist realm and the publication of guidelines for provincial bureaus of health,[297] the official newspaper of the Gansu provincial government announced plans to standardize medical education and practice in

[295] This earliest missionary hospital continued operations throughout the Republican decades and ultimately merged with the Gansu Provincial People's Hospital 甘肃省人民医院 in 1952. See Zhang Bendu 张本笃, "*Lanzhou gongjiao yiyuan qingkuang diandi* 兰州公教医院情况点滴," in *Zhongguo renmin zhengzhi xieshanghuiyi Gansu sheng Lanzhou shi weiyuanhui wenshi ziliao yanjiu weiyuanhui* 中国人民政治协商会议甘肃省兰州市委员会文史资料研究委员会, eds., Lanzhou wenshi ziliao huibian 《兰州文史资料选辑》vol. 1 (Lanzhou: Lanzhou daxue chubanshe 兰州大学出版社， 1983)，178-81.

[296] The Ministry of Health (*weisheng bu* 衛生部) was reorganized as the National Health Administration (NHA or *weisheng shu* 衛生署) in late 1929 and early 1930. See Chapter Two of this dissertation; see also John R. Watt, *Saving Lives in Wartime China: How Medical Reformers Built Modern Healthcare Systems amid War and Epidemics, 1928-1945* (Leiden: Brill, 2014), 45.

[297] For example, see *Guomin zhengfu weisheng bu* 國民政府衛生部, Difang weisheng xingzheng chuqi shishi fang'an 《地方衛生行政初期實施方案》 (Nanjing: January 1, 1929) (Modern Documents Room, Shanghai Library).

accordance with the central Ministry's promotion of biomedicine. A February 1929 proclamation directly from warlord Liu Yufen 劉郁芬, who administered Gansu with loyalty to Feng Yuxiang and, thereby, nominal allegiance to Nanjing, informed the public that all medical personnel in the province, including doctors, pharmacists, and midwives, must adhere to the central Ministry of Health's standards and procedures for licensed medical practice. According to this proclamation, enforcement of the Nanjing Ministry's requirements would go into effect two months later.[298]

As planned, Gansu's provincial government put into effect rigid licensing procedures in April 1929. In the province's official news outlet, Liu again gave personal endorsement for subjecting local midwives, specifically, to inspection and examination. To obtain licensure and permission to continue their practice, midwives must have had at least one year of formal education at a scientific midwifery training center and provide a certificate of completion. Also, midwives had to serve under the supervision of a licensed physician for at least one year before their examination by provincial health authorities. Midwives would also have to demonstrate knowledge of medical treatments for neonatal and postpartum illnesses as well as methods for disinfecting the site of childbirth. Those that supplied the necessary proof of education, obtained the prerequisite experience, and passed the required examination would be awarded with a formal license to practice midwifery throughout the province. Those that lacked the necessary certificates and/or failed the exam would be legally forbidden to assist in childbirth.[299]

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[298] Liu Yufen 劉郁芬, "*Gansu sheng zhengfu xunling* 甘肅省政府訓令*,"* Gansu sheng zhengfu gongbao《甘肅省政府公報》82 (February 26, 1929), 13-14.

[299] Liu Yufen 劉郁芬, "*Gansu sheng zhengfu xunling* 甘肅省政府訓令*,"* Gansu sheng zhengfu gongbao《甘肅省政府公報》90 (April 22, 1929), 14; see also *Minzhengting* 民政廳, "*Fu zhuchanshi kaoshi guize* 附助產士考試規則," Gansu sheng zhengfu gongbao《甘肅省政府公報》 90 (April 22, 1929), 15-16.

Practical and political challenges impeded the implementation of such rigid procedures. No officially sanctioned centers for midwifery education existed in Gansu before the mid-1930s, a fact that made it difficult for local midwives to obtain the certificates and experience necessary to sit for the exam regardless of the knowledge they may have gained through aiding parturient women. Further, the language used in the government's proclamation imposed the standards for midwifery practice without qualification, resulting in the *de jure* prohibition of doctors and midwives from eastern China or the West (who had almost certainly not sat for the provincial exam) practicing in Gansu.[300] In addition to these practical challenges in implementing rigidly defined standards, political upheaval and conflict further thwarted governance in Gansu. Military skirmishes persisted in the form of rebellions against Feng Yuxiang's *Guominjun* and conflicts between regional militarists with fleeting loyalty to Nanjing.[301]

By late 1929, Sun Yunzhong 孫運仲 had succeeded Liu Yufen, now governor of Shaanxi, in practice as military governor of Gansu, even though he referred to himself as a representative of Liu's government in at least some official correspondence. In September, Sun issued a proclamation that narrowed the scope of earlier regulations for midwives while also providing a measure of flexibility regarding the prerequisites for the midwifery examination. Before taking the official examination, candidates for midwifery licensure need only present documentation of apprenticeship under a licensed doctor *or* a certificate of completion from a midwifery training school, rather than both. Further, authorities imposed these requirements only on "women of the Chinese Republic" who should be twenty years old or older. Though the

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[300] Liu Yufen 劉郁芬, "*Gansu sheng zhengfu xunling* 甘肅省政府訓令*,"* Gansu sheng zhengfu gongbao 《甘肅省政府公報》90 (April 22, 1929), 14.

[301] Lipman, *Familiar Strangers*, 173-175.

clarifying proclamation maintained assumptions that tied both childbirth and ancillary medical practice to women, it accommodated the presence of foreign medical professionals not subject to the same terms of licensure.[302]

The political turmoil that had plagued Gansu throughout the early twentieth century once again interrupted these early efforts to promote and standardize medical midwifery in the region. Feng Yuxiang declared territories governed by his *Guominjun* army independent of Nanjing in late 1929, a move which had profound if brief consequences for the relationship between the Northwest and Nanjing. This intra-governmental conflict coincided with the escalation of rebellion in the region orchestrated by the Ma, a Hui family of militarists. The Ma professed loyalty to Nanjing in opposition to Feng Yuxiang, an opportunist and Christian who had used Gansu as a resource and tax mine for his military campaigns in the East. In 1930, Nationalist forces in alliance with the Ma family decisively defeated Feng (along with his chief allies, Yan Xishan 閻錫山 and Wang Jingwei 汪精衛) thereby gaining more direct administration of Gansu. The defeat of Liu Yufen's suzerain warlord Feng by Nationalist forces in the Central Plains War brought an abrupt end to both Liu's administration and his expressed plans to implement rigid standards for MIH. Sun Yunzhong, who had also governed Gansu under the auspices of Feng's *Guominjun* ultimately found other military employment in Nationalist campaigns to annihilate communists in the 1930s. This regime change also coincided with the reorganization of the Ministry of Health into the National Health Administration (NHA), with more clearly articulated aims, plans, and affiliations with the Rockefeller IHD and the LNHO.[303]

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[302] Sun Yunzhong 孫運仲, "*Gansu sheng zhengfu xunling* 甘肅省政府訓令*,"* Gansu sheng zhengfu gongbao 《甘肅省政府公報》 109 (September 4, 1929), 21-22.

[303] Lipman, *Familiar Strangers*, 173-175. See also Lipman, "The Ma Family Warlords of Gansu"; see also Chapter Two of this dissertation.

MIH and National Authorities in Gansu

The Nationalist defeat of rival militarists brought a measure of political stability to Gansu while also bringing the province more firmly under the administration based in Nanjing. Many in the Nationalist government harbored grand ambitions for the province and the broader Northwest region, based on its strategic positioning and suspected wealth of natural resources.[304] In 1933, these aims became codified in a formal petition submitted by the Association of Chinese Public Utility Corporations to the National Economic Council (NEC) and the Ministry of Commerce. According to the document, business interests in the coastal provinces of Jiangsu and Zhejiang had requested that the national government turn to its newly subjugated territories in the Northwest to supply oil for eastern provinces. The petition argued that tapping into these resources, given their prerequisite infrastructures, would benefit the economic and social development of the region and the country as a whole. Based further on the need for these resources in the East and China's current dependence on foreign sources, it was argued that the Nationalist government should develop plans to "open the Northwest."[305]

In 1934, the NEC publicized these ambitions through numerous national and regional publications that announced large-scale plans for developing the Northwest in the broadest terms. As one article conveyed, finance minister T.V. Soong (Song Ziwen 宋子文) had recently surveyed the Northwest and had returned to Nanjing with two conclusions. First, the Northwest harbored significant resources invaluable to the state-building aims of the Nationalist

[304] Tai, "The Northwest Question."

[305] *Quanguo minying dianye lianhe hui* 全國民營電業聯合會, "*Benhui cheng quanguo jingji weiyuan hui, shiye bu* 本会呈全國經濟委員會 實業部," Nov. 27, 1933 Dianye jikan 《電業季刊》4, no. 1 (1933): 236.

government. Second, the Northwest's lack of infrastructure made it difficult to mine these resources for the benefit of eastern provinces. Thus, it was argued, the Nationalist government aimed for the broad development of the Northwest through varied projects targeting transportation, water quality, agricultural production, epidemic disease prevention, and public health.[306]

The NEC formed partnerships with various government agencies to bring its plans to fruition. The NHA became one of the most critical actors in these joint ventures within the Nationalist government, even before the NEC made public its long-range goals. The choices made by the NHA as the plans for the Northwest took shape demonstrate the primacy of MIH for state-building, based on its now demonstrated capacity to spur the broader development of public health and medical education. From the view of the Nanjing- (and later Chongqing-) based NHA, MIH in Gansu remained integral to a national project that relied on the aid and expertise of international health organizations to combat mortality and shore up Nationalist authority in distant and disputed territory. That midwifery training centers and maternity clinics predated the founding of provincial health administrations or hospitals affirms the critical place of MIH in this endeavor. Drawing from 1920s precedent, the NHA used metrics of MIH to establish the need for public health interventions in the Northwest, while also counting on the needs of women and children to spur the broader public's interest in biomedical methods of treatment and prevention.

Descriptions of these plans in Chinese-language publications, many of which the Nationalist government produced, repeatedly used a shared rhetorical strategy to legitimize Nanjing's planned interventions in the region. As in most media of the era, nationalistic calls for

[306] Zhe 哲, "*Wei jianshe xibei xu quanguo jingji weiyuanhui* 为建设西北最全国经济委员会," Xibei pinglun《西北评论》(1934): 20-21.

strengthening the Chinese state and *minzu* permeated coverage of the NEC's plans for the Northwest. However, the justification for "developing the Northwest" also drew from descriptions of the suffering of local inhabitants. Here, the particular consequences for women and children provided a powerful narrative for framing national interventions as benevolent humanitarianism. The case for national intervention in Gansu and the broader northwestern frontier built on longstanding notions of the region as a savage and undeveloped wasteland. However, Chinese-language media and policy during the 1930s and 1940s also drew from the gendered, medicalized categories of difference that had shaped Rockefeller-interventions in eastern China since the later 1920s. Gansu's fundamental lack of development, national authorities argued, became most apparent in light of the unhygienic childbirth and childrearing practices that remained especially prevalent among women in the Northwest. The ignorance of old-style midwives threatened the women and children of the province, framed as in desperate need of rescue by educated, cosmopolitan elites from the East.[307] The perception of childbirth in Gansu as especially savage and dangerous, however true, became so integral to NHA action that it would be reiterated for more than a decade despite dramatic increases in the number of biomedical institutions and personnel.

The campaign to promote biomedical MIH in Gansu resumed in 1933 with two separate announcements that reflected the various parties operating in cooperation with the NHA. The first announcement published in the Chinese-language *China Medical Journal* framed the founding of a provincial midwifery school in Lanzhou as a nationalistic strengthening of the country and *minzu,* but also in terms of the Northwest's inferior development when compared

[307] In what follows, I provide multiple examples. For one example, see "*Gansu* 甘肃", Zhonghua yixue zazhi《中华医学杂志》 (1933): 578.

with other regions in China. Reminiscent of the imperial-era framing of the Northwest as the home of barbarians, this report depicted Gansu as rife with famine, disease, and backward customs. Nationalist-era observers' concerns centered on a declining population in the region and the exacerbation of local suffering by untrained midwives who contributed to high rates of infant mortality. The 1933 announcement began with an expression of pity for the broad ignorance of Gansu people. The author then turned specifically to "obstetrics" as a measure of development that rendered evident the differences between urban and rural areas as well as between geographic regions within China. The anonymous author wrote,

> No modern organizations for obstetrics exist anywhere in the province, whether in urban or rural areas. So, when women are pregnant, their only option is to subject themselves to the hands of ignorant old women. As a result, every day we hear reports of maternal and infant death as well as birth defects. Therefore, a school for professional midwifery should be established to train experts who can address the needs of this society.[308]

The author then tied the proposed midwifery school in Gansu to both the broader goals of developing the region and the growing, national MIH system begun several years earlier in Beiping. The author pointed specifically to FNMS as a flagship institution in an ever-expanding network of schools and clinics, arguing that biomedical reforms to childbirth and mothering remained central to the broader wellbeing of individuals and the strength of the Chinese *minzu*. As this author reported, graduates of the national program in Beiping were preparing to travel to Lanzhou as emissaries of the NHA to begin the work of saving Gansu's women.[309]

From Beiping, Yang Chongrui provided additional details on plans for the Gansu midwifery school in an English-language report to the Rockefeller Foundation, which continued to support and shape the course of Chinese MIH programs at the national level. This new school

[308] Ibid. This *China Medical Journal* should not be confused with the English-language publication bearing the same name.

[309] Ibid.

would become the most remote node in the network of official midwifery training schools and affiliated maternity clinics that had, as yet, remained largely in northern and east-central China. Although, as Chinese media reported, nationalistic motives contributed to the founding of the school, Yang's report suggests that many in the Rockefeller Foundation understood the expansion into Gansu as evidence of their successful efforts to extend the reach of their philanthropic project in China through midwifery training and MIH. In her fifth annual report to the Rockefeller Foundation in 1933, Yang, as head of the NHA's MIH division, affirmed that FNMS graduates would travel to Lanzhou to found a new provincial midwifery school. According to Yang's report, two midwives, J.W. Wu 吳瑞 and Y. T. Chen 陳怡迪, left FNMS in Beiping for Lanzhou in 1934. By 1935, FNMS had sent an additional midwife, Li Shiqin 李士勤. Yang herself also went to Gansu a matter of months later as part of an inspection tour that included stops at midwifery schools and maternity hospitals in Shaanxi, Henan, Hubei, Hunan, Jiangsu, Zhejiang, Shandong, and Hebei. By the end of the 1930s, a gynecologist, Chen Guiyun 陳桂雲, and additional midwife, Yang Yongni 楊永霓, from FNMS took over leadership of the school, which they maintained throughout the Nationalist decades and beyond the Communist Revolution.[310] Provincial and national governments in China jointly funded the operations of the school in Gansu, seen as critical for the broader development of the Northwest. However, as both Yang and the Rockefeller officials requiring her annual reports understood, the project remained

[310] Yang, Fifth Annual Report – First National Midwifery School; "*Gansu sheng shiyanchu minguo ershisi nian zhiyuan biao* 甘肅省實驗處民國二十四年職員表," in *Gansu sheng weisheng shiyanchu* 甘肅省衛生實驗處, eds., Gansu sheng weisheng shiyanchu di yi qi zongbaogao 《甘肅省衛生實驗處第一期總報告》 (Lanzhou: Gansu sheng weisheng shiyanchu 甘肅省衛生實驗處, 1936), 7-10; see also Chapter Five of this dissertation.

integral to the larger vision of their work in China and evidence of midwifery's utility in spurring the broader development of national public health.

The development of public health institutions in Gansu during the years immediately following these initial plans provided further evidence of MIH's ability to advance the broader public health goals of the NHA and its allies. Several months after national authorities announced plans to found a new midwifery training institute, Yao Xunyuan 姚尋源, the PUMC and Johns Hopkins graduate who also shaped public health policies in Yunnan, led a national delegation to Lanzhou in February 1934 that included Dr. Andrija Štampar of the LNHO. This investigative expedition on the heels of the dispatching of midwives and gynecologists explicitly tied itself to the development goals of the NEC with a particular focus on public health. An announcement of this tour published in the Chinese-language *China Medical Journal* reported, "The National Economic Council, in order to survey the situation in the Northwest and in accord with plans to develop the Northwest, has dispatched a group of observers to the region. The group includes experts in irrigation, transportation, public health, veterinary medicine, and agricultural development."[311] By September, Yao had developed formal arrangements for cooperative endeavors between the Nationalist government and provincial authorities to develop public health infrastructures in Gansu on the model of eastern provinces.[312]

A Provincial Health Institute founded in 1934 purportedly operated under the joint supervision of both national and provincial governments. However, this institute, which would

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[311] "*Weisheng shiyanchu pai Yao Xunyuan zhuren wang Xibei shicha* 衛生實驗處派姚尋源主任往西北視察," Zhonghua yixue zazhi 《中華醫學雜誌》20, no. 3 (1934): 420.

[312] For more on the work of Yao and Štampar in Yunnan, see Chapter Three of this dissertation; see also Han Lee Min 韓立民, "*Choubei jingguo* 籌備經過," in Gansu sheng weisheng shiyanchu di yi qi zongbaogao 《甘肅省衛生實驗處第一期總報告》, 1-2.

oversee all provincial-level public health enterprises in Gansu, remained under the leadership of NHA representatives from eastern provinces throughout the Nationalist decades.[313] After the very short, interim directorship of a doctor Zhang Zufen 張祖棻, Dr. Han Lee Min 韓立民 from Shandong province became Director of the Provincial Health Institute. Han, a graduate of the London School of Medicine, maintained close ties with the NHA and Štampar of the LNHO to expand initial programs for women and children into broader public health programs that served the aims of national authorities and their foreign partners.[314]

In the months surrounding the official opening of the midwifery school in 1935, new provincial bureaus, hospitals, clinics, and immunization programs came to Gansu, aided further after 1935 when the midwifery school expanded the reach of its services westward into more rural areas. Amid an influx of capital and medical personnel to Gansu, the discourse of the Northwest as particularly underdeveloped and disease-ridden continued to circulate widely, even beyond Chinese borders. As it had earlier and elsewhere, these gendered priorities and notions of disparate development together served the interests of both Chinese authorities and foreign public health workers, as the various projects of Nationalist-state institutions converged with the broader aims of the Rockefeller Foundation and the LNHO.

Public health enterprises in Gansu province gained even greater national significance in the later 1930s, when Nationalist military campaigns drove the Communist insurgency into the Northwest. As Han reported in his correspondence with Štampar of the LNHO, the fighting

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[313] Han Lee Min, "*Choubei jingguo*." As outlined later in this chapter, Lanzhou housed both "provincial" institutions, like the Gansu midwifery school, and "national" institutions, like the national Northwest hospital. In most cases, both provincial and national organizations remained under the leadership of medical professionals affiliated with the central NHA and trained in eastern provinces and/or the West.

[314] Liu Yimin 刘毅民, "*Jiefang qian Lanzhou diqu yiyao weisheng zhuangkuang* 解放前兰州地区医药卫生状况" in Lanzhou wenshi ziliao xuanji 《兰州文史资料选辑》, 172-74.

between Communist and Nationalist armies often interrupted the flow of communication and supplies to Gansu. Like institutes founded earlier in northern China, many clinics and offices in Gansu relocated to avoid military conflict. Yang reported to Štampar that Communist presence in the Northwest had resulted in the closure of two rural outposts of the Nationalist public health system and a blockade of the corridor between Xi'an and Lanzhou for more than two months.[315] In 1937, Yang reported that Zhang Xueliang's kidnapping of Chiang Kai-shek during the Xi'an Incident had delayed Yang's communications with Štampar in Geneva.[316]

Despite setbacks of military conflict and a late-1930s famine in the region, the NHA continued to expand its operations by developing new programs and institutes that relied on midwives and other ancillary practitioners to stretch westward from Lanzhou. Han's correspondence with Štampar in January of 1937 pointed to a developing plan to renew the Nationalist government's commitment to public health in the Northwest, later enacted by the central government in 1939. In Han's 1937 correspondence, he argued that the plan would use the resources of "the various parties" invested in public health to combat the poverty and disease that plagued rural people in Gansu. In non-native English, Han wrote,

> I am thinking of trying to stimulate the various parties to adopt an enlarged new scheme for [the] Northwest, namely to form many travelling units going through all the northwest provinces with their headquarter[s] at Lanchow [Lanzhou]. The plan should be a Central Government concern and co-operate with different provincial health centers…In my mind [there are] no other means by which the poor people [will be] directly benifited [sic.] and it is the best way to get the different races of people to understand the government better, and get rid of the existing misundertandings[sic.] among the different people. How far I can succeed I do not care but I will do my best.[317]

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[315] Yang to Štampar, December 9, 1936 (United Nations Archives, Geneva, R6060 1933-1936, Section 8A, Series 940, Dossier 28321).

[316] Han Lee Min to Štampar, January 4, 1937.

[317] Ibid.

Han's comments to Štampar foreshadowed escalating investments by both the LNHO and the NHA in Gansu, but they also show how local health authorities strategized, capitalizing on (inter-)national investments to further localized projects. Han argued that the Nationalist government's targeted plan for the northwest should be ambitious and even include Xinjiang west of Gansu.[318]

A policy enacted in 1939, though not entirely keeping with Han's scheme or geographic scope, devoted significant resources of the wartime Nationalist state to advancing public health in the Northwestern provinces of Shaanxi, Qinghai, Ningxia, Mongolia, and Gansu.[319] The Northwest Wartime Health Construction Plan 西北戰士衛生建設計畫 (NWHCP) demonstrated the priority given to both public health and the Northwest in the Nationalist government's state-building endeavors, which, as this plan attests, continued amid Communist insurgency and Japanese invasion. Further, the plan pointed to the continued significance of public health for varied organs of the state, even as the structure and constellation of those organs shifted. Amid the context of war, the NWHCP became a joint operation between the Military Affairs Commission (a wartime body overseeing national defense chaired by Chiang Kai-shek) and the NHA under the auspices of a broader Second Wartime Administration Plan overseen by the Ministry of Finance.[320]

The NWHCP grew out of a broader desire of the Ministry of Finance to strengthen ties between the national government, now based in the wartime capital of Chongqing, and the

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[318] Ibid.

[319] In accordance with the Nationalist party's vastly overstated claims to territory at the time, "Mongolia", without qualification, was included in the NWHCP. However, the majority of the provisions included within the law addressed the provinces of Gansu, Ningxia, and Shaanxi.

[320] "*Xibei zhanshi weisheng jianshe jihua xiangxi banfa shuoming* 西北戰時衛生建設計畫詳細辦法說明," 1939 (Academia Historica, Taipei).

surrounding provinces in which it had hitherto exercised limited influence. Initially, the government allocated funds to aid development throughout all western provinces. However, in 1939, the People's Political Council, a representative, advisory body discussed further in Chapter Six, identified the Northwest as significantly underdeveloped compared to the Southwest. Based on this assessment, the PPC successfully lobbied that authorities prioritize the Northwest frontier.[321]

The Northwest, it was argued, remained fundamentally different from other regions of the country due to its sparse population, arid climate, and distance from the central government. As noted in Chapter Three, the outbreak of war with Japan had resulted in the relocation of many medical professionals and institutions to the city of Kunming, which had enhanced the resources available for public health projects in the Southwest. In contrast, Lanzhou and the rural counties of Western Gansu, though now closer to the national government after its relocation to Chongqing, still had limited personnel and institutions. The challenges of wartime gave even greater urgency to public health work as integral to the broader development of the Northwest.[322]

In response to this persistent crisis, the Nationalist government enacted a number of reforms as part of the NWHCP. The law established a regional Northwest Health Director who reported directly to the central NHA and oversaw the work of what would become the National Northwest Hospital in Lanzhou in addition to special "health teams" operating in rural regions of northwestern provinces. The NHA-appointed director also worked with provincial governments to oversee the Provincial Health Institutes in both Gansu and neighboring Shaanxi. Though provincial health institutes would erect their own, subservient outposts in rural areas in the

[321] Ibid.

[322] Ibid.

following years, the NHA retained its direct oversight of operations even at the sub-provincial level through the founding of small, local public health offices and the national Northwest Epidemic Prevention Bureau.[323] The legislation also allocated a total of 20,000 yuan per month to support disease prevention in Lanzhou and the rural counties of Gansu province through six local clinics. These expenditures represented a financial commitment of the Chongqing government to Gansu specifically above and beyond the provisions for the Northwest more broadly. Contributing to what would become a large, Han in-migration to Gansu in the 1940s, the NWHCP also explicitly asserted that biomedically trained clinicians and educators from the East and South should staff these newly founded institutions.[324]

A 1944 article published in a magazine titled *Social Health* affirmed that Gansu had become critical to wartime state-building, referring to Lanzhou as the "center of the country." The author's mapping of public health in Lanzhou addressed six key areas, including hospitals, medical education, public sanitation, disease prevention, and the availability of pharmaceutical drugs. The author also made explicit the role of U.S. medical aid in supporting the public health priorities now largely determined by the Nationalist government. The author reported that unspecified donations from the U.S. in recent years had been allocated by the central government to accelerate the development of maternal and infant health specifically at the Northwest Hospital overseen by the NHA.[325]

The targeted efforts of the NHA, backed by foreign expertise and funding, had significant impact in Gansu province. Throughout the 1940s, various observers reported on the successes of

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[323] Ibid.

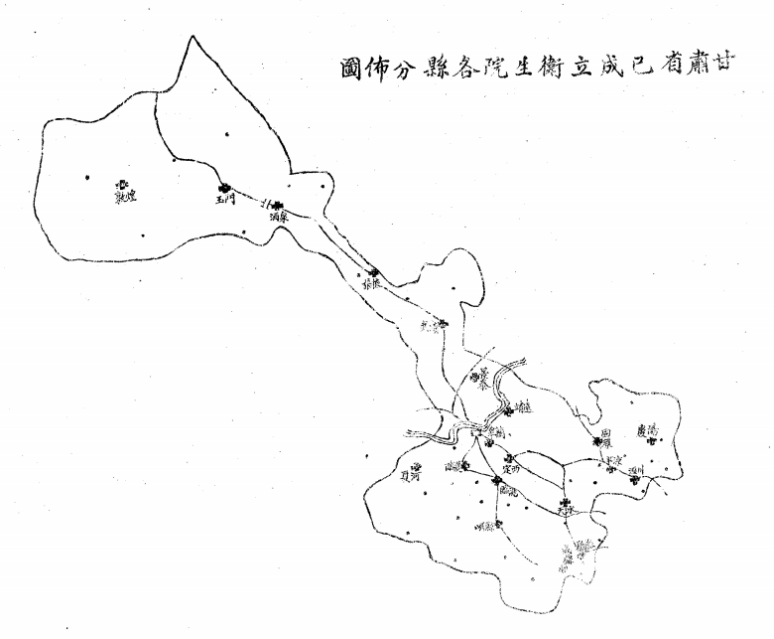
[324] Ibid.

[325] Zhang Chali 張查理,"*Lanzhou yiyao weisheng xianzhuang zhi suxie* 蘭州醫藥衛生現狀之速寫," Shehui weisheng 《社會衛生》 1, no. 2 (1944).

the targeted effort of the Nationalist government and its allied foreign organizations to develop public health in the Northwest—Gansu province in particular. In 1942, the Gansu provincial government published an exhaustive report of the work that had been done in the roughly three years since the enactment of the NWHCP. From 1939 to the end of 1941, the Gansu Provincial Health Institute had established twenty-one local clinics scattered throughout the province including villages in the remote West far from Lanzhou (see Figure 4.1). As a result, the erecting of new buildings, hiring of staff, and purchase of equipment had dramatically increased the amount spent by the provincial government on public health. Health spending by the provincial government (excluding that spent by the NHA directly under the provisions of the NWHCP) increased by a factor of forty from less than 300 yuan per month in 1938 to more than 12,000 yuan per month in late 1941. In the three years reported, the total number of patients treated for illnesses in provincial institutions and by itinerant medical workers more than quadrupled from 21,307 in 1939 to 97,246 in 1941.[326]

[326] Gansu sheng zhi weisheng shiye《甘肅省之衛生事業》(Lanzhou: Gansu sheng zhengfu 甘肅省政府, 1942), 5-6, 10.

Figure 4.1 “Existing Public Health Offices of Gansu Province – Village Distribution Map” - 1942



Source: *Gansu sheng zhi weisheng shiye* 甘肅省之衛生事業, (Lanzhou: Gansu sheng zhengfu 甘肅省政府, 1942).

John Grant affirmed these gains in his reporting on a trip through Nationalist China during July and August of 1942. In his report to the Rockefeller IHD, the original architect of biomedical midwifery education in China wrote, “The quantitative expansion in the provinces of ‘health units’ is almost incredible, particularly under war circumstances. The concept of State Medicine may almost be said to be over-sold to the public.”[327] From Grant’s perspective, China’s problem no longer lay in a dearth of medical institutions or in a disregard of health concerns among the public, but rather in a public health system that had expanded so rapidly that the quality of treatment and personnel became the foremost concern. Grant also expressed fears that the war precisely because of its generative effect on institutions of public health had produced a vast array of hospitals and clinics that extended beyond what the NHA could oversee. These

[327] John Black Grant, “Report on Trip to China: July 16 – August 6, 1942” (RAC, Rockefeller Foundation Archives, Sleepy Hollow, NY, RG 2, Series 601, Box 240, Folder 1662).

observations led him to advise the IHD, which maintained a degree of influence in both the Chinese Nationalist and American governments, to emphasize quality medical education and centralized planning in public health policy. But the rhetoric of Chinese public health workers at both national and local levels continued to emphasize a dearth of personnel and institutions, especially in Gansu, despite quantitative data that affirmed Grant's 1942 observations. As outlined above, this persistent assessment by national authorities served broader goals of economic and infrastructural development. For local public health workers, strategic affirmations of these national narratives shored up calls for additional resources and support for their endeavors.[328]

On the Ground: The Local Dynamics of MIH in Gansu

Reports from local health workers offer a different perspective on the dynamics of MIH in Gansu and the Northwest. In their reporting to both national officials and the public, local health workers consistently deployed a strategic framing of their work that emphasized challenges, setbacks, and the need for additional financial support while obscuring consistent if modest advances. Reports written throughout the 1930s and 1940s by various authors all contain this common dissonance. Whether in formal communications between provincial and national authorities or published in the media for a general audience, these reports from local actors frequently affirmed assumptions regarding the persistent backwardness and underdeveloped nature of Gansu, usually attached to calls for additional support and resources. These same reports also contained statistical data that demonstrated the steady expansion of MIH services, in terms of personnel, patients, and geographic distribution. Many local public health workers

[328] Ibid.

asserted that their observations on the ground affirmed national narratives of the Northwest, figured in gendered and biomedical terms. These repeated affirmations of Gansu's difference often justified local adaptations of national policies and requests for continued national support for local endeavors.

Further, these reports from medical practitioners also shed light on the role of local women in shaping the enactment of public health policy. As health workers reported, the particular needs of local women necessitated adjustments to provincial and national MIH programs. Even as MIH services expanded, local women primarily sought prenatal examinations, aid in delivery, and exams for their young children only after these particular services became readily accessible. In response to these dynamics, local medical practitioners in dialogue with national authorities and international philanthropists worked to remove economic and geographic barriers to treatment while developing sensitivity to the particular needs and interests of local populations.

Less than two years after the announcement of initial plans, the Gansu Provincial Midwifery School began recruiting students in Lanzhou through printed advertisements in local newspapers.[329] In March 1935, classes began with an initial class of sixteen students. Dr. Wu Ruifang 吳瑞芳 became the school's first director, aided by the doctor and midwives sent directly from FNMS in Beiping to Lanzhou. Wu, a female surgeon trained in Great Britain, shared Shandong origins with Yao Xunyuan. Media circulated throughout China framed the school she operated as the brainchild of the newly founded Provincial Health Institute, obscuring the fact that plans for a midwifery training center predated the founding of the provincial

[329] See, for example, "*Gansu shengli zhuchan xuexiao xuzhao xinsheng guanggao* 甘肅省立助產學校續招新生廣告," Gansu minguo ribao《甘肅民國日報》February 21, 1935.

institute by roughly one year and originated with national-level offices affiliated with the NHA.[330]

As Wu reported, the early work of the school in Lanzhou met numerous challenges, stemming primarily from the divisions that separated local people from public health workers from eastern provinces. In a report published for a general audience shortly after the school opened, Wu highlighted Gansu's difference from other regions in China. Here, Wu connected her work in midwifery training to longstanding perceptions of the Northwest in the Han imaginary, as well as the broad development goals of national authorities. The article began with the assertion that the "Northwest was the site of the Chinese *minzu*'s origin," but due to the vastness of unpopulated territory that made communication and transportation difficult, culture, knowledge, and enterprise "lagged behind" that of the coastal East. Gansu in particular remained scarcely populated and undeveloped. Natural disasters and war further compounded the challenges of public health work even as they also exacerbated the need for medical personnel and institutions. Recent waves of immigration from the East had provided the province with greater resources in human terms, while also placing a heavier burden on nascent public health services.[331]

In diplomatic and strategic terms, Wu further connected her work with local women to both provincial and national projects. She explicitly asserted the importance of her endeavors in MIH as integral to the broader, now well-publicized aims of the national government to "open the Northwest." Wu further praised the recently founded Provincial Health Institute,

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[330] Wu Ruifang, "*Gansu shengli zhuchan xuexiao gongzuo gaikuang* 甘肅省立助產學校工作概況," Gonggong weisheng yuekan 《公共衛生月刊》 (1935): 49-52, 49.

[331] Ibid., 49-50.

commending what she saw as the provincial institute's provision of a "foundation" for public health before emphasizing the need for additional resources to support MIH, specifically.[332]

As Wu continued to describe her experiences in Lanzhou, her emphasis shifted from the nationalistic language of "developing the Northwest" to her interactions with patients and their embodied suffering. Many of her patients thus far had been immigrants from eastern China who sought her aid in childbirth. The demands of these few patients had already placed a significant burden on the small clinic she oversaw, which had, as yet, barely reached the local population in Lanzhou, much less those living in more remote areas of Gansu. For Wu, the aim of reaching the broader population remained the ultimate goal and the impetus for her training of midwives. Like those in other provinces, Wu aimed to train midwives and dispatch them to more remote areas, providing aid to women far from hospitals while extending the reach of the growing public health system.[333]

The curriculum of the Lanzhou school reflected the varied aims surrounding its founding. Midwives-in-training took courses in standard Chinese language and "citizenship," reflecting the aims of Nanjing to strengthen ties between locals and the newly arrived institutions of the Republican government. Students took practical classes in first-aid, household management, and MIH, with at least some also pursuing more advanced coursework in biology, childhood education, pharmacology, and bacteriology. Echoing statements made elsewhere by her colleagues Yang Chongrui and Yang Yongni,[334] Wu articulated how this broad training promised to provide a path to upward mobility for at least some locally recruited students. The most

[332] Ibid. 49-50.

[333] Ibid., 49-52.

[334] See Chapter Five of this dissertation.

promising graduates of the Lanzhou school would be sent for further advanced study at FNMS in Beiping through what was quickly becoming a multidirectional network of MIH institutions and practitioners.[335]

Much like the case of Yunnan discussed in Chapter Three, Wu's desire to reach rural populations led her to develop less formal MIH training programs to retrain lay midwives beyond the provincial school in Lanzhou. These programs began shortly after the school's founding, reflecting their priority among the aims harbored by Wu and her colleagues. In her 1935 article, Wu expressed her goal of expanding these satellite training programs and extending their geographic reach further into rural areas in the years to come.[336]

One year later, an unsigned report on MIH published within a broader assessment of all provincial health operations echoed many of Wu's sentiments from 1935. Here, the unnamed author also emphasized the backwardness of Gansu as presenting persistent challenges, particularly in the field of MIH. The section of the report devoted to MIH began, "This province is situated in the Northwest. Communication is obstructed; culture lags behind. Promoting MIH work is truly not an easy endeavor. Despite two years of diligent work, we have only been able to cultivate a small foundation and have not yet been able to see great development."[337] The clinic affiliated with the midwifery training center had begun providing prenatal and postnatal examinations for limited numbers of local women. As the author of this report outlined, significantly more women sought prenatal than postnatal examinations. The number of women

[335] Wu Ruifang, "*Gansu shengli zhuchan xuexiao gongzuo gaikuang*," 49-52.

[336] Ibid., 52.

[337] *Gansu sheng weisheng shiyanchu* 甘肅省衛生實驗處, eds., Gansu sheng weisheng shiyanchu di yi qi zongbaogao 《甘肅省衛生實驗處第一期總報告》, 24.

who sought medical aid after birth remained in the single digits for each of the twenty months recorded. In some months, MIH personnel recorded no postnatal examinations. From the perspective of locals, it was argued, once a healthy baby had been born safely, women no longer needed medical assistance from midwives. Thus, despite the urging of public health authorities, few mothers returned to the clinic for multiple examinations.[338]

In a discussion of deliveries, the author pointed to further barriers that had hampered MIH work in the province. According to this report,

> People in Lanzhou are bound by vulgar habits and preconceived notions that run deep. Regarding new-style birth, all of them have a "do not dare to ask" sort of mentality. In the eyes and minds of the average person here, "new-style" birth is just about using scissors instead of a knife. So, despite more than a year of work, the number of births recorded remains unsatisfactory.[339]

Here, the author affirmed for national authorities long circulated notions of the Northwest as well as widely held views regarding rural women, their birthing habits, and the conclusions that could be drawn from those habits. However, the author also shifted the discussion of births to highlight economic barriers that had prevented many local women from seeking MIH services during the period under review. As late as July of 1935, midwives affiliated with the provincial institute operated under a statute that set fees for their services. However, as this author reported, because many poor women in the province could not afford to pay, these fees had been waived in most cases. The reality of this situation had led to a change in the regulations governing midwives that now provided birthing services free of charge.[340]

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[338] Ibid., 24.

[339] Ibid., 24.

[340] Ibid., 24; For more on free healthcare for Lanzhou residents, see "*Guanyu weisheng shiwu suo dui shimin mianfei jiesheng zhi Lanzhou shi zhengfu de gonghan* 關於衛生事務所對市民免費接生致蘭州市政府的公函," December 14, 1945 (Gansu Provincial Archives, Lanzhou).

The statistics that accompanied this report conveyed advancements and trends obscured by the rather dismal assessments provided in the author's narrative preface. Quantitative data affirmed the limited impact of prenatal and postnatal examinations during the early years of the school's operation. In several months, less than ten women had sought either type of service. Midwives had been moderately more successful in their aim to oversee deliveries, particularly after the total removal of the above-mentioned economic barriers. In a one-year period (July 1935 to June 1936), the clinic had aided 104 women in childbirth. In a trend similar to that seen in Yunnan, other services provided to women and young children (older than newborn infants) had attracted significantly greater numbers of patients. During the nineteen months surveyed (November 1934 to May 1936), 1,021 women had received gynecological services with an additional 814 patients treated in pediatrics. Further, healthy child competitions had attracted between 200 and 300 children per annum (more than twice the number of deliveries) suggesting that in Gansu, like in Yunnan, programs that went beyond childbirth and infancy to engage mothers and their young children in eugenic mothercraft proved more successful in attracting local populations. Here figures also showed a gender imbalance, with significantly greater numbers of male babies and young boys participating in the competitions than girls.[341]

Further reflecting similarities with provincial projects in Yunnan, midwives trained at the Lanzhou school became ambassadors of public health to more rural and remote areas. As the data in this report showed, Wu Ruifang's earlier aim of reaching beyond Lanzhou had seen moderate gains in the mid 1930s, as midwives penetrated to the level of individual households. However, here again, the report conveyed significant resistance among the local population to "household inspections," in which, the report relayed, public health workers had encountered

[341] Ibid., 24-27.

"profound difficulty." In many cases, local people reportedly hid from public health workers and refused to let them enter their homes. Nonetheless, MIH workers (presumably midwives) had visited 311 parturient women between December 1934 and June 1936, with many women receiving multiple visits at their homes. The author of this official report expressed the aim to continue with this strategy despite local resistance, given the perceived necessity of reaching beyond the walls of the school and its clinic.[342]

In the later 1930s, national developments shaped the local contours of MIH in Gansu province. Beginning in 1937, the Japanese invasion in the East displaced countless thousands, disproportionately affecting women and children. As displaced persons poured into Western regions, Lanzhou and its surrounding hinterland saw a groundswell of population and an increased demand for the medical treatment of women and children. As outlined in Chapter Three, the war also drove many urban medical practitioners from the East into western regions, along with the seat of the Nationalist government which relocated to the southwestern city of Chongqing.

In 1939, Dr. Chen Guiyun 陳桂雲 and her lifelong companion, midwife Yang Yongni 楊永霓, arrived in Lanzhou to take over the leadership of the provincial midwifery school and its affiliated clinic. As discussed in more detail in Chapter Five, Chen and Yang had met at FNMS in Beiping where they both came to share Yang Chongrui's perception of midwifery training as having a two-fold empowering impact for women. First, midwifery provided a clear path toward reducing suffering and death among China's women and children. Second, midwifery training provided an opportunity for single, young women, often with prerequisite educations to become

[342] Ibid., 26.

professionals and achieve economic independence. In various documents from both before and after 1949, Chen and Yang articulated a vision of MIH practice as feminist praxis, with broader political implications for the health and wellbeing of the Chinese *minzu.*[343]

With this commitment to MIH and building on the earlier work of Wu Ruifang, Chen and Yang quickly saw significant results in Lanzhou. By the early 1940s, the Nationalist state's added investments in public health through the NWHCP provided further support to their growing endeavors. The size and scope of MIH enterprises in the province expanded dramatically even as many at both the local and national level continued to lament frequent challenges. At the Lanzhou midwifery school, expanding class sizes and an influx of medical practitioners from the East had increased the number of biomedically trained midwives operating under the auspices of the provincial public health bureau from eighteen in 1939, to 825 in 1940, to 1,242 in 1941. These midwives included those stationed in each of twenty-one local clinics as well as those who traveled to deliver infants outside of medical institutions. With the increase in the number of clinics and midwives, the number of parturient women screened also increased significantly. Prenatal screenings alone increased from a total of 163 in 1939, to 2,992 in 1940, to 4,949 in 1941. The number of postnatal screenings also increased from ninety-five in 1939, to 1,584 in 1940, to 2,450 in 1941.[344] The "healthy child competitions" that had attracted 200 to 300 children per annum in the mid-1930s now engaged roughly five times as many women and

[343] See Chapter Five of this dissertation. See also Yang Yongni 楊永霓, "*Tan yi tan xibei zhuchan shiye yu zhuchan jiaoyu*," 談一談西北助產事業與助產教育 ," Zhuchan xuebao《助產學報》1, no. 1 (1948): 33-35.

[344] Gansu sheng zhi weisheng shiye《甘肅省之衛生事業》 (Lanzhou: Gansu sheng zhengfu 甘肅省政府, 1942), 11-13.

children. From 1940 to 1941, more than 1,250 children had participated in these competitions arranged by local health workers.[345]

Despite these gains and the trend toward expansion, local health workers continued to emphasize challenges over successes to assert the need for greater support from national authorities. In addition to the peculiar customs of locals, provincial reports emphasized the continued prevalence of lay midwives throughout Gansu that became increasingly apparent as MIH services expanded into rural and remote areas. Echoing earlier assessments, a 1942 report read, "The people here are bound by old habits, and many pregnant women still give birth with old-style midwives. These midwives do not understand human physiology or procedures for sterilization, and thus threaten the safety of women and children."[346] This assessment affirmed widely held notions by officials in the NHA regarding the prevalence of old-style midwives and the threat they posed to public health. However, the assertion that lay midwives remained particularly vexing in Gansu came to support local pragmatism that bore resemblance to that of Yunnan province. In contrast to the hard line against 'old-style' midwives found in some national-level policy, local health workers had further developed the strategy endorsed earlier by Wu Ruifang, through which informal, short-term courses provided training to lay midwives in rural and remote areas. While affirming that these rural health stations would be used to gain supervision over lay midwives, local workers also reported an intent to use these lay practitioners, once they had received additional training, to aid the project of reducing maternal and infant mortality in rural areas several years prior to the founding of the People's Republic.[347]

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[345] Ibid; see also Yunnan quansheng weisheng shiyanchu er nian gongzuo gaikuang 《雲南全省衛生實驗處二年工作概況, 1936-1938》 (Nationalist Party Archives, Taipei).

[346] Gansu sheng zhi weisheng shiye《甘肅省之衛生事業》, 19.

[347] Ibid., 19-20.

In 1944, Yang Shuxin 楊樹信, then Director of the Provincial Health Institute, provided a wide-ranging report on "Midwifery Education in Gansu" for a general-audience magazine focused on the Northwest's development. Yang cited widely circulated notions of social Darwinism and eugenics to affirm the critical role of MIH in shoring up the status of China's *minzu* in a global competitive ranking of nations. The article began,

> The modern competition between the races (*zhongzu*) still follows the principle of survival of the fittest, in which the existence of the fit remains bound by evolutionary theory. The persistence of a given *minzu* depends on a set of criteria; the decline of a *minzu* also results from a particular set of factors, the most frightening of which are intrinsic. By intrinsic factors, I mean the withering away of newly born life, the devastation of vigor, and the depression of the will to live.[348]

Here, Yang connected the local dynamics of MIH in Gansu to both national defense and international relations. He continued, "Thus, in order to fundamentally restore the youthfulness and physical strength of the *minzu*, we must promote the work of maternal and infant health, so that we can establish a healthy foundation for the *minzu's* new life."[349]

These broad aims, given increased urgency within the context of war, depended upon skilled, local personnel, Yang argued, "If we talk about maternal and infant health work, we must first arrange the professional education of midwives. Not until we cultivate personnel for this work can we have a way of pursuing these endeavors."[350] To further assert the critical role of

[348] Yang Shuxin 楊樹信, "*Gansu zhi zhuchan jiaoyu* 甘肅之助產教育," Xin xibei yuekan 《新西北月刊》7, no. 78 (1944), 26. For more on Yang Shuxin's contributions to MIH in Gansu, see "*Ziwei Yang Shuxin jian dai gansu shengli Lanzhou gaoji zhuchan hushi zhiye xuexiao xiaozhang* 茲委楊樹信兼代甘肅省立蘭州高級助產護士職業學校校長," September 8, 1939 (Gansu Provincial Archives, Lanzhou).

[349] Yang, "*Gansu zhi zhuchan jiaoyu*, 26.

[350] Ibid., 26.

trained midwives, Yang pointed to the now infamous "old-style" midwives that remained prevalent throughout China.

> Most of these old women who attend childbirth, cling to their old methods and lack basic knowledge about physical health. They do not even adhere to the idea of sterilization, and thus poison many women and children whose lives are threatened. (For example, when women suffer from puerperal fever or infants suffer from tetanus and so on, old-style midwives are the root of the problem).[351]

The crisis caused by these harmful "birthing grannies" could only be solved by additional resources to support the continued expansion of midwifery education in Gansu.[352]

The brief and introductory affirmation of midwifery's role in such broad political aims of national authorities soon gave way to a more focused assessment of the plight of Gansu. Yang's affirmation of widely circulated discourses blaming lay midwives for China's political predicament served to justify both the significance of his work in Gansu and calls for continued investments from those outside the province. Yang went so far as to assert that the needs in Gansu superseded those elsewhere in China.

> Because in this province transportation is inconvenient and education is not developed, the old midwives' knowledge and skill are especially crude and the number of women sacrificed before and after birth is higher than in any other province. So the establishment and expansion of midwifery education in this province is too urgent to be put off.[353]

Here, Yang went beyond an articulation of MIH work as serving "the nation" to emphasize the especially critical nature of the local enterprises he oversaw and their dependence on national resources. Like many before him, Yang framed the training of midwives in Gansu in terms of the national project that had begun roughly fifteen years earlier at FNMS in Beiping. Yang affirmed

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[351] Ibid., 26.

[352] Ibid., 26.

[353] Ibid., 26.

in explicit terms that MIH work in Gansu thus relied not only on provincial support, but also the continued investments of the national government.[354]

Yang's report contained statistical data showing significant increases in the number of institutions, medical personnel, and patients that belied his emphasis on Gansu's depravity, figured in gendered and medical terms, as justification for renewed investments. Yang framed quantitative gains in the number of biomedically trained midwives as embarrassingly inadequate. Given Gansu's population of more than six million, Yang argued, the estimated 180,000 infants born per annum in the province required a minimum of 1,500 midwives, with each midwife attending 120 births per year. Yang argued, without providing the current total number of biomedically trained midwives, that the disparities between the absolute minimum required number of 1,500 and the current number remained vast. In conclusion, Yang advocated for additional resources to expand midwifery training, a more concerted effort to recruit students, and a transformation in local customs through which the education of women in general would become valued by all in Gansu.[355]

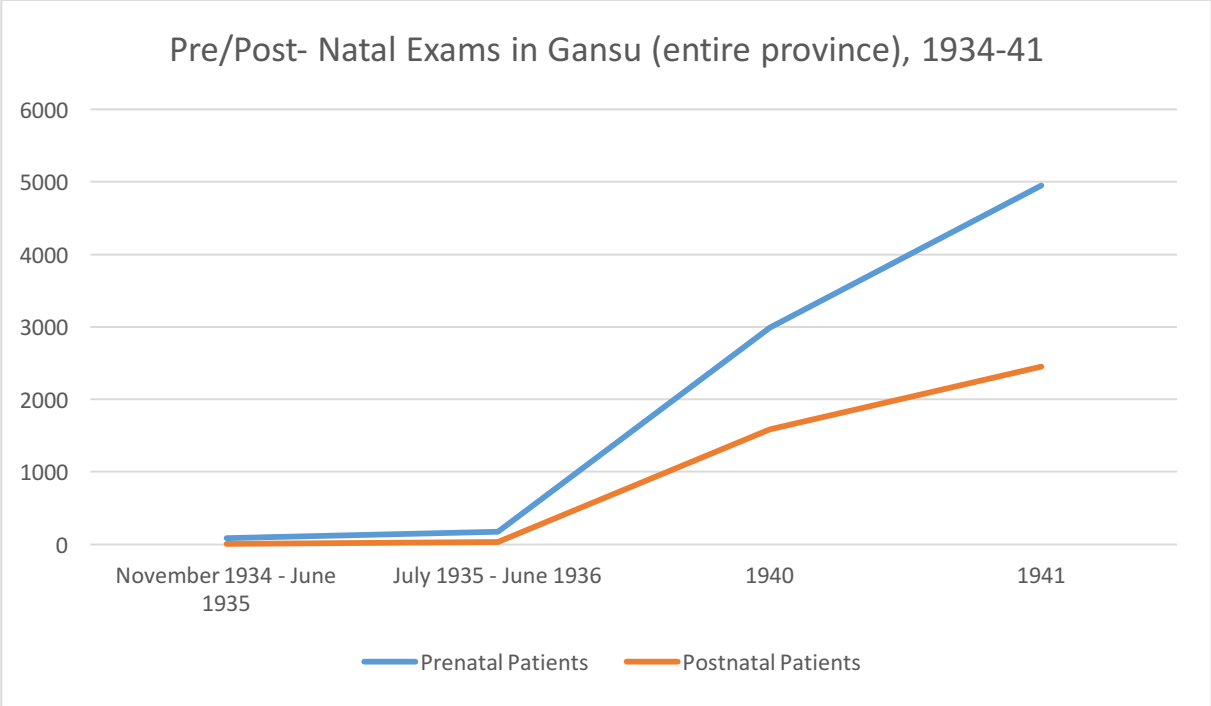
As Yang noted, the overall percentage of Gansu women served by the provincial health system remained relatively small. Further, though health workers often pointed to quantitative data in various reports, they provided little information on the methods through which statistics were collected. The data provided across these varied reports (as outlined in the figures below) point toward a quickly expanding enterprise gaining momentum, particularly after the outbreak of war and the added investments of the NWHCP. Further, as outlined in the map above (Figure

[354] Ibid., 26-27.

[355] Ibid., 27-28; See also "*Gansu zhi zhuchan jiaoyu* 甘肅之助產教育;" "*Guo nei xiaoxi*: *Guanyu xibei weisheng jianshe zhi tanhua huiwen* 國內消息: 關於西北衛生建設之談話彙聞."

4.1), provincial authorities reported an expanding network of MIH personnel and clinics that reached westward far beyond Lanzhou, through outposts along the Gansu corridor.[356] In 1946, the national Northwest Hospital reported that the Gansu provincial midwifery school had a current class of 112 students (nearly double that reported by Yang Shuxin two years earlier), not including scores of midwives trained through the more localized and informal programs developed since the later 1930s. According to this and other reports, 2,942 women had given birth under biomedical supervision at the Northwest Hospital in Lanzhou alone during 1945-6, with an additional 1123 deliveries overseen by the provincial midwifery school in Lanzhou, and more still (figures unknown) supervised by rural outposts and other hospitals.[357]

Figure 4.2 – MIH Examinations in Gansu, 1934-41

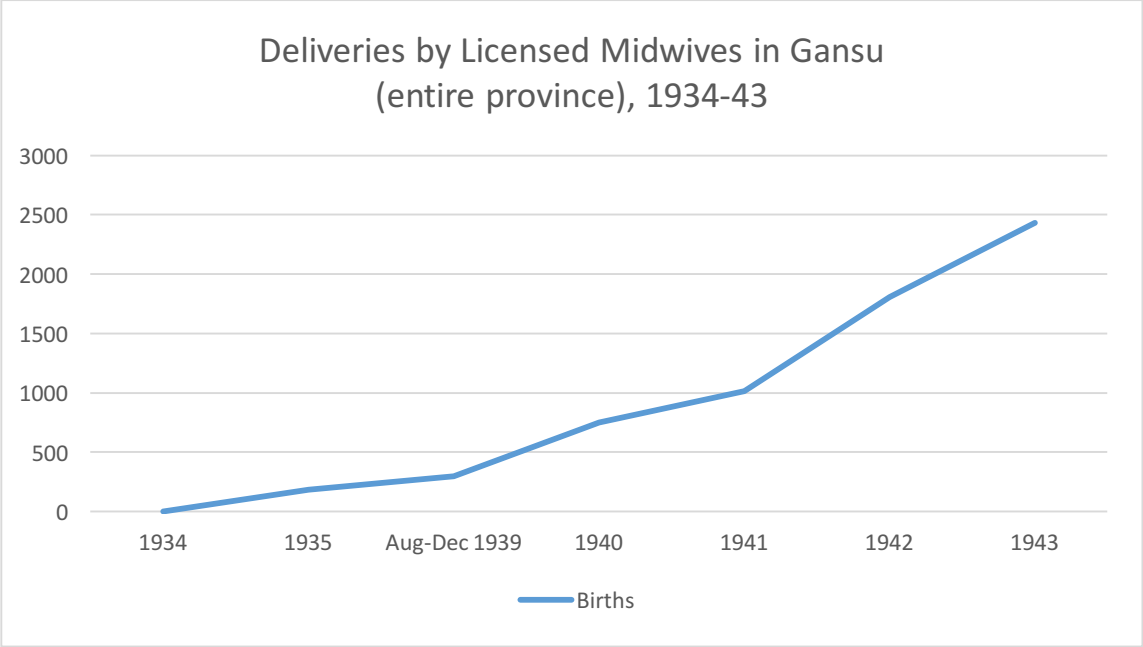


Sources: *Gansu sheng weisheng shiyanchu* 甘肅省衛生實驗處, eds., Gansu sheng weisheng shiyanchu di yi qi zongbaogao《甘肅省衛生實驗處第一期總報告》（Lanzhou：*Gansu sheng weisheng shiyanchu* 甘肅省衛生實驗處，1936）; Gansu sheng zhi weisheng shiye.

[356] Gansu sheng zhi weisheng shiye, 4-5, 11-13.

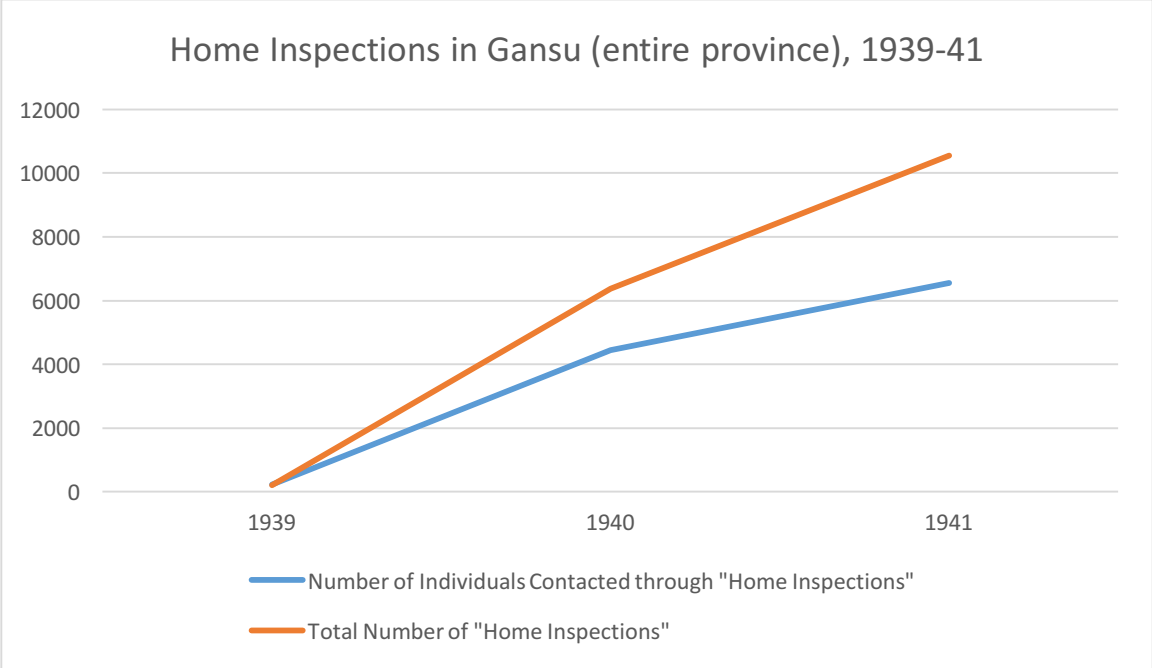
[357] *Weisheng shu xibei yiyuan nianbao*《衛生署西北醫院年報》1946 (Academia Historica, Taipei); see also Yang Yongni, "Tan yi tan xibei zhuchan shiye yu zhuchan jiaoyu."

Figure 4.3 – Deliveries by Licensed Midwives in Gansu, 1934-43



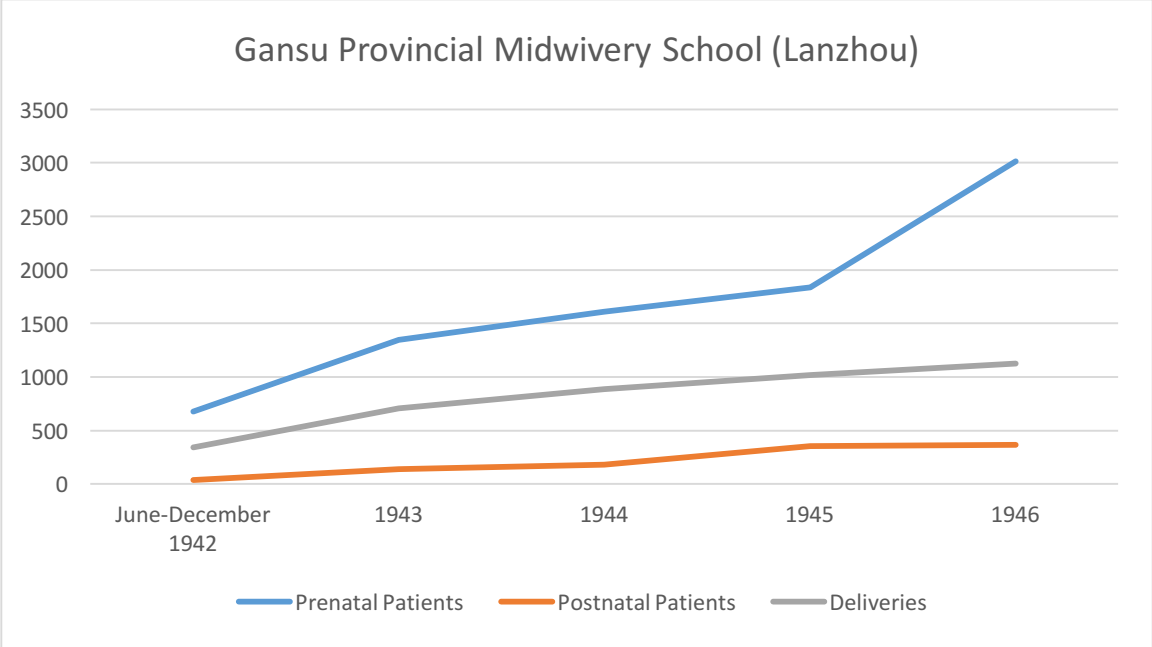
Sources: Gansu sheng weisheng shiyanchu, eds., *Gansu sheng weisheng shiyanchu di yi qi zongbaogao*; Gansu sheng zhi weisheng shiye; Yang Shuxin 楊樹信, "*Gansu zhi zhuchan jiaoyu* 甘肅之助產教育," Xin xibei yuekan 《新西北月刊》7, no. 78 (1944).

Figure 4.4—Home Inspections in Gansu, 1939-41



Sources: Gansu sheng zhi weisheng shiye.

Figure 4.5—Work of Gansu Provincial Midwifery School in Lanzhou, 1942-46



This chart shows only figures from the Gansu Provincial Midwifery School in Lanzhou. Gynecological services provided through rural clinics, the provincial hospital, or the national hospital are not included. Source: Yang Yongni, "*Tan yi tan xibei zhuchan shiye yu zhuchan jiaoyu*."

Estimates used by contemporary demographers and public health organizations provide tools for evaluating the proportional impact of MIH programs in Lanzhou based on the data provided in reports from the 1930s and 1940s. As Table 4.4 shows, the Gansu Provincial Midwifery School in Lanzhou provided prenatal examinations to 3,016 pregnant women in 1946 alone. According to United Nations data, the population of Lanzhou in 1950 was roughly 336,000, and the crude birth rate (CBR, births per 100,000) for all of China was 42.2. Using UN methods for estimation in refugee populations, pregnant women would make up 3.6% of this total population in a given period if the CBR were slightly higher at 45 per 100,000. Using these figures, the Lanzhou midwifery school alone, excluding other hospitals and rural outposts, would have overseen roughly one quarter of all births occurring in the city by the late 1940s. These advances from virtually zero were achieved in only eleven years of the school's operation. As Yang Yongni noted in her 1948 report that supplied the figures shown in Table 4.4, the total

percentage of births in Lanzhou overseen by biomedically trained midwives would have been significantly higher, given the growing number of personnel in facilities other than the Lanzhou school. As Yang Shuxin noted in 1944, the situation remained bleaker in more remote areas of the province, though provincial reports do show significant and consistent expansion in both the geographic reach of and the number of patients treated by Gansu's licensed midwives.[358]

Despite these gains and upward trends, local and provincial reports to national authorities and the public continued to minimize advances while connecting local MIH services to the most pressing concerns of the national government. Local public health workers remained well aware of the limits of their successes, given the limited proportion of the population they served. But in 1948, Yang Yongni, in contrast to her colleagues, noted significant gains in addition to persistent challenges.[359] The dissonance between quantifiable gains and dismal rhetoric along with the frequent, explicit citing of the national project of "developing the Northwest" suggests a rhetorical choice to emphasize challenges over successes. By affirming the backwardness of Gansu and the need for continued development, local health workers asserted the necessity of their work and made calls for continued national investments in a local project that remained unfinished and under-supported.

Global Health, International Philanthropy, and the Communist Party

[358] UNFPA, UNHCR, WHO, "Annex 5: Estimating the Number of Pregnant Women in the Population," *Reproductive Health in Refugee Situations: An Inter-Agency Field Manual* (1999), http://helid.digicollection.org/en/d/Jwho34e/12.7.html (accessed January 12, 2017); see also United Nations Population Division, *World Population Prospects: The 2012 Revision* (New York, 2013), http://data.un.org/Data.aspx?d=PopDiv&f=variableID%3A53#PopDiv (accessed January 12, 2017); see also Yang Yongni 楊永霓, "Tan yi tan xibei zhuchan shiye yu zhuchan jiaoyu;" Yang Shuxin, "*Gansu zhi zhuchan jiaoyu."*

[359] Yang Yongni, "*Tan yi tan xibei zhuchan shiye yu zhuchan jiaoyu*."

Throughout the 1930s and 1940s, Gansu also became a key site for foreign philanthropy in China. In addition to the LNHO, American organizations, including the Rockefeller Foundation, the American Bureau of Medical Aid to China (ABMAC), and United China Relief (UCR), provided varying degrees of logistical and financial support for public health and child welfare operations. These organizations varied in their aims, allies, and philosophies, yet all shared an investment in public health and MIH in particular as critical to shaping the development and international orientation of postwar China. In the case of Gansu, foreign philanthropy transcended partisan divisions between Communists and Nationalists to aid public health and child welfare in both NHA institutions and the administration of the Shaan-Gan-Ning Border Region.

While the Rockefeller IHD retained a degree of oversight over the expansion of midwifery education through sustained ties with the NHA and the flagship FNMS, the LNHO became integrally involved in efforts to expand other areas of the Nationalist state's public health operations in Gansu. As noted above and in Chapter Three, Andrija Štampar of the LNHO traveled throughout western China conducting surveys and advising newly formed provincial bureaus. On the heels of 1933 announcements to fund a midwifery training center in Lanzhou, Štampar embarked on a six-month long survey of the Northwest region with NHA representative Yao Xunyuan.[360]

This cooperative study between the Chinese NHA and the LNHO produced preliminary plans for public health in Gansu made public in the Chinese-language *Medical News* (*Yiyao*

[360] In Chinese-language sources, Štampar's name is transliterated as "*Sidangba* 斯當巴" or "*Sidanba* 司丹巴." He is almost always identified as a medical advisor from the League of Nations. For more on Štampar's endeavors elsewhere in China, see Yunnan quansheng weisheng shiyanchu er nian gongzuo gaikuang 《雲南全省衛生實驗處二年工作概況, 1936-1938》(Nationalist Party Archives, Taipei); see also Chapter Three of this dissertation.

xiaoxi) in 1934. In this translated statement, Štampar provided the rationale and methodology for the joint efforts of the LNHO and the Nationalist government throughout the Northwest, with particular focus given to Gansu. Echoing the newly medicalized discourse of the western frontier as desolate and disease-ridden, Štampar argued that the province had lost nearly one-third of its population due to a drought that had been compounded by epidemics of tuberculosis and typhoid between the years of 1925 and 1930. A dramatic decrease in population from seven million to five million inhabitants exacerbated the challenges of bringing a modern public health system to Gansu. A sparse and widely dispersed population required medical personnel who could drive motor vehicles and ride on horseback. Štampar also reported that *ad hoc* offices of "health affairs 衛生事務" had been established in the provincial capitals and cities of the Northwest.[361]

The published report of Štampar's survey tour, especially when read in connection to assessments of other parties with investments in public health, demonstrates the distinct political projects and perspectives converging on the issue of MIH. Articulating the shared goal of the LNHO and the NHA to bring biomedicine to undeveloped regions of western China, Štampar argued that the structure and design of health offices "imitated" those used in Europe during the First World War. Yet, these offices also evinced the demonstrated priorities of the Nationalist government to prioritize the reproductive and caregiving roles of women as well as the particularities of longstanding Chinese medical practice. Each health office included a small-scale midwifery institute, a separate office for maternal and infant health, an additional school for general health education, and a team designated to conduct rural fieldwork. Despite the fact that, in much of the West, childbirth had increasingly become the purview of male surgeons, Štampar, based on observations in the immediate aftermath of war, presented this clear emphasis

[361] "*Guo nei xiaoxi: Guanyu xibei weisheng jianshe zhi tanhua huiwen*."

on midwifery training as an idea with European origins. These claims contrasted further with the history of John Grant's proposals from the later 1920s, which framed the choice to (re-)train midwives as seizing a unique opportunity to pair American philanthropy with Chinese conditions.[362] Štampar's statement preceded a report by Chinese NHA official P. Z. King 金寶善, who had accompanied Štampar during much of his work in the Northwest. King largely echoed Štampar's claims. However, King's statement presented midwifery reform in Gansu as a triumph of Chinese institutions, specifically citing the planned provincial midwifery school in Lanzhou as one of several endeavors orchestrated by the rapidly expanding NHA. Both Štampar and King noted the advent of epidemiological research in Gansu on the heels of health offices, clinics, and the provincial midwifery school.[363]

Štampar forged enduring relationships with Chinese public health workers during his time in China and through these contacts continued to influence the development of public health policy in the region after his return to Europe. From Europe, Štampar maintained regular correspondence with Chinese doctors in Gansu to sustain the cooperation begun between the LNHO and the NHA in this developing program of disease prevention. Dr. Han Lee Min, the first permanent director of the provincial institute, remained one of Štampar's primary interlocutors in China throughout 1936-37. According to a letter to Mr. Smetz of the LNHO from

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[362] "*Guo nei xiaoxi: Guanyu xibei weisheng jianshe zhi tanhua huiwen*." See also Chapter Two of this dissertation.

[363] "*Guo nei xiaoxi: Guanyu xibei weisheng jianshe zhi tanhua huiwen*." Following a medical education at Chiba Medical College in Japan and Johns Hopkins University, Jin held various public health positions in China, working first in Beijing and Tianjin, and later, as an NHA representative in Gansu province. Jin later became a medical adviser to the United Nations International Children's Emergency Fund (UNICEF) in the 1940s. Jin continued working to promote public health in China after 1949, however, following critical comments made about the state of the PRC's public health system, he suffered a fate similar to many prominent biomedical doctors that worked during the Nationalist period. He was labeled a rightist in the later 1950s and faced further political persecution during the Cultural Revolution of the 1960s-1970s. See Wolfgang Bartke, *Who was Who in the People's Republic of China* (Hamburg: Institute of Asian Affairs, 1997), 194.

Štampar on March 6, 1937, Han remained critical to the ongoing collaboration between the LNHO and the Nationalist government.[364] In his correspondence, Štampar framed the varied public health operations in Gansu as integral to the LNHO's broader, global project to investigate and promote rural health. As in the case of Yunnan, Štampar encouraged Chinese representatives, including Han, to provide information on their work and to participate in LNHO-sponsored rural health conferences. Štampar specifically requested reports at least once monthly from Han in Gansu.[365] Štampar also wrote frequently to Yang Shuxin before his appointment as director of the Gansu Provincial Health Institute in 1942.[366]

As the NHA gained greater presence in Gansu, foreign—especially American—aid shored up the expansion of public health infrastructures in Nationalist-controlled areas in the 1940s. Millions of dollars devoted to public health work accompanied American medical experts into China during the war years. Building on the earlier endeavors of the Rockefeller IHD and their close ties to both the Chinese and American governments, the Rockefeller Foundation successfully coordinated increased public health aid to China from missionary societies, medical organizations, and the U.S. government. In addition to substantial financial donations made by the Christian Medical Council for Overseas Work and ABMAC, the U.S. State Department also worked in cooperation with the Rockefeller Foundation to send "technical experts" in "medical science and public health" to China in a number of fields, including

[364] Štampar to Smetz, March 6, 1937. (United Nations Archives, Geneva, R6060 1933-1936, Section 8A, Series 940, Dossier 28321).

[365] See Han Lee Min to Štampar, January 4, 1937; Štampar to Han Lee Min, March 6, 1937 (United Nations Archives, Geneva, R6060 1933-1936, Section 8A, Series 940, Dossier 28321).

[366] Štampar to Yang, June 5, 1937; Yang to Štampar, April 30, 1937 (United Nations Archives, Geneva, R6060 1933-1936, Section 8A, Series 940, Dossier 28321); see also Liu Yimin, "*Jiefang qian Lanzhou diqu yiyao weisheng zhuangkuang*," 174.

"general problems of urban and rural health in China," "social hygiene," and "maternity and child welfare."[367]

In February of 1942, the U.S. State Department convened a meeting with the varied medical and philanthropic organizations providing public health aid to China to arrange for a centrally managed effort that avoided duplication of services. In memoranda from the U.S. government, giving medical advice to the Chinese government remained secondary to the priority of "surveying" conditions throughout China and arranging for experts that would give thorough reports upon their return and be available for continued consultation in the future. The minutes of the conference revealed a vast network of American actors operating in China with varied ties to the governments of both countries. UCR alone had invested more than 3,000,000 U.S. dollars in China during its first year of operation, with an expected additional 7,000,000 dollar investment in 1942 to projects including "medical relief", "social rehabilitation," and "child welfare."[368]

UCR's investments in China included targeted support of MCH in the Northwest. Though the region had been a site for competitive state-building enterprises between Communist and Nationalist administrations, UCR's philanthropy cut across these partisan divides to support both the Nationalist health system and the Communist-administered Shaan-Gan-Ning Border Region. UCR's support of endeavors in Communist areas proved controversial, but many personnel defended these investments given the dire needs of the region, the diversity of political

[367] Charles A. Thomson, Chief, Division of Cultural Relations, U.S. State Department to Dr. Raymond B. Fosdick, President, Rockefeller Foundation, February 7, 1942; "Agenda for Discussion at Meeting of Representatives of China Medical Organization," February 7, 1942; "Memorandum on Conference Held at Cultural Relations Division of State Department, Washington, D. C.," February 11, 1942 (RAC, Rockefeller Foundation Archives, Sleepy Hollow, NY, RG 2 Series 601 Box 240 Folder 1662).

[368] "Memorandum on conference held at Cultural Relations Division of State Department."

views within Communist areas, and a belief that any future Chinese state would require the support and inclusion of the Communist insurgency. In 1941, UCR personnel circulated a report titled, "A Missionary Doctor on the Northwest Trail," with a preface outlining the significance of UCR support of public health in the Northwest. According to this preface,

> The questions of democracy, social and political reform, and economic liberalism, should be separated from the communist problem. China has many leaders in and out of the government, in and out of the Party, who are deeply concerned with these questions and who are working for a better social order in China. They are against dictatorship, they want to see a free and progressive China emerge from this struggle and they are willing to fight against corruption and for better government. They think of China as an ally of the democracies. Their number is growing. They are not communists.[369]

From the perspective of this American observer, the political landscape in China exceeded any narrowly conceived notions of a struggle between Nationalist and Communists, as intellectuals and health workers in both parties shared common aims and diverged from the rigid ideologies of their party affiliations. Thus, UCR should support this group of pragmatic figures that crossed party lines, rather than re-inscribing the overdetermined divisions between Communist and Nationalist camps.[370]

The report that followed this preface asserted the critical place of public health in the Northwest to American political and business interests, circulated here to focus UCR philanthropy. The report quoted Dr. Wallace Crawford, who portrayed Gansu as similar to the American western frontier. Crawford reported favorably on his observations of public health in Gansu, praising the work of local doctors and specifically naming the Northwest Epidemic Prevention Bureau and the Nationalist NHA. Given the NHA's role in the broader Nationalist

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[369] Copy of "A Missionary Doctor on the Northwest Trail," *New China* 3, no. 2 (Sept. 30, 1941) (UCR Records, Box 2, Folder 14, New York Public Library); see also Odd Arne Westad, *Decisive Encounters: The Chinese Civil War, 1946-1950* (Stanford: Stanford University Press, 2003), 29-39.

[370] Ibid.

project of "developing the Northwest," these figures likely shaped Crawford's perception of the importance of Gansu and northwestern provinces. In his case for focusing American philanthropy on the Northwest, Crawford turned to Gansu's strategic location and natural resources. He wrote,

> Kansu [Gansu] is a dry and dusty province in great need of afforestation, and improved irrigation…There are great possibilities for agricultural improvement, opening up of mineral resources (including possibly oil), use of water power, and industrial development. China's gateway province to central Asia and Soviet Russia is certain to play a more significant part in the future of this country.[371]

Crawford's report bore the influence of Nationalist authorities and specifically praised the Nationalist government and its allied in public health. But UCR also diverged from Nationalist narratives in its support of the Communist border-region government. Here, the aid from UCR focused disproportionately on child welfare and MIH. According to an internal UCR report from January 1941, the Civilian Department of the Border Region government had established a broad program for child welfare that included health programs for expectant/new mothers and their infants.[372]

Maternity clinics in the Border Region remained cruder than those in Nationalist-administered areas, according to reporting by foreign observers to UCR. A 1942 summary of Dr. Stanton Lautenschlager's observations provided detailed descriptions of a maternity clinic housed in caves. Lautenschlager, a returned missionary, had visited China's Northwest frontier in 1941. The UCR report quoted Lautenschlager as noting primitive but egalitarian arrangements to provide medical care to parturient women. According to the Lautenschlager, "Seven caves are

[371] Ibid.

[372] "Program for Child Welfare, Shensi-Kansu-Ninghsia Border Region," January 27, 1941 (UCR Records, Box 2, Folder 5, New York Public Library).

'waiting caves' for expectant mothers. Five are for after-delivery cases. Here factory workers, professors' wives, student mothers, officials' wives and all mothers from government institutions receive the same care in the same 'first-class wards.'" Despite these limited facilities, Lautenschlager asserted that he "never saw anywhere else so many happy young mothers and so many healthy, fat babies."[373] Many of the few Americans who visited Communist base areas during the war came away with similar assessments. In their view, the primitive conditions and limited resources of Communist areas did little to thwart a sincere and modestly successful campaign of the Chinese Communists to improve the lives of rural peasants. However, after the war, many in the United States, including some who had visited Communist areas, came to believe that they had been fooled by Communist propaganda efforts.[374]

Much like rural midwives in Nationalist areas, representatives from the Child Welfare Section of the Border Region government surveyed each village administered by the Communist party, collecting "statistical information on the number of mothers, women capable of bearing children, numbers of children, and general information on health and hygiene problems."[375] To engage locals in this registration and surveillance, each healthy one-year-old registered with the Border Region earned mothers a small cash "bonus." Like in Nationalist-controlled areas at this time, all mothers and children in Communist-controlled areas of the Northwest received free treatment and training in scientific mothercraft. In both Nationalist and Communist areas, mothers and children also participated in health competitions.[376]

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[373] Mr. Lennig Sweet to Miss [Mildred] Price, November 16, 1942 (UCR Records, Box 2, Folder 5, New York Public Library).

[374] See Carolle J. Carter, *Mission to Yenan: American Liaison with the Chinese Communists, 1944-1947* (Lexington: University Press of Kentucky, 1997), 222-225, *passim*; see also Westad, *Decisive Encounters,* 29-39.

[375] Ibid.

[376] Ibid.

According to this report, Communist health authorities remained even more antagonistic to the work of 'old-style' midwives than their Nationalist counterparts. By this time, MIH workers at the highest levels of the Nationalist state had begun tempering their hard line on local customs, even as they continued work to identify and retrain 'old-style' midwives. A 1942 report quoted Yang Chongrui, then affiliated with the Nationalist health system, as advocating an approach that built on existing customs rather than eradicating them. Yang asserted, "We found it wise to build the new on the old foundations, and, so far as we could, we have explained our modern medical steps by tieing[sic.] them up with the old, already understood superstitions."[377] According to Yang, many women believed that, during childbirth, "something in the room should be opened—a door, or trunk top, or box top. This was supposed to ensure easy delivery. This superstition does not hurt our care of the young mother, and we observe it."[378] Yang provided another example, in which local customs often dictated the consumption of a special dumpling on the twelfth day of a child's life. "We have taken advantage of this rite," Yang conveyed, "by giving on this 12th[sic.] day the usual examination made by all modern doctors just before the young mother is allowed to leave the sickroom."[379] Further, Yang concluded, "China's midwives never force a mother to do anything she does not approve of…In a poor household we advise the expectant mother to go to a hospital. But we do not force her to, if her own judgement is against it."[380] This description of the NHA's MCH division differed starkly

[377] "20th Century College-Trained Midwives Take Over Gigantic Task of Maternal and Child Health to Supplant Herb Doctors in Free China," January 16, 1942 (UCR Records, Box 1, Folder 7, New York Public Library).

[378] Ibid.

[379] Ibid.

[380] Ibid.

from the contemporary report from the Communist border region, which stated, "Old superstitions and 'cures' for difficulty in childbirth (such as 'arresting devils', 'chasing away devils', etc.) are to be condemned and abolished."[381]

The Border Region also differed from Nationalist state policy in its emphasis on guaranteed periods of rest for all pregnant women and new mothers, which included weeks away from work and fewer working hours throughout early pregnancy and for nursing mothers.[382] Lautenschlager reported that all mothers received six weeks of free care and an allowance of forty yuan to clothe the baby, with an additional monthly stipend of ten yuan for food.[383] Those who endured a miscarriage or still-birth received an allowance from the government and a two-month holiday. Further, no man in the Border Region could divorce a pregnant or nursing wife before the child's first birthday.[384]

In the correspondence surrounding varied MCH enterprises in Communist and Nationalist areas of the Northwest, UCR representatives remained expressly committed to MCH, a peaceful resolution of hostilities within China, and the cultivation of allies amenable to American philanthropy, business, and foreign policy. Following its assessment of the political landscape of the region, UCR cultivated allies in both camps, seeing neither government as antithetical to their aims despite American ideological opposition to communism. While the League of Nations, the Rockefeller Foundation, and ABMAC primarily supported the Nationalist NHA's MIH programs, UCR's engagement with the Communist Border Region further

[381] "Program for Child Welfare, Shensi-Kansu-Ninghsia Border Region."

[382] Ibid.

[383] Mr. Lennig Sweet to Miss [Mildred] Price, November 16, 1942.

[384] "Program for Child Welfare, Shensi-Kansu-Ninghsia Border Region."

demonstrates the varied actors and aims shaping the continued development of MIH in Gansu and the Northwest prior to the founding of the PRC.

Conclusion

On the eve of the founding of the PRC, Gansu thus housed a pluralistic public health landscape, characterized by diversified actors linked through networks of practitioners, officials, and philanthropists. Lanzhou alone housed multiple institutes variably funded and overseen by provincial authorities, the national government, and international organizations. In the neighboring Border Region administered by the Communist party, foreign philanthropy further supported MIH programs with differing priorities but similar goals to those allied with the Nationalist government. As foreign observers noted, both parties simultaneously pursued biomedical methods of reducing maternal and infant mortality and regulated lay midwives. Thus, the development of MIH in Gansu integrated a variety of political projects and crossed partisan divides.

In both Nationalist- and Communist-administered regions, mobile midwives and satellite clinics reached remote areas along the Northwest frontier, engaging the rural women of Gansu in multifaceted endeavors to biomedically reform childbirth and motherhood. Together these diversified aims had produced significant results, quantified in local reports to national authorities and affirmed by foreign observers. The dissonance between these quantitative advances and more dismal, narrative assessments suggests not only the limited proportional impact of MIH programs but also the strategic necessity of affirming national narratives. In addition to lamenting that much work remained to be done, local workers allied with the Nationalist government also explicitly reiterated the refrain of "developing the Northwest" in

broad terms of development, affirming the necessity of their local endeavors for national priorities.

This broad view of MIH in Gansu builds on earlier chapters to demonstrate the convergence of varied actors on the reproductive functions of Chinese women within a single province. Given the intertwined histories of foreign philanthropy, Nationalist state-building, Communist administration, and localized practice, MIH can no longer be evaluated in terms of the successes or failures of any ill-defined and narrowly conceived state. The following chapter further pluralizes the actors and investments shaping Nationalist-era MIH through an examination of maternalism and medicine as feminist praxis.

Chapter 5: Maternalism, Medicine, and Feminist Praxis

The notions of difference undergirding state and philanthropic projects in MIH also shaped the development of Chinese feminisms throughout the Nationalist decades. This chapter and the next show how shared investments in a uniquely feminine capacity to nurture and the purportedly self-evident links between mortality and mothering shaped feminist political projects, which diverged from state and philanthropic aims at key points. This chapter argues that the global conjuncture that made Chinese MIH critical to state-building and international philanthropy also enabled the political activism of feminist medical practitioners. The elevation of these practitioners as skilled experts in the sciences of mothering, combined with the castigation of less-skilled practitioners in policy and propaganda, produced new hierarchies between women. However, as this chapter and the next demonstrate, these evident hierarchies also alerted some elite, urban feminists to the particular suffering of the rural and poor, facilitating a reconceptualization of the subject and scope of the Chinese women's movement. Thus, the tethering of the quotidian tasks of motherhood to demographic measures of mortality produced not only categories of hierarchical difference, but also new subject positions for certain Chinese women, as well as a vocabulary and justification for highlighting structural inequities, systemic oppression, and the disparate effects of disease and violence.

The politics of motherhood have divided the field of women's history. In recent decades, historians have turned to late nineteenth- and early twentieth-century feminist entanglements to complicate and historicize the politics of maternal roles. Much of this research has adopted the

paradigm of maternalism, a contested framing of "ideologies that exalted women's capacity to mother and extended to society as a whole the values of care, nurturance, and morality."[385] Taken together, this now large body of scholarship shows that factions throughout the world deployed maternalism toward varied ends. The particularities of national cases have shaped contrasting conclusions regarding the effects of maternalist politics. In various instances, maternalism has been interpreted as feminist advocacy for welfare states, bourgeois complicity with the oppression of workers, or the subjugation of women's concerns to those of a masculinist polity.[386]

Within Chinese studies, scholars have arrived at generally negative assessments regarding the implications of political investments in the maternal role for Chinese women.[387] However, recent scholarship has highlighted the coexistence of feminist activism and what I, following historians outside of Chinese studies, refer to as "maternalism" in the Nationalist decades, noting how certain politically engaged women redefined the maternal role.[388] This

[385] Seth Koven and Sonya Michel, "Womanly Duties: Maternalist Politics and the Origins of Welfare States in France, Germany, Great Britain and the United States, 1880-1920," *The American Historical Review* 95, no. 4 (1990): 1076-1108; 1079.

[386] Notable scholarship on maternalism includes Koven and Michel, "Womanly Duties;" see also Seth Koven and Sonya Michel, *Mothers of a New World: Maternalist Politics and the Origins of Welfare States* (New York: Routledge, 1993); Molly Ladd-Taylor, *Mother-Work: Women, Child Welfare and the State 1890-1930* (University of Illinois Press, 1994); Ann Taylor Allen, *Feminism and Motherhood in Western Europe, 1890-1970* (New York: Palgrave Macmillan, 2005); Donna J. Guy, *Women Build the Welfare State: Performing Charity and Creating Rights in Argentina, 1880-1995* (Durham: Duke University Press, 2009); Jodi Vandenberg-Daves, *Modern Motherhood: An American History* (New Brunswick: Rutgers University Press, 2014); see also "International Trends: Maternalism as a Paradigm," *Journal of Women's History* 5, no. 2 (1993): 95-131; Marian van der Klein, Rebecca Jo Plant, Nichole Sanders, and Lori R. Weintrob, eds., *Maternalism Reconsidered: Motherhood, Welfare and Social Policy in the Twentieth Century* (New York: Berghahn Books, 2012).

[387] See, for example, "Citizens or Mothers of Citizens?: Gender and the Meaning of Modern Chinese Citizenship," in Elizabeth Perry and Merle Goldman. eds., *Citizenship in Modern China* (Cambridge, MA: Harvard Contemporary China Series, 2002), 23-43.

[388] See Danke Li, *Echoes of Chongqing: Women in Wartime China* (Urbana and Chicago: University of Illinois Press, 2010), 37; Helen Schneider, *Keeping the Nation's House: Domestic Management and the Making of Modern China* (Vancouver: UBC Press, 2011), 73-77.

chapter takes this line of inquiry one step further, to demonstrate how political investments in motherhood, particularly in their intersection with public health, proved foundational to certain forms of public and political engagement by and on behalf of women *qua* women.

Further, notwithstanding national particularities, Chinese investments in the maternal role emerged in close relation to contemporary movements throughout the world. The following analysis focused on the Nationalist period (1927-49) points toward a rethinking of not only the Chinese case, but of maternalism itself as resulting from a global linking of macropolitical and social spheres with varied political effects. This global alignment that produced maternalism provided the conditions for both statist biopolitical projects and certain modes of feminist politics. By situating the lives of select Chinese women physicians within the (trans)national historical conditions that produced maternalist ideologies, I argue that the political elevation of women's reproduction and caregiving at once delimited and enabled a particular feminist praxis in Nationalist China and the broader interwar world.

Chinese Maternalism and Transnational Feminisms

After decades of transnational feminist scholarship, feminism can no longer be envisioned as a monolithic, Western export to the rest of the globe.[389] As Mrinalini Sinha has argued, "neither feminisms nor women are ever articulated *outside* macropolitical structures that condition and delimit their political effects."[390] Thus, Chinese women's political investments in reproduction and caregiving remain indicative of the historical conditions in which they

[389] See, for example, Kumari Jayawardena. *Feminism and Nationalism in the Third World* (Atlantic Highlands, NJ: Zed Books, 1986); Chandra Talpade Mohanty, *Feminism without Borders: Decolonizing Theory, Practicing Solidarity* (Durham, NC: Duke University Press, 2003).

[390] Mrinalini Sinha, "Mapping the Imperial Social Formation: A Modest Proposal for Feminist History," *Signs* 25, no. 4 (2000): 1077-1082, 1078.

operated, rather than deficient feminism or merely the subjugation of women's issues to statist causes. At a particular moment in the twentieth century, maternalism served as both a disciplinary ideology and an important zone of empowerment for subjects constituted at the intersection of female gender and subjugated nation. I do not refute the disciplinary dynamics of maternalism. In the words of Inderpal Grewal, "Many forms of feminism existed through participating in certain dominant discourses." Following Grewal, my analysis represents not a "search for a transparent or transcendent feminism" but rather an effort to examine the historical conditions of possibility that shaped a particular mode of feminist praxis in China and the broader world at a specific juncture.[391]

When examined in isolation, statist rhetoric glorifying the maternal role may be read narrowly as the policing and appropriating of women's labor. However, as Saba Mahmood reminds us, norms are "performed, inhabited, and experienced in a variety of ways."[392] In an attempt to move away from "an agonistic and dualistic framework—one in which norms are conceptualized on the model of doing and undoing, consolidation and subversion," Mahmood has advocated for analyses of the "ways in which norms are lived and inhabited, aspired to, reached for, and consummated."[393] Heuristics of compliance or resistance distort the realities of lived experience without consideration of the subjects constituted through more complex relationships to normative ideologies, cultural symbols, and their underlying material and historical conditions. Mahmood expands the terrain of the political through a focus on interiority

[391] Inderpal Grewal, *Home and Harem: Nation, Gender, Empire, and the Cultures of Travel* (Durham: Duke University Press, 1996), 11.

[392] Saba Mahmood, *Politics of Piety: The Islamic Revival and the Feminist Subject* (Princeton, NJ: Princeton University Press, 2005), 22.

[393] Ibid., 23; 24-25.

and subjectivity.[394] Yet, the Chinese case demonstrates how agentic inhabiting of putatively oppressive norms also constitutes a repertoire of strategies within the realms of policy and formal politics. The women surveyed here did not oppose or resignify the biopolitical state's rhetoric regarding the political significance of a distinctly feminine capacity to reproduce and nurture. Rather, they embodied state-sanctioned norms to advance distinct, explicitly feminist agendas.

Maternalism emerged as a transnational discourse shaped by the global development of capitalism, imperialism, nationalism, and public health. At both national and global scales, shared assumptions regarding the value of women's reproduction and nurturing simultaneously undergirded a variety of political projects. The value ascribed to women's nurturing roles provided new metrics to articulate hierarchies among women on the basis of class and race, particularly in colonial contexts. The notion that mothering required virtue and skill made maternalism a discourse most beneficial for middle- and upper-class women, as it shored up class hierarchies. In some cases, maternalism's highlighting of difference also provided an idiom for articulating structural inequities between women. Further, the formative stages of welfare states and international organizations in the early decades of the twentieth-century presented opportunities for maternalists throughout the world to shape the design and policy aims of state and intergovernmental institutions. Maternalism also animated anti-colonial nationalist movements through shared investments in women's eugenic and nurturing roles as critical to the survival of subjugated nations.[395]

[394] Ibid., passim.

[395] Koven and Michel, "Womanly Duties," 1077-78; see also Rebecca Jo Plant and Marian van der Klein, "Introduction: A New Generation of Scholars on Maternalism," in *Maternalism Reconsidered,* 1-21.

The transnational scope of my inquiry facilitates not only a reframing of the Chinese case, but also a highlighting of the global political resonances of maternalism during the second quarter of the twentieth century. Within the context of biomedical hegemony and imperialism, maternalism linked the macropolitical and social realms by framing mundane tasks of childbirth and mothering as critical to global rankings of races, nations, and states.[396] Affirming the feminization of reproduction and caregiving, many Chinese women drew from transnational networks to pursue economic justice for women and shield them from the suffering wrought by disease and violence. For some, the elevation of women's reproduction and caregiving counterintuitively enabled circumvention of compulsory heterosexuality and lives centered on bonds with other women. To demonstrate these claims, I draw from the history of medicine to offer an alternative genealogy of maternalism in China before turning to the praxes of four representative feminist medical professionals.

Women and Caregiving in Chinese History

Material and historical conditions imbued Chinese women's caregiving with international political significance. Throughout the later imperial period (960-1912), medical expertise served as a marker of refined masculinity. Often, the men of a single family dominated medical practice in a given locale as knowledge passed from father to son and accumulated across generations. Gendered divisions of inner and outer spheres led some women to work as healers, usually within their own households and almost always in service to other women. Due to the fact that both sickness and healing occurred within the home, certain aspects of medical practice became

[396] I draw here from Mrinalini Sinha's concept of an interwar "imperial social formation." See Sinha, "Mapping the Imperial Social Formation;" see also Mrinalini Sinha, *Specters of Mother India: The Global Restructuring of an Empire* (Durham: Duke University Press, 2006), 16-19.

domestic skills of women particularly in medical lineages through which women gained specialized knowledge.[397]

The development of "women's medicine" in the Song dynasty (960-1279) elevated the study of menstruation, conception, and childbirth to a medical specialization. As "women's medicine" became integrated into the medical mainstream, theoretical knowledge of fertility and reproduction fell increasingly under the exclusive purview of male literati. Dominant discourses of the female body further marginalized women's knowledge and experience across the Ming (1368-1644) and Qing (1644-1912) dynasties. As Yi-li Wu has argued, "Female knowledge of women's bodies was simply not a useful source of epistemological authority..."[398] The genre of imperial "women's medicine" thus remained largely male-authored.

Even as men maintained dominance through print, their dissemination of medical texts fostered the wide availability of manuals and thereby the proliferation of amateur practitioners. While men asserted their epistemological authority through literature on "women's medicine," gender segregation excluded male physicians from the physical site of childbirth. Parturient women thus turned to female family members and lay midwives, much to the disdain of male physicians.[399]

Imperialism, in its many forms, and the challenge of foreign medicines inaugurated a realignment of the relationship between women, medicine, and caregiving in China. In 1834,

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[397] Charlotte Furth, *A Flourishing Yin*: *Gender in China's Medical History, 960-1665* (Berkeley and Los Angeles: University of California Press, 1999), 266-267.see also Susan Mann, *The Talented Women of the Zhang Family* (Berkeley and Los Angeles: University of California Press, 2007), 20-28; 54-58.

[398] Furth, *A Flourishing Yin,* 266-67; see also Yi-li Wu, *Reproducing Women: Medicine, Metaphor, and Childbirth in Late Imperial China* (Berkeley and Los Angeles: University of California Press, 2010), 21-2; Mann, *The Talented Women of the Zhang Family,* 56-58.

[399] Wu, *Reproducing Women*, 180, 229-30; see also Mann, *The Talented Women of the Zhang Family,* 19-25.

American missionary Peter Parker opened an ophthalmologic hospital in Guangzhou—an act cited as the arrival of "modern medicine in China."[400] As their prevalence in China increased following the First Opium War (1839-42), missionaries expanded their medical practice into the Chinese interior despite the Qing dynasty's efforts to restrict their invasive surgical methods.[401] Reports of inferior health and hygiene in China circulated in missionary and medical journals to affirm the necessity of these endeavors. A contributor to the *Christian Advocate* in 1884 praised the work of medical missions based on observations that, "The Chinese know nothing of hygiene. Filth and vermin encompass them as with a garment."[402] Medical missionaries reported famine and pestilence, with the "dead and dying, lying just where they happened to fall."[403] These transnational discourses rooted in material suffering shored up the use of medical measures to articulate racial and national hierarchies.

Women featured prominently in such descriptions of international health disparities. Imprints and photographs of bound feet provided scientific evidence of Chinese barbarism, while evolutionary and eugenicist thought focused attention on unhygienic childbirth and inept mothering as contributing to racial degeneration. The biomedical vocabulary used to articulate corporeal, racial hierarchies in imperialist worldviews thus also served a contemporaneous ranking of civilizations based on the relative status and/or virtue of women.[404]

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[400] Samuel C. Harvey, "Peter Parker: Initiator of Modern Medicine in China," *Yale Journal of Biology and Medicine* 8, no. 3 (1936): 225-41.

[401] Sean Hsiang-lin Lei, *Neither Donkey nor Horse: Medicine in the Struggle over China's Modernity* (Chicago: University of Chicago Press, 2014), 45-47.

[402] "Work of Women Physicians in China," *Christian Advocate,* June 12, 1884, 394.

[403] Ibid.

[404] Dorothy Ko, *Cinderella's Sisters: A Revisionist History of Footbinding* (Berkeley and Los Angeles: University of California Press, 2005), 40-2; see also Hiroko Sakamoto, "The Cult of Love and Eugenics in May Fourth Movement Discourse," *Positions: East Asia Cultures Critique* 12, no. 2 (2004): 329-376; 349-51; Joan Judge, *The Precious Raft of History: The Past, the West, and the Woman Question in China* (Stanford, CA: Stanford

Foreign medicines also presented a challenge to the medical authority of male *literati* doctors, while norms of gender segregation—especially those surrounding childbirth and childrearing—continued to fuel an increase in female practitioners.[405] These developments, combined with missionary and, later, Qing efforts to expand education fostered professional opportunities for both foreign and Chinese women. Westerners pointed to the "peculiar social customs of the Chinese" that had thwarted male missionaries to such an extent that they had "been able to do comparatively nothing for suffering women."[406] Missionaries reported, "Native women would rather die than call in a foreign man" to aid in childbirth, "but may be persuaded to trust themselves in the hands of a foreign woman."[407] Beginning in the later nineteenth century, Western (especially American) women excluded from medical professions in their own countries traveled to Asia where they found a growing demand for their expertise. In 1878, American doctors Julia A. Sparr and Sigourney Trask reportedly initiated the biomedical education of Chinese women at their hospital in Fuzhou. Throughout *fin-de-siècle* China, missionaries founded women's medical schools in such dispersed locales as Suzhou, Guangzhou, Shanghai, and Beijing. Beginning in 1884, Sparr and Trask secured sponsorship for Chinese women's international education through the Woman's Foreign Missionary Society (WFMS) of

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University Press, 2008), 7-12; Hu Ying, "Naming the First 'New Woman,'" *Nan Nü: Men, Women and Gender in China* 3, no. 2 (2001): 196-231; 199-200.

[405] Although the doctors surveyed in this article largely embraced biomedical hegemony, many Chinese thinkers challenged the dominance of biomedicine. As noted elsewhere in this dissertation, some maintained the superiority of indigenous medicines while others attempted to reconcile biomedicine with indigenous medical practices. See Lei, *Neither Donkey nor Horse,* 69-96, *passim*; *See* also Nicole Richardson, "The Nation *in Utero*: Translating the Science of Fetal Education in Republican China," *Frontiers of History in China* 7, no. 1 (2012): 4-31; Nicole Richardson, "A Nation *In Utero:* Pregnancy and Fetal Education in Early Republican China" (PhD diss., UC Davis, 2015), 55-82, *passim.*

[406] "Work of Women Physicians in China," 394.

[407] "Women Physicians in China," *China Medical Missionary Journal* 14, no. 3 (July 1900).

the Methodist Episcopal Church with the condition that their students return to "lift the womanhood of China to a higher plane."[408] These encounters, like later study tours funded by international health organizations and Chinese governments, fostered transnational networks of medical philanthropists and feminists throughout the late nineteenth and early twentieth centuries.[409]

In 1892, WFMS supported the American medical education of Ida Kahn (Kang Cheng or Kang Aide) at the University of Michigan. Kahn later repatriated and rose quickly to notoriety, due in part to an 1897 biography by preeminent Chinese reformer Liang Qichao. Liang selected and manipulated details from Kahn's life to present her as a foil for the "talented women (*cainü)*" of the imperial period he despised. In Liang's portrayal, Kahn, China's first "new woman," had admirably shed the bonds of traditional femininity to pursue Western education and career.[410]

Liang's biography competed with starkly different portrayals of Kahn in the West and with many of the facts of Kahn's life. Kahn had been orphaned at a young age, and her Western education came about through close associations with American missionaries including her adoptive mother, Gertrude Howe. Hu Ying has read Kahn's own writing as resistance to her nationalist appropriation, arguing that her choice to never marry likely reveals a stronger commitment to the female community of missionaries, students, and patients she inhabited

[408] "Work of Women Physicians in China," 394.

[409] Gerald H. Choa, *'Heal the Sick' was their Motto: The Protestant Medical Missionaries in China* (Hong Kong: Chinese University Press, 1990), 116-125.

[410] Hu, "Naming the First 'New Woman,'" 199-210.

throughout her life.[411] Liang framed Kahn's eschewing of marriage as affording greater priority to national over familial service and thus evidence of modern subjectivity. Liang's selection of a medical doctor as archetype consolidated scientific education, national duty, and specialized caregiving as intrinsic to modern Chinese womanhood while elevating the status of women physicians and legitimizing singlehood.

Liang's biography of Kahn entered into a pluralistic, transnational debate over whether or how modernity necessitated a redefinition of feminine virtue. In its Chinese iteration, this "woman question" encompassed both male and female voices and a wide range of arguments, including radical critiques of liberalism, capitalism, and familial structures; the embrace of Western political and economic philosophies; and renewed commitments to indigenous culture. In most cases, Chinese thinkers' responses to the woman question shared with imperialist discourses a belief in the political significance of the social realm of women and children. The global alignment of social and political concerns found particular resonance in China, given that Confucian thought had long emphasized the family as foundational to the larger social and political order. But, the woman question brought enhanced scrutiny and expanded political significance to the domestic sphere, now seen not only as a microcosm of the larger polity but also as critical to China's status in a global ranking of nations.[412]

The woman question ascribed new significance to women's reproduction and nurturing. Fertility and reproduction had remained central to medical theories of women's bodies for

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[411] Ibid., 218-26; n. 41; see also Connie A. Shemo, *The Chinese Medical Ministries of Kang Cheng and Shi Meiyu, 1872-1937: On a Cross-Cultural Frontier of Gender, Race, and Nation* (Lanham, MD: Rowman & Littlefield, 2011).

[412] Judge, *The Precious Raft of History,* 7; *passim;* Susan Mann, *Precious Records: Women in China's Long Eighteenth Century* (Stanford, CA: Stanford University Press, 1997), 15. Mann sees this High-Qing conception of the state as distinct from earlier notions.

centuries, and the pronatalist aspects of Chinese culture had long placed importance on childbirth. Yet, political and cultural forces in late imperial China had prioritized wifely devotion and chastity over the maternal role. Particularly after Qing China's defeat in the First Sino-Japanese War of 1894-95, many Chinese intellectuals' embrace of social Darwinism and biomedicine brought notions of scientific, republican motherhood to bear on the macropolitical consequences of Chinese women's nurturing roles.[413] The new, more capacious value of reproduction and caregiving now included hopes of racial rejuvenation and resistance against imperialism.

The further development of the woman question in the early decades of the twentieth century produced competing ideals of the modern Chinese woman. The New Culture critique of polygamy and the elevation of romantic love shaped new norms of companionate marriage, the nuclear family, and domesticity as a skilled practice. In urban women's magazines, authors promoted women's education based on the belief that skilled domestic management and mothercraft required adequate knowledge of science and medicine. Alongside advertisements that linked the consumption of pharmaceuticals and hygienic products to modernity and motherhood, didactic articles cited foreign experts (such as Ellen Key) to emphasized the eugenic aims for modern maternity. To redress the subjugation of the Chinese nation and state, the "wise mother" reared healthy offspring through biomedical modes of hygiene and mothercraft.[414]

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[413] Judge, *The Precious Raft of History,* 112-14, passim; see also Wang Zheng, *Women in the Chinese Enlightenment: Oral and Textual Histories* (Berkeley and Los Angeles: University of California Press, 1999), 14-15, 69-70, 126; Lydia H. Liu, Rebecca E. Karl, and Dorothy Ko, eds., *The Birth of Chinese Feminism: Essential Texts in Transnational Theory* (New York: Columbia University Press, 2013), 1-8; Schneider, *Keeping the Nation's House,* 2-3; 8-9.

[414] Yung-chen Chiang, "Womanhood, Motherhood and Biology: The Early Phases of *The Ladies' Journal,* 1915-25," *Gender & History* 18, no. 3 (2006): 519-45; 531-40; Sakamoto, "The Cult of Love and Eugenics in May Fourth Movement Discourse," 329-376; Susan Glosser, *Chinese Visions of Family and State,* 1915-1953 (Berkeley

An alternative constellation of scientism, iconoclasm, nationalism, and feminism advanced the competing archetype of the single, educated career woman in the vein of Ida Kahn. In accordance with the New Culture condemnation of Confucian patriarchy, a feminist discourse of "independent personhood" rejected narrowly conceived roles of "good wife, wise mother." Many women built lives centered on the pursuit of education and career rather than that of marriage and family, believing that current conditions precluded any just marriage of equals. As in the case of Ida Kahn, nationalism legitimized women's marriage resistance as an act of self-sacrifice to political causes. Particularly in the Nationalist decades, explicit rules forbidding public health workers from marrying or having children limited opportunities for some women while further legitimizing the actions of those who chose not to marry. Along with academia, business, and law, medicine in particular became a primary field for the realization of the career woman archetype as an alternative, feminist engagement with metaphors linking individual and national bodies.[415]

In many ways, the founding of the Nationalist state in 1927 narrowed the pluralistic discourse of earlier decades through censorship and fascistic investments in putatively indigenous culture. However, these aspects are but part of more complex dynamics of the 1920s. Along with the May Fourth Incident (1919), the reorganization of the Nationalist Party (1919), and the birth of the Chinese Communist Party (1921), the founding of the Nationalist state served as a catalyst for expanding Chinese feminisms from "a realm of theorization" to also include a diverse set of institutionalized practices aimed at improving the material conditions shaping

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and Los Angeles: University of California Press, 2003), 3-5, 31-8; see also Tani E. Barlow, "Event, Abyss, Excess: The Event of Women in Chinese Commercial Advertisement, 1910s-1930s," *Differences: A Journal of Feminist Cultural Studies* 24, no. 2 (2013): 51-92; 71-78.

[415] Wang, *Women in the Chinese Enlightenment,* 124-32; 280-82; see also Tina Phillips Johnson, *Childbirth in Republican China: Delivering Modernity* (Lanham, MD: Lexington Books, 2011)*,* 106-7.

women's lives.[416] The fragility of political structures and scarcity of public health institutions had hitherto limited the efficacy of medical career as feminist praxis beyond its effects for middle-class individuals. In contrast to the circumscribed clinical practice of missionary-affiliated doctors, the Nationalist state's institutionalization of public health and medical education provided new structures through which feminist career women shaped the course of state-building, nationalism, and resistance to foreign imperialism. The significance afforded decidedly feminized roles and proscriptions against marriage in some fields intersected with nationalistic and feminist interpretations of foregoing marriage to open up new possibilities for civic engagement, women-centered lives, and the articulation of political demands for and by women.

The Nationalist state leveraged foreign resources for biopolitical purposes, thereby extending the reach of international health organizations into the Chinese interior. For foreign agencies, the discovery of puerperal fever and neonatal tetanus as leading causes of mortality made maternity and infant health (MIH) a philanthropic priority.[417] In Chinese policy and propaganda, the eugenic aspects of MIH aided aims of racial improvement and the disciplining of hygienic citizens. Longstanding customs of gender segregation and the career woman ideal also converged to make MIH professions and institutions optimal sites for women to advance feminist agendas within state structures. By 1938, nearly one thousand female doctors had formally registered with the Nationalist government. This figure represented roughly ten percent of the total number of licensed, biomedical doctors in China (excluding foreigners), a percentage

[416] Rebecca Karl, "Feminism in Modern China," *Journal of Modern Chinese History* 6, no. 2 (2012): 235-55; 236-37.

[417] John Grant to Victor Heiser, May 26, 1926 (Rockefeller Archive Center, hereafter RAC, RG 1.1 Series 601 Folder 371).

twice that of doctors who were women in the U. S. as late as the 1960s.[418] The professionalization of midwifery and nursing further aided women's entry into medical careers, particularly given the demand for medical personnel after the Japanese invasion of 1937. According to government figures, women constituted roughly forty-one percent of all registered medical personnel in the Republic of China by 1938.[419]

Some Chinese women medical professionals made use of the transnational political investments in their work to co-author a maternalist politics that diverged from the narrower aims of the state at key points. Through the expanded significance of the maternal role, these women positioned themselves as nurturers of fellow Chinese women and orphaned children, conceiving of their work as integral not only to state-building and the flourishing of the race, but also the material wellbeing of all women. In contrast to maternalists elsewhere in the world who ascended to prominence, in part, by claiming a masculine position,[420] the Chinese maternalists surveyed here often emphasized their embodiment of hegemonic norms of femininity rooted in putatively indigenous tradition. In the Chinese context, claims to expertise in mothercraft often required both this demonstration of feminine virtue and biomedical knowledge.

To be sure, maternalism and feminism remained overlapping but not coterminous spheres, both within and outside China. The prominent Shanghai obstetrician Su Cengxiang fused her foreign medical education with localized norms surrounding motherhood to position herself as an expert in mothering and thereby a feminine exemplar in popular media. Like other

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[418] Roughly four to five percent of American doctors were women from the late nineteenth century to the 1960s. See Regina Morantz-Sanchez, *Sympathy and Science: Women Physicians in American Medicine* (New York: Oxford University Press, 1985), 49. See also *Weisheng tongji* 衛生統計, (Chongqing: Neizheng bu, 1938), 34-35.

[419] *Weisheng tongji* 衛生統計, (Chongqing: Neizheng bu, 1938), 34-35.

[420] Licia Fiol-Matta has made this case in her analysis of Gabriela Mistral in Latin America. See Licia Fiol-Matta, *A Queer Mother for the Nation: The State and Gabriela Mistral* (Minneapolis: University of Minnesota Press, 2002), 125-26.

maternalists surveyed in this chapter, she remained single throughout much of the Nationalist decades after a public divorce. However, she explicitly shunned any association of her maternalist politics with feminism, stating, "I usually do not consider the topic of gender equality. I think it is baseless to speak of 'women's rights.'"[421]

The assertion that feminine caregiving required scientific knowledge differentiated elite and middle-class doctors from the subaltern women they served. Statist and philanthropic rhetoric lauding scientific mothercraft framed prominent female doctors as antitheses of the "old-style" midwives that threatened the lives of women and children. Scientific mothercraft's prerequisite expertise underwrote a technocratic position for prominent maternalists, whose authority rested, in part, on the social, cultural, and economic resources available to limited numbers of Chinese women. Two of the maternalists surveyed below, Yang Chongrui and Wu Zhimei, explicitly criticized the ignorance of rural midwives and suspect morality of concubines prior to the outbreak of war.[422] However, as demonstrated by the cases of Chen Guiyun and Yang Yongni, maternalist ideologies and the institutions they produced also expanded opportunities for some rural and lower-class women through programs promoting midwifery and medical education, particularly after the onset of the Second Sino-Japanese War. All of the women surveyed in this chapter remained implicated in the missionary and philanthropic projects

[421] Ji Ping 寄萍, "Su Cengxiang boshi tan nüquan yu nüneng 蘇曾祥博士談女權與女能," *Shenbao* (Dec. 12, 1936); see also See Su Cengxiang 蘇曾祥, "Wanju yu weisheng 玩具與衛生," *Weisheng yuekan* 《衛生月刊》 6, no. 8 (1936); Su Cengxiang 蘇曾祥, "Dang haizi shengbing de shihou 當孩子生病的時候," *Jia* 《家》 no. 19 (1946).

[422] See Tina Phillips Johnson, "Yang Chongrui and the First National Midwifery School: Childbirth Reform in Early Twentieth-Century China," *Asian Medicine* 4 (2008): 280-302, 285; Christina Gilmartin, *Engendering the Chinese Revolution: Radical Women, Communist Politics, and Mass Movements in the 1920s* (Berkeley and Los Angeles: University of California Press, 1995), 241n5.

of empire that conditioned maternalist feminist praxis in China, even as they passionately critiqued the suffering wrought by the Japanese invasion.

Yang, Wu, and Chen serve as but three examples of many prominent and politically engaged women among China's "second generation" of female doctors born in the 1890s.[423] Along with midwife Yang Yongni, all held missionary educations and shared investments in MIH. Yet, they moved in separate circles within and outside China. Yang Chongrui remained closely aligned with international health organizations and the public health bureaucracy of the Nationalist state, while Wu operated primarily in international women's organizations and the representative, advisory bodies of the Chinese government. Chen from Manchuria and Yang from Sichuan formed an enduring partnership in Beiping that moved westward to Xi'an, Chongqing, and ultimately Lanzhou. Yang Chongrui's ties lie primarily in Beiping, Western Europe, and the United States, while Wu, originally from Guangdong province in the South, traveled extensively throughout Southeast Asia, Oceania, and Latin America. Yang Yongni, despite a career that traversed thousands of miles and five provinces, remained in China with Chen, who left only for a brief, six-month study tour in the U.S. during the 1940s.[424] Together these cases affirm that maternalism in China ultimately came to cut across regions, classes, and political factions. Further, Chinese maternalism remained integral to a transnational movement spanning varied regions and spheres, rather than a wholly disciplinary discourse originating with a particular state.

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[423] Grace Seton Thompson was among the first to label this "second generation" of Chinese women doctors. See Grace Seton Thompson, *Chinese Lanterns* (New York: Dodd, Mead, and Company, 1924), 260. Others among this generation, including Ye Shiqin and Xiong Jin, appear elsewhere in this dissertation.

[424] Jiaoyu ting zhang Ning Ke 教育廳長寧恪, "Ju zhuchan xuexiao xiaozhang Chen Guiyun chuguo kaocha ni zhunbao liuyue wu you Yang Zuohua daili qiancheng 据助產學校校長陳桂雲出國考察擬准報六月務由楊作華代理簽呈," July 12, 1947 (Gansu Provincial Archives, Lanzhou).

The Japanese invasion of 1937 brought all of these women to the Nationalist wartime capital of Chongqing for varied lengths of time. As their own words attest, increased contact with suffering women in rural and Western China led them to espouse more inclusive agendas and a sharper focus on the threat of Japanese imperialism. In contrast to statist rhetoric that emphasized women's maternal failures, feminist advocacy centered on the bodily suffering wrought by disease and violence and the state's failure to provide adequate resources. Their activism was thus rooted in both an explicit engagement with biomedical, regional, and socioeconomic differences between women and a belief in women's shared and unique capacities to reproduce and nurture.[425]

Yang Chongrui (Marion Yang) 楊崇瑞

Yang Chongrui, known to her Anglophone contemporaries as Marion Yang, appears in recent historiography as a medical reformer aiding the modernization and professionalization of midwifery, but the political consciousness animating her career remains understudied.[426] As an advocate for women and children who shaped the course of both Chinese and global public health, Yang's life demonstrates the transnational conditions that shaped Chinese maternalism and its varied effects. Yang's published writing, private correspondence, and career choices are

[425] I take up this refashioning of the subject and scope of the Chinese women's movement in greater detail in Chapter Six.

[426] Recent works include Yuehtsen Juliette Chung, *Struggle for National Survival: Eugenics in Sino-Japanese Contexts, 1896-1945* (New York: Routledge, 2002); Johnson, *Childbirth in Republican China*; Yao Yi 姚毅, *Kindai Chūgoku no shussan to kokka shakai: yishi, josanshi,* sesseiba 近代中国の 出産と国家社会：医師,助産士,接生婆, (Tokyo: Kenbun shuppan, 2011); Nicole Barnes, "Protecting the National Body: Gender and Public Health in Southwest China during the War with Japan, 1937-1945" (PhD diss., University of California, Irvine, 2012); Mirela Violeta David, "Free Love, Marriage, and Eugenics: Global and Local Debates on Sex, Birth Control, Venereal Disease and Population in 1920s-1930s China" (PhD diss., New York University, 2014).

consistent in affirming her belief in the varied political utility of hygienic childbirth and scientific mothercraft.

Yang's autobiographical writing points to encounters early in her career that first raised her consciousness of medical practice as feminist praxis. Shortly after her graduation from a missionary-run medical school in 1917, Yang joined a government-sponsored relief effort in the wake of devastating floods in Shandong province. Through these endeavors, Yang developed an awareness of the precarious place of rural Chinese and the compounding effects of a lack of access to biomedical care. This realization initiated a shift in Yang's focus from clinical medicine to public health, based on an explicit desire to empower her fellow Chinese.[427]

Yang's interests in public health intensified and assumed a gendered focus at the Rockefeller-funded Peking Union Medical College in the 1920s. Her preference for public health over clinical medicine led her outside the hospital walls, where she performed examinations and health demonstrations for local women. Yang's recounting of this period emphasized the bodily suffering of women as the impetus behind her public health activism. Yang regularly met women for whom pregnancy and childbirth presented life-threatening danger. Some of her patients died of ruptured uteruses due to the distances between their villages and any hospital. Once word spread of her work, rural villagers from Beiping's surrounding hinterland sought her out, desperate to avoid suffering and death among their kin. These encounters fostered a sustained commitment to advance public health in general and MIH in particular, toward nationalistic and feminist aims aided by her foreign philanthropist colleagues. Yang's observation of the crisis in Chinese women's reproductive health coincided with the Rockefeller Foundation's recognition

[427] Yang Chongrui, "Wo de zizhuan 我的自传," (Oct. 1949) in Yan Renying 严人英,, ed., *Yang Chongrui boshi: danchen bainian jinian* 《楊崇瑞博士： 誕辰百年紀念》(Beijing: Beijing yike daxue/ Zhongguo xiehe yike daxue, 1990): 143-53, 144.

of midwifery reform as an "ideal entering wedge" to extend its operations in China.[428] With the funding and provisions of the Rockefeller Foundation, Yang left China to begin advanced study in gynecology and public health at institutions throughout North America and Europe.[429]

Yang's foreign tour provided vocabulary and context for her later work in China. From a new global perspective, Yang came to perceive the suffering of Chinese women as resulting from wealth disparities between China and the West—a point which she passionately pointed out to those who attempted to denigrate Chinese conditions based on Western standards. Believing that public health work rather than in-hospital gynecology provided the best means for "ensuring the wellbeing of the people," Yang returned to China with zeal to expand access to healthcare through strategic development of MIH programs. Her ambitions found common ground with the policy aims of the newly founded Nationalist state and its foreign advisors. By 1929, Yang had ascended to leadership roles at the First National Midwifery School (FNMS), the National Midwifery Board, and the National Health Administration's Division of MIH.[430]

Like many of her contemporaries, Yang made strategic use of cultural ideals that feminized caregiving and childbirth. She largely embraced these ideals, especially the national significance that facilitated their enacting on a broader scale beyond the home. In no uncertain terms, Yang also asserted the feminist utility and motives of her work. Though many portrayals of Yang and her fellow doctors relied on biomedical measures and education level to differentiate between women, Yang herself, particularly later in her career, emphasized solidarity with her patients and a focus on their material suffering. She wrote, "I am a woman. My utmost

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[428] Roger S. Greene to Henry Houghton, October 29, 1926 (RAC, RG 1.1 Series 601 Box 268 Folder 3398).

[429] Yang, "Wo de zizhuan," 144-47; see also Marion Yang, Personal History Record and Application for Fellowship, December 6, 1924; Marion Yang to M. K. Eggleston, January 9, 1926 (RAC, CMB Records, Box 76 Folder 538); Greene to Heiser, September 20, 1926 (RAC, RG 1 Series 601 Box 268 Folder 3398).

[430] Yang, "Wo de zizhuan," 146-47.

concern is of course the safety and suffering of women. This has always been a foundational point."[431] Yang viewed these aims as enabled by gendered and politicized notions of childbirth and caregiving, which she believed fostered particular opportunities to simultaneously advance the physical health and economic independence of Chinese women. Yang articulated two decidedly feminist aims behind her choice to expand and professionalize midwifery: expanding women's access to reproductive healthcare and providing new educational and career opportunities for women.[432]

Yang expressed these ideals most explicitly in an October 1949 autobiographical essay, shaped by the political demands of the Communist Revolution. However, her actions and correspondence during the Nationalist decades suggest consistent principles across the 1949 divide, despite shifting rhetoric and a later distortion of her family's class.[433] The scale and scope of Yang's MIH advocacy expanded dramatically in the 1930s. At FNMS, training diversified to accommodate women from varied backgrounds through courses for new midwives, retraining for old-style midwives, and "refresher courses" for missionary-trained midwives seeking official licenses. Under her supervision, Yang's students and colleagues founded midwifery training schools and hospitals throughout the country while extending their operations into rural areas through health demonstrations and satellite clinics.[434]

[431] Ibid., 147.

[432] Ibid., 147.

[433] Ibid., *passim.*

[434] Ibid., 147.

Praise for Yang's endeavors circulated around the world in documents originating in Beiping, Manila, Geneva, and New York.[435] Due in part to praise from foreign philanthropists, Yang became an internationally celebrated medical expert featured in publications including the *New York Times*.[436] The international attention expanded the reach of Yang's MIH advocacy beyond national borders, making her a pioneer in the development of global health. In 1937, she became a representative of the League of Nations Health Organization and promoted MIH and biomedical midwifery in fifteen countries throughout Europe and Asia.[437]

Yang's global perspective of MIH disparities gained particular urgency and focus in light of the Japanese invasion of China in 1937. Her correspondence demonstrates a deeply held belief in her MIH practice as integral to China's struggle against Japanese imperialism. Yang remained "anxious to return [to China] as soon as possible," unless she might "render some useful service to the war by remaining [abroad]." When her colleagues at the Rockefeller Foundation questioned whether Yang was "needed that badly in China," she replied, "I am not in position to answer you 'yes' or 'no', but I do know that I have something to do with the National Maternity and Child Health Program." To further support her case that arrangements be made for her swift return to China, Yang continued, "…this war requires more physicians than ever before. In peace-time, I will be very happy in settling down and study for a period of years. When in war-time, trained as a physician and a position held as mine and stay away from duties, feel

[435] For example, see Roger Greene to John D. Rockefeller, Jr., October 17, 1933 (RAC, CMB Records, Box 76 Folder 538).

[436] A. T. Steele, Special Correspondence, *The New York Times*, Feb. 11, 1934.

[437] Yang, "Wo de zizhuan," 150-51.

somewhat guilty."[438] Yang believed that her return to China might also inspire other physicians to follow her example.[439]

Communications with other MIH doctors provide further insight into Yang's conceptualization of MIH as a profoundly significant political enterprise. Yang showed little patience for those who harbored more individualistic motives for gynecological practice. When a fellow female doctor asked for an extension of her Rockefeller-funded study tour, Yang dismissed her request based on the critical place of MIH in China's war of resistance. She responded,

> Your desire to stay in the United States is not encouraging. We usually do give recommendations to extend fellowships…But we are in WAR now; we are among the few medical personnel we have in China; particularly in the field of the Maternity and Child Health Work. You and I know well enough that our work is suffering without you and I…You know as well as I do that the Maternity and Child Health personnel are far from enough…So I still suggest that you return...[440]

Here, as elsewhere, Yang articulated personal, political investments in MIH as critical to resisting imperialist aggression.

Yang's activities upon her return to China suggest what her correspondence omits, namely the specific value of MIH work to anti-imperialist struggles. In addition to hegemonic associations between scientific mothercraft and a global ranking of states, feminized caregiving in MIH attained sharper political meaning amid the thousands of women and children displaced by the Japanese invasion and the barriers to medical care exacerbated by the war in some locales. Some of Yang's students embedded themselves within communist guerrilla forces behind

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[438] Yang wrote in non-native English. See Yang to Stevens, March 23, 1942 (RAC, CMB Records, Box 77 Folder 540).

[439] Ibid.

[440] Yang Chongrui to Dr. Y. T. Yang, June 6, 1942 (RAC, CMB Records, Box 77 Folder 540).

Japanese lines, facilitating sterilized childbirth with crude instruments for rural women in war-torn regions. Others, like Yang herself, operated through Nationalist-state structures to aid a westward expansion of MIH enterprises from the new wartime capital of Chongqing. Through orphan relief work and lectures on scientific mothercraft in underserved regions, Yang aligned herself with nationalistic maternalism toward empowering those most vulnerable—namely women and children—in the face of disease and violence.[441]

In essays from this period, Yang articulated a shared assumption with statist rhetoric, namely the relationship between macropolitical conditions and the Chinese maternal role. For example, in a 1941 essay titled "The Cries of Children," Yang elevated comforting a crying child to "an individual's responsibility to benefit household, society, and country." Here, Yang framed her arguments in the language of state policy, asserting that "cultivating good habits in children is the foundational step in providing the country with good citizens."[442] However, when considered along with Yang's life, activism, and private correspondence, Yang's maternalist politics remain more capacious than the aims of the biopolitical state, informed by a global perspective and feminist consciousness. Within the context of war, Yang's writing portrayed motherhood and caregiving as integral to the resistance of Japanese imperialism, which had

[441] See Interview with Zuo Qi 左奇, *Ershi shiji zhongguo nüxing shi* 二十世纪中国女性史 vol. 8: *Shengyu geming* 生育革命. DVD. Directed by Feng Xuesong 馮雪松(Beijing: China Central Television, 1999); see also Yang Chongrui, *Fuying weisheng jiangzuo* 《婦嬰衛生講座》 (*Xinyun funü zhidao weiyuanhui* 新運婦女指導委員會, 1945), preface. Nicole Barnes has read Yang's work in orphan relief as the state diverting her from her work in gynecology, and a letter from John Black Grant mentions that Yang remained frustrated in her orphan relief work. However, Grant's letter emphasizes Yang's dissatisfaction with Soong May-ling's management of the orphan relief program rather an opposition to orphan relief work itself. Given the context of Yang's writing and career, I interpret aid to orphans as consistent with her broader political commitments. See Barnes, "Protecting the National Body," 280-81; see also Grant to "Betty and Jim" (his children), October 22, 1938, enclosed with Grant to Victor Heiser, November 10, 1938 (American Philosophical Society Archives, Victor Heiser Papers, Series I, Folder: Grant, Dr. John B.).

[442] Yang Chongrui, "Ertong de ku 兒童的哭," *Zhonghua jiankang zazhi*《中華健康雜誌》 3, no.2 (1941) :19-21.

wrought devastation upon Chinese women and children in particular. Her deference to the aims of the state illustrates not only points of convergence between feminist and biopolitical aims, but also the varied effects of maternalist ideology that at once enabled and delimited her feminist praxis.

Several aspects of Yang's career after the end of the war with Japan further demonstrate the consistency of her maternalist political positions. Yang's prominence in the developing field of global health led to a leadership position with the World Health Organization (WHO) in the later 1940s, and, as outlined later in Chapter Seven, the principles guiding the early work of the organization bore the influence of Yang and those who shared her maternalist views of health and welfare.[443] In contrast to others who, like Wu Zhimei, joined the Nationalists in Taiwan after the founding of the PRC, Yang left her post with the WHO to ultimately assume the directorship of the People's Republic of China's Maternal and Child Health Bureau in September 1950.[444]

Yang's brand of scientific maternalism diverged from the pronatalist aims of both Nationalist and early Communist states in China in her sustained promotion of birth control, a position that contributed to her downfall and political oppression as a "rightist" in 1957. Drawing from international contacts that included Margaret Sanger, Yang's promotion of birth control emphasized removing economic barriers for the poor, to advance both the vitality of the race and women's reproductive autonomy. In addition to eugenicist and Malthusian motives, Yang aimed

[443] "Maternal and Child Health" *WHO Chronicle* 3, no. 3 (March 1949): 45-6; see also James A. Doull and Morton Kramer, "The First World Health Assembly," *Public Health Reports* 63, no. 43 (Oct. 22, 1948): 1379-1403, 1386-88.

[444] See *Ershi shiji zhongguo nüxing shi,* vol. 8.

to reduce the physical suffering of her patients, for whom multiple births had caused prolapsed or ruptured uteruses and overstretched cervixes.[445]

These patients, along with Yang's students and colleagues in MIH, constituted a female community enabled by maternalist politics. Like many MIH practitioners of the era, Yang became a maternal exemplar despite never marrying or bearing children of her own.[446] Thus, for Yang and a number of her colleagues, the broader, political significance of the maternal role provided the conditions not only for advancing the health and economic independence of women, but also the circumvention of compulsory heterosexuality and lives centered on homosocial bonds.

Chen Guiyun 陳桂雲 and Yang Yongni 楊詠霓

Unlike many of the most prominent medical professionals, both Chen Guiyun and Yang Yongni came from comparatively humble beginnings. Chen's father worked as a manual laborer before opening a small restaurant in their native Manchurian city of Shenyang (Mukden). After studying at charitable girls' schools founded by missionaries, Chen entered the North China Union Medical College for Women, where a scholarship funding her education came with the condition that she work in missionary-funded hospitals after graduation. She returned to Shenyang upon graduation in 1921 to practice medicine at Shenyang Women's Hospital and teach at Liaoning Medical College.[447]

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[445] Ibid.; Diary of George C. Payne, December 30, 1947 (RAC, RG 2 Series 601 Box 387 Folder 2608); Robert Briggs Watson to Dr. Yang, October 27, 1947 (RAC, RG 2 Series 601 Box 387 Folder 2609).

[446] See Johnson, *Childbirth in Republican China,* 35, 107.

[447] *Gansu wenshi ziliao xuanji* 《甘肃文史资料选辑》Vol. 23 (Lanzhou: Zhongguo renmin zhengzhi xieshang huiyi gansusheng weiyuanhui wenshi ziliao yanjiu weiyuanhui 中国人民政治协商会议甘肃省委员会文史资料研究委员会，1985), 60-63.

According to histories written in the later ear of the People's Republic of China, Chen's political consciousness vis-a-vis medical practice emerged through the tumult of 1930s Manchuria. In 1931, the Mukden Incident led to full-scale Japanese colonization under the puppet-state regime of Manchukuo. Two of Chen's brothers entered forced labor as punishment for resistance. Fearing for her own safety, Chen fled Manchuria to pursue specialized skills in gynecology under the mentorship of Dr. Yang Chongrui in Beiping. From 1931-34, Chen and Yang Chongrui trained midwives and treated mothers as two of only four doctors at Beiping's First National Midwifery School (FNMS).[448]

Yang Yongni was born Yang Qiongxian 琼仙 in distant Sichuan, where she studied in missionary schools throughout girlhood. Yang then attended a normal university and worked as a teacher in Chongqing from 1926 to 1930. In August of 1930, Yang left Sichuan to enter the midwifery training program at FNMS in Beiping, where she met Chen Guiyun. There, the two formed an enduring partnership. Chen nor Yang ever married, but remained lifelong companions with shared commitments to midwifery education and MIH.[449]

Chen and Yang became pioneering figures in the westward expansion of MIH programs in China. In 1934, the pair left Beiping together for the northwestern city of Xi'an, where they founded a provincial midwifery school and maternity hospital.[450] During their time in Xi'an, Chen wrote an article for a provincial magazine that sheds light on her social positioning and her

[448] Ibid., see also Marion Yang, First National Midwifery School - Fifth Annual Report, 1933-4 (RAC, Rockefeller Foundation Archives, RG 5, Folder 2774).

[449] Zhonggong Gansu sheng weixuan jiaoyu sufan wuren xiaozu 中共甘肃省委宣教育肃反五人小组, "Guanyu Yang Yongni an de pifu 关于杨永霓案的批复," January 23, 1959 (Gansu Provincial Archives, Lanzhou); *Gansu wenshi ziliao xuanji* 《甘肃文史资料选辑》, 62-66; *Gansu sheng zhi weisheng shiye* 《甘肃省之衛生事業》(Lanzhou: Gansusheng zhengfu 甘肃省政府, 1942).

[450] Ibid.; see also *Gansu wenshi ziliao xuanji* 《甘肃文史资料选辑》, 62-66.

perception of the political stakes of mothercraft, especially when read alongside her other writing and the record of her life. In this article, Chen, who never bore any children of her own, positioned herself as an expert in mothering including but going beyond issues of health or hygiene. Modeling the habits of the virtuous mother, Chen wrote,

> For example, when a child cries, if a mother says, "Don't cry or a tiger will come and bite you," then the child will hold this idea in his mind forever. Even when the child is grown, if he sees a child crying, he will tell them, "Don't cry, or a tiger will come!" This child will acquire honorable habits from the time he is small. If parents teach children from an early age not to spit on the ground or throw things, then he will also in time become a model of good behavior. As the child grows up he naturally will have these good habits and will lead other children down the right path.[451]

Associating herself with dominant tropes in statist rhetoric, Chen asserted the indigeneity of skilled mothercraft with references to the *Three Character Classic* (Sanzi jing) and the unimpeachable example of Mencius's mother. Mencius, she argued, grew to become a preeminent sage due to the fact that his mother "understood how to foster an environment beneficial to a child."[452] Thus, from antiquity to the present Chen argued, Chinese women's rearing of children had constituted gendered and critical service to civilization.[453]

This turn to indigenous culture affirmed the rhetoric of the Nationalist state vis-à-vis motherhood, as did Chen's explicit references to mothercraft as an integral component of the state's New Life Movement. But, reading this text alongside Chen's later writing presents a more complex picture of the motives surrounding her medical practice. Chen, along with Yang, traversed thousands of miles to found clinics and schools in rural and remote areas through

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[451] Chen Guiyun 陳桂雲, "Ertong jiaoyu yu huanjing 兒童教育與環境，" *Shaanxi jiaoyu yuekan*《陝西教育月刊》 8, no. 2 (1935).

[452] Ibid.

[453] Ibid.

careers that spanned five decades and both Nationalist and Communist regimes. As outlined later in Chapter Seven, Chen also couched her advocacy of MIH and scientific mothercraft within the rhetoric and campaigns of the Communist state, strategically attaching her personal and political objectives to the broad policy aims of the state. Across this dramatic shift in framing, from references to Mencius' mother and the New Life Movement to an emphasis on Mao Zedong's leadership and the Great Leap Forward, Chen remained consistent in her advocacy for women's reproductive health, in her social positioning as an expert in a skilled science of mothering, and in the broad political significance of women's reproduction for society, state, and China's status among nations.[454]

In September 1938, Chen's demonstrated abilities in gynecology and administration attracted the interest of the Nationalist government, which recruited her to an administrative post in Chongqing. Chen accepted the position, but soon grew restless and dissatisfied. Like Yang Chongrui, she reportedly preferred treating patients to administrative tasks. According to official histories, Chen also felt that her medical expertise was both of critical importance to the war effort and wasted in administration. Growing increasingly dissatisfied with both her work and the Nationalist government's response to the Japanese invasion, Chen abandoned her post in Chongqing after roughly one year. In December 1939, she relocated with her companion, Yang Yongni, to Lanzhou in remote Gansu province.[455]

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[454] See Chapter Seven of this dissertation. See also Chen Guiyun 陈桂云, "Chen Guiyun daibiao zai sheng erjie yici rendaihui shang de fayan (sheng baojian yuan) 陈桂云代表在省二届一次人代会上的发言（省保健院）" 1958 (Gansu Provincial Archives, Lanzhou); Chen Guiyun 陈桂云, "Jibing saochu shenti zhuang—shenghuo meimanle yang yang—Chen Guiyun weiyuan de fayan 疾病扫除身体壮　生活美满乐洋洋 陈桂云委员的发言," *Renmin Ribao* 《人民日报》, April 16, 1960.

[455] *Gansu wenshi ziliao xuanji* 《甘肃文史资料选辑》, 62-66; Zhonggong Gansu sheng weixuan jiaoyu sufan wuren xiaozu 中共甘肃省委宣教育肃反五人小组, "Guanyu Yang Yongni an de pifu 关于杨永霓案的批复."

The move to Lanzhou coincided with an influx of migrants and national interest in the region. Refugees fleeing Japanese violence in the East poured into Lanzhou by the thousands along with significant investments in infrastructure and public health by foreign philanthropists and the Nationalist government.[456] To relieve the overextended provincial health minister Yang Shuxin, Chen took over directorship of the recently founded Gansu Provincial Midwifery School and began work to expand the size and scope of the school's activities.[457]

Yang Yongni reflected on this period of her work with Chen Guiyun in a 1948 article about midwifery and MIH in China's northwestern frontier. Articulating the integrated politics of feminism, maternalism, and nationalism that shaped her practice, Yang wrote,

> The health and strength of the people remains intimately related to whether or not their nation flourishes or prospers, exists or perishes. If we examine the reason why Western nations are strong, we can see that it results from the quality of physical health and the development of public health programs. The aspect of public health work most relevant to the strength of the people and the growth of the population is maternal and infant health work.[458]

Here, Yang cited statist notions of public health as fostering a strong citizenry while emphasizing the primacy of her work to relieve the bodily suffering and economic oppression of China's women. Echoing the mission articulated earlier by Yang Chongrui, Yang Yongni outlined a commitment to midwifery education that aimed not only to benefit parturient women, but also to spur the development of educational and career opportunities for women to empower them against economic oppression. These intertwined missions held particular importance in the

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[456] See Chapter Four of this dissertation.

[457] Gansu sheng zhengfu 甘肃省政府, "Ziwei Yang Shuxin jian dai Gansu shengli Lanzhou gaoji zhuchan hushi zhiye xuexiao xiaozhang 茲委楊樹信兼代甘肅省立蘭州高級助產護士職業學校校長," September 8, 1939 (Gansu Provincial Archives, Lanzhou); see also *Gansu wenshi ziliao xuanji,* 62-66.

[458] Yang Yongni 楊詠霓, "Tan yi tan xibei zhuchan shiye yu zhuchan jiaoyu 談一談西北助產事業與助產教育 ," *Zhuchan xuebao*《助產學報》1, no. 1 (1948): 33-35, 33.

Northwest, where both educational and medical institutions remained scarce. To support her claims of progress, Yang cited not only the more than 150 births that the expanded school and clinic oversaw each month, but also the scores of female students who had seized the state-supported opportunity to pursue training and careers in midwifery. According to Yang's report, the clinic at the Lanzhou midwifery school overseen by Chen Guiyun saw more than 1100 patients annually by 1947.[459]

As in the case of Yang Chongrui, the broad elevation of women's reproduction and caregiving provided the conditions for Chen and Yang Yongni to shape public policy, empower other women, and build lives centered on female bonds. The investments of the Nationalist state and foreign philanthropists in a politically significant, expanded maternal role informed a repertoire of strategies for feminist career women to maintain positions of influence and to address gendered, systemic oppression. As outlined later in Chapter Seven, Chen and Yang remained committed to these aims in Gansu across the rupture of 1949, even as a radically altered political landscape required a shift in their allegiances and rhetoric as well as a negation of their earlier work in the Nationalist decades.

Wu Zhimei (Wu Chi Moy/ Ng Chi Mooy) 伍智梅

The sparse treatment of the Cantonese doctor Wu Zhimei in Anglophone historiography is striking when considered against her notoriety during the Nationalist decades.[460] Wu's natal family earned renown throughout Guangdong province for both medical practice and

[459] Ibid., 33-35.

[460] The few, brief mentions of Wu Zhimei have emphasized her suffragist activism over public health advocacy. See Gilmartin, *Engendering the Chinese Revolution*, 241n5; Louise Edwards, *Gender, Politics, and Democracy: Women's Suffrage in China* (Stanford, CA: Stanford University Press, 2008), 114-16; 178-80, 203-18.

revolutionary politics. Her father, Wu Hanchi, founded clinics as a biomedical doctor before joining the revolution that overthrew the Qing dynasty in 1911-12. Wu Zhimei followed her father's example as a politically engaged doctor within the bounds of normative femininity. After earning a medical degree from the missionary-founded Hackett Medical College for Women, she joined the Nationalist Party (before its rise to power) as a founding member of the United Women's Association (UWA) in 1921.[461]

Competing allegiances and aims shaped Wu's early adult life. By some accounts, Wu followed more traditional ideals of feminine virtue fused with her family's Christian beliefs. In compliance with familial obligations, she entered into an arranged marriage in 1919 and bore four children within the next six years. She notoriously opposed the inclusion of concubines in women's organizations based on what she perceived as their suspect morality. When her husband fell ill, she complied with her father-in-law's dictum that he be treated solely by literati physicians.[462]

During this same period, Wu rose within the ranks of the Nationalist Party as an advocate for women's suffrage, while also treating patients and overseeing a hospital for women and children. She made a lasting impression on the American suffragist Grace Seton Thompson during her visit to Guangdong in the early 1920s. In stories that circulated in *Reader's Digest, Our World,* and the book *Chinese Lanterns,* Seton Thompson quoted Wu as making explicit the feminist aims behind her medical practice. Wu reportedly asserted, "Women have suffered so

[461] "Wu Zhimei shishi xiaoxi 伍智梅逝世消息," *Zhongyang Ribao* 中央日報, November 13, 1956; Li Youning 李又寧, "Wu Zhimei yu Guomindang 伍智梅與國民黨," in *Zhonghua minguo jianguo bashinian xueshu taolun ji*《中華民國建國八十年學術討論集》 vol. 1, eds. Zhonghua minguo jianguo bashinian xueshu taolunji bianji weiyuanhui (Taipei: Jiandai Zhonguo Chubanshe, 1991), 413-47.

[462] Li, "Wu Zhimei yu Guomindang." see also Gilmartin, *Engendering the Chinese Revolution,* 241n5.

long…they must have power…They must be educated and know how to stand up for themselves."[463] These statements foreshadowed the political attitudes and foreign contacts that would inform Wu's activism later in life.

In what some have interpreted as a result of her father-in-law's prohibitions on biomedical treatment, Wu's husband died from illness when she was twenty-seven years old. The event signaled a turning point for Wu that gave focus to her pursuits. She left her four children in the charge of extended family and vowed to devote the remainder of her life to public service and her political goals. Wu never remarried. Instead, she began lifelong political advocacy for women's and children's health and welfare that moved between local, national, and international scales.[464] Her apparent personal rejection of narrowly defined roles of wife and mother ironically aided an embrace of a broader maternal role rooted in the transnational, political elevation of women's caregiving.

In 1927, Wu embarked on a tour of Cuba, Canada, Mexico, and the United States sponsored by the provincial government for the purposes of raising funds and "investigating matters related to childhood education."[465] This trip fostered exchanges with women's groups abroad and thereby an expanded conception of feminist activism. Wu's assessment of the trip upon her return in late 1929 pointed to examples of maternalist feminist praxis that could enhance the material conditions shaping Chinese women's lives. As a model, she highlighted the American chapter of the International Alliance of Women, which had begun with a focus on suffrage but later came to prioritize labor conditions and health due in part to a diversification of

[463] Seton Thompson, *Chinese Lanterns,* 264-65.

[464] Li, "Wu Zhimei yu Guomindang."

[465] Wu Zhimei, "Nülianhui huanying xishang yanshuoci 女聯會歡迎席上演說詞, *Guangzhou minguo ribao* 《廣州民國日報》, Dec. 3, 1929.

its membership. Specifically, Wu singled out the successful founding of the Women's Bureau within the U.S. Department of Labor as a model for advancing women's material wellbeing and economic independence through state institutions.[466]

Wu conducted additional tours throughout Europe, North America, Southeast Asia, and Australia while rising in the Nationalist Party government during the 1930s.[467] In China, Wu advocated for measures targeting women's health and welfare through the official organs of the Nationalist state. As a representative to the National Congress of the Nationalist Party, Wu drafted a petition that demonstrated a now global perspective on the political significance of public health.

> The rise and fall of nations is related to the health of the people; if the masses are strong, the country is strong. This is a certain truth...If citizens truly understand the way of public health, the country will become a healthful environment, thus the productivity of society will surely increase and the national economy will naturally prosper, thereby benefitting the strength of the nation.[468]

Wu's petition made use of widely held assumptions within and beyond the Nationalist state regarding the links between public health and national survival. But her petition also pointed to the state's failures to live up to its promises, thereby using the state's own assumptions to justify demands for additional resources. Pointing specifically to the state of maternal and infant

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[466] Ibid., Wu zhimei dao hu ji fu mei kaocha jiaoyu 伍智梅到滬即赴美考察教育," *Zhongyang ribao* 《中央日報》 (Sept. 3, 1932); see also "Zhu Masai lingguan tongxun 駐馬賽領館通訊," *Waibu zhoukan* 《外部周刊》 83, no. 27, Sept 4, 1935.

[467] "Woman Doctor from Canton Studying Local Health Services," *The Straits Times* (Singapore), June 6, 1935, 12.

[468] Wu Zhimei, "Cujin wancheng woguo gongong weisheng xingzheng sheshi jihua an 促進完成我國公共衛生行政設施計畫案," Fifth National Congress of the Nationalist Party (Nanjing: 1935) (Nationalist Party Archives, Taipei).

mortality amid a host of public health concerns, Wu lobbied for special education programs for mothers and routine health examinations in schools.[469]

Throughout the war with Japan, Wu supplemented her policy proposals in official organs of government with caregiving to orphans and collections of donations for wounded soldiers. Wu understood these acts as indivisible from feminist activism, rather than compulsory acts of sacrifice to the state. At the conclusion of the war, Wu articulated the enduring connections she perceived between feminized caregiving, feminism, and anti-imperialist nationalism. In a women's magazine of her home province, Wu framed her advocacy for the health and welfare of women and children as integral to both the pursuit of "gender equality" and a now decades-long effort to resist imperialism. After tracing the role of Guangdong-based women's organizations across three-and-a-half decades through the Xinhai Revolution (1912), the May Fourth Movement (1919-25), the founding of the Nationalist Republic (1927), and the war of resistance against Japan (1937-45), Wu offered a vision of a feminist future in which constitutional protections for women's health and welfare guaranteed material foundations for political suffrage and economic independence.[470]

As outlined further in Chapter Six, Wu's renewed commitment to women's health and child welfare as feminist causes rested also on a reflexive assessment of previous weaknesses in the women's movement. Here, Wu's activism increasingly bore the indirect influence of socialist ideas circulated in Chinese feminist media in the years during and immediately after the war with Japan. In the wake of a war that had relocated the Nationalist capital to the remote southwest and had displaced thousands of rural villagers, Wu acknowledge the limits of a movement that had

[469] Ibid.

[470] Wu Zhimei, "Guangdong funü yundong zhi huigu 廣東婦女運動之回顧," *Shidai funü*《時代婦女》1 (1946): 5-7.

once centered on the needs and perspectives of urban, educated women from eastern China. Pointing specifically to the precarious state of rural Chinese women, Wu listed "the issue of rural health work" among the primary foci for the future of a nationalistically inflected maternalist feminism. In this article and in formal petitions within the Nationalist state, Wu advocated for improved rural sanitation, a state-subsidized medical system that provided free healthcare to all, and MIH classes that would make use of drama and healthy infant competitions to engage illiterate peasants and refugees.[471]

Conclusion

The women surveyed in this chapter provide but a few examples of many politically engaged female medical professionals who advanced feminist agendas through maternalist symbols and roles during the Nationalist decades. That avowedly feminist, single, career women associated themselves with nationalistic investments in motherhood to advance critiques of both imperialism and the Nationalist state points toward a reassessment of the politics of motherhood in China. The elevation of women's reproductive and caregiving roles in China resulted, in part, from a global alignment of macropolitical and social realms that produced diversified effects. On the one hand, the political significance of feminine reproduction and caregiving aided disciplinary, statist aims that delimited women's roles. But, on the other hand, the linking of broadly conceived maternal labor to national strength and international hierarchies fostered new spaces for women to redress the gendered effects of disease and violence. For some, these conditions also facilitated economic independence and a circumvention of compulsory

[471] Ibid.; see also Chapter Six of this dissertation; Wu Zhimei 伍智梅, "Qing jianli gongyi zhidu yi zengjin guomin jiankang an 請建立公醫制度以增進國民健康案," Sixth National Congress of the Nationalist Party (Chongqing: 1945) (Nationalist Party Archives, Taipei); Edwards, *Gender*, *Politics, and Democracy,* 220-25.

heterosexuality. The emphasis on motherhood as a skilled, scientific craft that elevated the careers of some also affirmed hierarchies between women based class and varied capacities to nurture. However, as the cases above and the next chapter illustrate, the encounters fostered by MIH practice also alerted some middle- and upper-class women to the particular suffering of lower classes, leading them to expand the scope and focus of their activism.

This study of Nationalist China advances the broader historiography of maternalism by highlighting transnational origins and effects. Comparative studies have affirmed the global prevalence of maternalist politics while noting its varied impact within particular nation-states. The analysis here highlights not only intertwined histories of maternalisms but also their shared, global conditions. The historical developments animating Chinese maternalism—the woman question, imperialism, nationalism, eugenics, and public health—remained global phenomena that linked the nurturing roles of women to hierarchies of nations, states, and races. The effects of this alignment were both disciplinary and productive, divisive and binding. While shoring up hierarchies between women and aiding disciplinary aims of states, maternalism also conditioned and delimited a transnational feminist praxis aimed at combatting the bodily suffering and systemic oppression of women and children. The next chapter further demonstrates the utility of maternalism as feminist praxis in China, with a focus on Wu Zhimei's advocacy for a modern welfare state through her positions within the Nationalist government during the later 1940s.

Chapter 6: Differences that Confound:

Maternalist Solidarities, Gendered Citizenship, and the Welfare State

MIH's diffused influence across international philanthropy, national policy, and local governance had unexpected effects for the Chinese women's movement. As outlined in the previous chapter, converging investments in women's reproductive health produced new subject positions for Chinese women, thereby conditioning new modes of feminist praxis. This chapter delves deeper into the effects of these developments by examining feminist campaigns for health and welfare from the mid-1930s to the late 1940s.

The allocation of state resources for women's health, codified in the 1947 Constitution, emerged through more than a decade of struggle that refashioned the subject and scope of a particular Chinese feminism. During the dozen or so years examined here, the relocation of many urban women from the East to western China as a result of war forced them to confront the suffering of women in the interior. This remained especially true for women who practiced medicine. A Second United Front between Communist and Nationalist forces, though fragile and short-lived, further facilitated exchange and collaboration between Chinese women with differing partisan affiliations.[472] The continued movement of Chinese women throughout the world, most often through the funding and connections of the Rockefeller Foundation and the

[472] Louise Edwards, *Gender, Politics, and Democracy* (Stanford: Stanford University Press, 2008), 223; see also Danke Li, *Echoes of Chongqing: Women in Wartime China* (Urbana and Chicago: University of Illinois Press, 2010), 130-31.

League of Nations, led many women to envision the global stakes of their activism and an international women's movement. In feminist media, these varied perspectives shaped a reflexive critique of the earlier Chinese women's movement, ultimately coalescing in a campaign that affirmed women's shared and unique capacity to reproduce and nurture while emphasizing the differences between women highlighted by the pervasive metrics and vocabulary of MIH.

Scholars have debated the conceptualization of equality and difference in the historiography of feminism both within and beyond the Chinese case. In Chinese studies, Tani Barlow argued that "progressive Chinese feminism's" acceptance of the Victorian sex binary, though necessary for envisioning the subject of feminist theorizing, also entailed a concession of women's inherent inferiority to men.[473] Wang Zheng rebutted this view, arguing that May Fourth-Era Chinese feminism embraced liberal humanism as a more powerful alternative to Confucian hierarchies than the Victorian sex binary. Wang argued, "Chinese women…were not regulated to become the 'other' of man, but rather, were called on to be the same as man."[474] Louise Edwards, with limited attention to Wu Zhimei's advocacy for suffrage, revisited the question of equality and difference, framing the two categories as strategic options. After affirming Wang's analysis of the May Fourth Era, Edwards argued that the later-1940s push for guaranteed quotas in legislative bodies required a shift in strategy from a campaign rooted in equality to one asserting difference. Edwards argued that this campaign succeeded due to a compelling case that "women's difference from men required special political provisions."[475]

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[473] Tani E. Barlow, "Theorizing Woman: *Funü, Guojia, Jiating,*" in *Body, Subject, and Power in China,* ed. Angela Zito and Tani E. Barlow (Chicago: University of Chicago Press, 1994): 253-89; see also Tani E. Barlow, *The Question of Women in Chinese Feminism,* (Durham: Duke University Press, 2004), 37-55.

[474] Wang Zheng, *Women in the Chinese Enlightenment: Oral and Textual Histories* (Berkeley and Los Angeles: University of California Press, 1999), 18-19.

[475] Edwards, *Gender, Politics, and Democracy: Women's Suffrage in China*, 195.

As Joan Scott noted nearly three decades ago, the framing of "equality" and "difference" as oppositional categories has more accurately characterized movements seeking to delegitimize feminist claims than women's movements themselves. Scott rejected the false assumption that equality must connote sameness. Rather, the "critical feminist position," she argued, must refuse hierarchies, "not in the name of an equality that implies sameness or identity, but rather…in the name of an equality that rests on differences—differences that confound, disrupt, and render ambiguous the meaning of any fixed binary opposition."[476]

Archives provide little support for the notion that the Chinese feminists surveyed here embraced either similitude with men as a condition of equality or the homogenizing effects of a facile framing of binary, gendered difference. Rather, the feminist framing of "gender equality" in this context rested on a belief that equality could only be realized through sustained engagement with intersecting differences between and within genders and across national borders. Rather than merely arguing that every citizen deserved the same opportunities and rights, feminists asserted that *de jure* equality remained meaningless without guaranteed resources and legal protections to address structural inequities between women.

These claims by Chinese feminists rested on notions of gendered citizenship that also appeared in anti-feminist discourses. I have dubbed these discourses "exclusionary narratives" to highlight their intended effect of justifying the withholding of full citizenship to women. Both feminist and exclusionary narratives surrounding maternalism asserted that all women possessed a unique capacity to nurture, and that this capacity remained fundamental to their relationship to the state. Many feminists active in the legislative, advisory, and bureaucratic organs of the Nationalist state embraced these notions while challenging policies that assumed a self-evident

[476] Joan W. Scott, "Deconstructing Equality-versus-Difference: Or, the Uses of Postructuralist Theory for Feminism," *Feminist Studies* 14, no. 1 (spring 1988): 32-50, 48-9.

constituency of women with identical access to resources. These actors, many of whom were biomedical doctors, rarely refuted the "facts" of maternal and infant mortality, the links between these metrics and the individualized acts of childbirth and mothering, or the notion that biomedical methods remained optimal for childbirth and childrearing. Rather, they pointed to these very "facts" to highlight differing levels of access to the biomedical care, education, and economic resources required for republican, scientific mothercraft. In contrast to exclusionary narratives which blamed women for China's comparatively abysmal rates of maternal and infant mortality, feminists reframed these "facts" as evidence of systemic oppression and the Nationalist bureaucracy's failure to fulfill the reciprocal duties of citizenship.

In this chapter, I first outline exclusionary narratives in Nationalist China that emphasized Chinese women's ineffectual nurturing to justify withholding citizenship. I then show how Chinese feminists intervened in this narrative. Drawing from the vigorous debates published in feminist media, I outline how certain figures in the women's movement pursued solidarities across a broadly imagined constituency of women, rooted in the now pervasive notion of women's shared yet varied capacity to reproduce and nurture. From these debates emerged not a reductive sisterhood, but rather a solidarity forged through sustained engagement with differences between women, even as it affirmed an essentialist view of feminine reproductive capacity.[477] The exchanges recorded in feminist media produced a political campaign that brought socialist notions of structural inequity and economic justice to bear on the platform of the Nationalist Party and the policies of the Chinese government. Based primarily on Wu Zhimei's formal petitions to the representative bodies of the Nationalist Party and Republic

[477] I take this notion of "solidarity" from Chandra Talpade Mohanty, who has argued that "solidarity is always an achievement, the result of active struggle to construct the universal on the basis of particulars/differences." See Chandra Talpade Mohanty, *Feminism Without Borders: Decolonizing Theory, Practicing Solidarity* (Durham: Duke University Press, 2003), 7.

of China, I further demonstrate that the design of a universal, subsidized healthcare system, along with constitutional protections for women's health and welfare, resulted, in part, from maternalist solidarities forged in the Chinese women's movement, conditioned by the rise of biomedical MIH.

Gendered Difference in the Narrative of Exclusion

In 1940, a male, Nationalist-party official named Fang Qingru 方青儒 affirmed widely circulated notions regarding the relationship between Chinese women and the Chinese state. His treatise, though circulated primarily within his home province, provides a representative example of exclusionary narratives. Women, Fang argued, possessed particular capacities to reproduce and nurture that remained vital to the state's futurity and strength. Fang opined that, given the critical importance of women's reproductive labor, women's contributions to society and state were ultimately of greater consequence than those of men. Fang framed these roles as "women's responsibilities" that Chinese women had yet to fulfill. Fang elevated these responsibilities over women's rights of suffrage, arguing that the women's movement's misguided priorities hampered China's war of resistance against Japan.[478]

Fang offered two reasons for delaying full citizenship to women, framed as "guidelines for the future of the women's movement." First, he argued, women had failed to contribute adequately to China's economy. As a result, productive labor had fallen disproportionately on

[478] Fang Qingru 方青儒, "*Jinhou fuyun de liang da fangzhen* 今後婦運的兩大方針," Zhejiang Minzhong 《浙江民眾》no. 3 (1940): 2 − 3. Fang Qingru served in various bodies of the Nationalist government at local, provincial, and national levels throughout the 1930s and 1940s. In 1940, while much of Zhejiang remained under Japanese control, Fang held the position of committee member of the provincial department of the Nationalist party. In late 1940, he joined the national People's Political Council. See Liu Guoming 刘国铭, ed., Zhongguo Guomindang bainian renwu quanshu 《中国国民党百年人物全书》 vol. 1 (Beijing: Tuanjie chubanshe 团结出版社, 2005), 93.

the shoulders of men. Though Fang argued that the physical limitations of women kept them from many difficult occupations, he maintained that women could and should become teachers, shopkeepers, bank tellers, and factory workers. "Diligent productive labor," he argued, would "not only increase the country's resources, solve the problem of rural poverty, and increase the strength of the war of resistance, but also help women obtain social status and achieve real progress in the movement for gender equality."[479]

By 1940, such arguments for withholding citizenship from women were common, if not trite. The notion of Chinese women as unproductive, parasitic consumers had been a trope repeated by male intellectuals for more than half a century.[480] However, Fang's second "guideline" deployed more recently elevated discourses of MIH, giving newer vocabulary to a familiar narrative that blamed women for China's perceived backwardness and subjugation in the current international order of nation-states. The indisputable facts of inferior Chinese bodies, he argued, hindered China's economy and its war effort, as well as the entry of women into politics. In particular, the unhygienic practices of mothers exacerbated the current national crisis. Fang asserted that women's ignorance regarding health and hygiene had led to high rates of infant mortality and the spread of contagion. The deficiencies of Chinese bodies resulted from women's inept and unscientific mothering, Fang claimed, as he cited a lack of attention to prenatal health, improper nursing, and inadequate childhood nutrition.[481]

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[479] Ibid., 2.

[480] This has been well-documented in the gender history of the late-Qing period, but Francesca Bray offers perhaps the pithiest summation and critique of this argument. See Francesca Bray, *Technology, Gender and History in Imperial China: Great Transformations Reconsidered* (New York: Routledge, 2013), 118-20.

[481] Fang, "Two Guidelines for the Future of the Women's Movement," 2-3.

Like the feminists he criticized, Fang maintained a global perspective regarding the stakes of MIH. Pointing to the links between China's subjugated status on the world stage and women's nurturing, he asserted,

> It has been said that the reason why the physical health of us Chinese is inferior to that of Europeans and Americans is that European and American children receive nurturing and education superior to that seen in our country. These arguments have merit. In these matters of nurturing and education, of education within the home, ninety percent of the burden lies with our female compatriots.[482]

For Fang, any discussion of women's rights had first to address these failures of Chinese women, on whom he placed the double-bind of productive and reproductive labor as prerequisites of citizenship. "Now we talk of the women's movement," he continued, "but these issues must be understood: because Chinese women, despite their great responsibilities, remain largely ignorant, without great ability, and physically unhealthy, a true awakening must happen among them so that they can fulfill these responsibilities."[483] Fang's statements took for granted a self-evident and homogenous "woman," whose primary impediment to citizenship remained her ignorance and lack of will. As recent scholarship has noted, many voices in the Nationalist decades echoed Fang's articulation of skilled motherhood as women's necessary sacrifices to the state.[484]

Fang's words point toward the maternalist ideologies undergirding Chinese women's citizenship in the Nationalist state, similar to dynamics elsewhere in the world. As outlined in Chapter Five, the woman question, the advent of public health, and new modes of imperialism made women's reproduction and nurturing integral to a hierarchical order of nation-states.

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[482] Ibid.

[483] Ibid.

[484] Ibid., For historiographic examples, see Sarah E. Stevens, "Hygienic Bodies and Public Mothers: The Rhetoric of Reproduction, Fetal Education, and Childhood in Republican China," in *Mapping Meanings: The Field of New Learning in Late Qing China* (Leiden: Brill, 2004): 659-684*;* Nicole Barnes, "Protecting the National Body: Gender and Public Health in Southwest China during the War with Japan, 1937-45" (PhD diss., UC Irvine, 2012).

Within China, these developments legitimated the embrace of putatively traditional gender roles to constitute definitive characteristics of womanhood and gendered civic duties. But these foundational assumptions provided the basis for a variety of political claims including but not limited to those articulated by individuals like Fang Qingru. Feminist voices also leveraged maternalist arguments to advance women's status, enhance women's wellbeing, and, as this chapter demonstrates, articulate political claims for the health and welfare of a broadly imagined constituency of women.

Engaging Differences in Chinese Feminist Media

As noted in the introduction to this chapter, interrelated national and global developments of the later 1930s and 1940s shaped debates in Chinese feminist media regarding the subject and scope of what writers commonly referenced as "the women's movement 婦女運動." The increased encounters between women of varied classes, partisan affiliations, regions, and nations initiated a reflexive, often explicit, critique of a Chinese women's movement that had hitherto centered on eastern, urban, middle- and upper-class women. Beginning in the mid-1930s, contributors to women's periodicals increasingly devoted attention to the plight of rural and working women both within China and around the world. These debates remained shaped in profound ways by the ongoing strife between Nationalist and Communist forces within China that often manifested in socialist-inflected critiques of Nationalist policy and organizations. Much of this discourse shared with exclusionary narratives an investment in women's shared and unique capacity to reproduce and nurture. However, while exclusionary narratives blamed women's ineffectual nurturing for China's subjugated status, feminist media tended to highlight systems of oppression that gave women differing levels of access to the prerequisite resources of

scientific mothercraft.

One early example from the magazine *Women's Resonance* foreshadowed later efforts to forge solidarities across classes, nations, and political parties. This anonymous and comparatively lengthy article published in 1935 put forth a scathing critique of the Chinese women's movement. From the outset, the author associated herself with the very movement she criticized while making clear its primary failures. She wrote, "Our past activism on behalf of women has been limited to urban intellectuals, with no one showing any interest in rural women who are sinking into the eighteenth level of hell."[485] According to this author, the women's movement had been "plagued by empty words and lukewarm passion," with a focus on ending footbinding and expanding education in urban areas while ignoring, if not contributing to, the oppression of rural women. Given that China's population remained largely rural, she argued, the women's movement had thus far had limited impact.[486]

In addition to critiquing an exclusionary women's movement, the author further attacked hollow commitments to "gender equality" that permeated state policy and propaganda. "Since the unification of the Republic," she asserted, "'gender equality' has become a pervasive slogan, but many key players in the women's movement—reveling in a kind of false equality—remain unwilling to do anything of benefit for women among the masses."[487] The government's emphasis on equality between the sexes had rung hollow because of the failure to engage with the systemic forces that divided women of different regions and classes. According to this

[485] Yi 谊，"*Nongcun funü wenti* 農村婦女問題," Funü gongming《婦女共鸣》4, no. 1 (1935): 13-18, 13.

[486] Ibid., 13.

[487] Ibid., 13.

author, "women workers and rural women remain[ed] just as they were before the revolution, continuing in their slave life. What a grievous matter this is!"[488] The author's opening critique thus advanced a formulation of gender equality indivisible from an engagement with differences between and within genders. The capacious goal of equality for all women required simultaneously addressing gender hierarchy and the structural inequities that divided women of differing regions and classes.

The author drew explicitly from German thinker August Bebel's critique of "the capitalist class," making apparent the impact of transnational socialist thought on her feminist consciousness. Though the author made clear that investments in rural women's health, education, and welfare had implications for the survival of the Chinese *minzu*, her political consciousness remained more capacious than mere allegiance to the Chinese state. From the perspective of the international socialist movement, the author connected the plight of rural Chinese women to that of the working classes around the world. Recounting the plight of European masses in the years surrounding the First World War, she wrote,

> After enduring hundreds of years of oppression, the working classes were becoming increasingly civilized and developing class consciousness. The working classes were able to seize the opportunity of the war in Europe to expand class struggle to all of the factories of the world, culminating in the Russian Revolution. But women, who have suffered thousands of years of oppression, remain in bleak villages without any opportunity to develop such a consciousness.[489]

Here, socialist notions of class struggle came to bear on the author's indictment of the women's movement. However, these global perspectives shaped not only models for mobilizing rural Chinese women, but also an adjustment of global socialist ideals based on the particularities of

[488] Ibid., 13.

[489] Ibid., 14-15.

the Chinese case. In this article, the author's positioning as a Chinese feminist led her to use gender and the locally salient category of the rural to intervene in transnational discourses regarding class, perpetuating a dialogue between global and local dynamics that would continue to shape the refashioning of the Chinese women's movement into the war.[490]

While highlighting intersecting differences of gender, class, and urbanity that cut across nation-states, the author affirmed a uniquely feminine capacity to reproduce and nurture as the basis for a collective woman. However, a woman's capacity to reproduce and nurture in a biomedically sound mode rested on access to medical knowledge, healthcare, and a hygienic environment. The author argued, "If our hope is for women to become the backbone of the current *minzu*, caretakers of the future *minzu*, major players in economic production, and members of the political elite, then first we must provide women with complete dignity by making them healthy in body, spirit, and mind."[491] Further, she wrote, "If we consider the issue of children, we must first consider that women are not only current citizens, but are also the mothers of the next generation of citizens. We must have healthy and whole mothers before we can have healthy and whole children."[492] This statement echoed exclusionary narratives of republican motherhood as a prerequisite of citizenship. But in this author's treatise, these notions provided the basis for calls to redress the particular oppression of rural women.

> Readers, if you yourselves were from a rural village, consider what your childhood would have been like compared to that of someone who had grown up in the city. How do children who grow up with the guidance of a skilled, urban mother become intelligent, vivacious, and healthy? Now, consider that five-to-six-year-old rural child eating on the ground among chicken excrement, hungry and frail, only in the company of vulgar people. Then you will know how closely related mothers and children are.[493]

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[490] Ibid., 14-15.

[491] Ibid., 16.

[492] Ibid., 15.

The author's critique of the "good wife, wise mother" ideal pointed not to its inherent heteronormativity or association with hegemonic femininity, but rather its bias toward the urban elite who had greater access to the prerequisites for skilled mothercraft. After affirming the notion that women's reproduction and nurturing remained critical to the futurity of the state and *minzu,* she concluded by reframing this truism as evidence of an ineffectual government and a disingenuous women's movement. She continued, "If we are unwilling to continue to lag behind, unwilling to have future citizens remain in such conditions with no nurturing, then we cannot continue to be lax about women's liberation."[494]

On the eve of the Japanese invasion, another feminist magazine, *Women's Life,* affirmed the centrality of MIH to both the Chinese women's movement and China's place in a competitive, global ranking of nations. Throughout the war, this magazine, run by the underground CCP member Shen Zijiu 沈兹九, became a key site for refashioning the Chinese women's movement.[495] A late 1937 article titled "Advancing Maternal and Infant Health" began with a report that the Shanghai Municipal Public Health Bureau would extend its operations into the rural hinterland to provide prenatal and postnatal examinations, midwifery services, and childrearing guidance free of charge to rural residents. The anonymous author asserted, "This is indeed wonderful news for the women's movement!"[496]

These actions by the local government led the author to reflect on the composition and

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[493] Ibid., 15.

[494] Ibid., 15.

[495] Wang Zheng, *Finding Women in the State: A Socialist Feminist Revolution in the People's Republic of China, 1949-1964* (Berkeley and Los Angeles: University of California Press, 2017), 278, n. 11, 81-82.

[496] "*Banyue xunhui: Gaijin fuying weisheng* 半月巡迴：改進婦嬰衛生," Funü shenghuo 《婦女生活》3, no. 12 (1937), 1.

focus of the broader, (trans)national political movement that purported to advance the needs of women. Like the state agencies and philanthropies that had dominated discourses of women's health, this author situated Chinese MIH within its global context, though with notably different emphases. "In many nations, longstanding efforts to improve childbirth have led to enhanced treatment for pregnant and parturient women, but in China—China, which lags behind in every aspect—women giving birth is indeed a 'give birth, enter death' matter of hardship and suffering."[497] As the author pointed out, not all Chinese women experienced these dangers to the same degree. Turning specifically to rural peasants and urban laborers, she argued

> Peasant women give birth in the fields or they run hurriedly back to their homes to give birth, without even the assistance of old-style midwives, making the crudest of arrangements for their infants before returning to labor in the fields. Another common occurrence is women workers who, after being pregnant for many months, must still work standing by their machines and because of this give birth on the factory floor or on the side of the road.[498]

Despite the now decade-long development of public health at the national level in China, the author maintained a pessimistic assessment that took into account differences of class and urbanity. "Maternal and infant health," she argued, "has certainly not addressed these issues."[499]

Throughout the war with Japan, these arguments gained further prominence in *Women's Life*. A 1939 article began with a summary of "rural women's lives and characteristics." The author, Lin Bin 林彬, highlighted the suffering of rural women that resulted from interconnected, systemic oppressions. Social scorn, economic dependence, and patriarchy reduced rural women to commodities, she argued, as they were exchanged between families against their will and subjected to slave labor. These systemic forces made it impossible for them to nurture their

[497] Ibid., 1.

[498] Ibid., 1.

[499] Ibid., 1.

children, Lin argued, given a lack of economic resources and the fact that the compounding demands of manual labor, childbearing, and childrearing often resulted in death by exhaustion.[500]

Lin's assessment of rural women affirmed long-held norms that bound caregiving and motherhood to femininity, while pointing to the conditions that produced unequal access to the prerequisites of scientific mothercraft. But Lin, like many contributors to wartime women's periodicals, pointed to inadequate familial, social, and political support for rural mothers. "The reason why they appear to be more conservative, disorganized, short-sighted, narrow-minded, and self-interested….is because their lives are full of suffering, household work remains arduous, and they have not been afforded the opportunity to pursue education or social work."[501] With this line of argument, Lin inverted the cause and effect of exclusionary narratives while retaining the eugenicist ideals of maternalism. In both the feminist movement and the exclusionary narratives of its adversaries, motherhood remained a skilled practice of critical political significance. However, Lin, like many others, framed state and societal failures as the cause of rural women's ineffectual motherhood, rather than the other way around.[502]

Lin argued that any Chinese women's movement had to address these issues of rural women to have any real impact. "When we work with these [rural] women, we'll often encounter many factors contributing to poverty and disputes regarding marriage. We must earnestly intervene to help in these matters. Before you can bring them into the movement, you must first redress their personal suffering."[503] Lin maintained throughout the article that the primary

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[500] Lin Bin 林彬, "*Zenme zuo nongcun funü gongzuo* 怎麼做農村婦女工作," Funü shenghuo《婦女生活》7, no. 8 (1939): 3-6, 3.

[501] Ibid., 3.

[502] Ibid., 3.

[503] Ibid., 3.

political cause of the day remained the war against Japan and that women's liberation would be impossible without the liberation of the Chinese people from imperialism. However, her proposed method for bringing rural women into such a movement differed from exclusionary narratives emphasizing sacrifice. Rather, Lin framed material improvements to rural women's lives as the groundwork for their later service as mothers and caregivers.[504]

The doctor Ye Shiqin, who held positions within the NHA during the Nationalist decades, also published several articles to *Women's Life* during the war years, contributing to this ongoing assessment of the Chinese women's movement. Some of her articles focused on translating biomedical knowledge to a lay audience, with Ye providing advice on topics such as venereal disease, pregnancy, and menstruation.[505] But Ye also remained an outspoken proponent of feminist causes in various articles that connected her expertise in MIH to debates occurring within the Chinese women's movement from the outbreak of war with Japan up to the founding of the PRC in 1949. In these articles, Ye, too, affirmed women's capacity to reproduce and nurture to legitimize claims to suffrage and healthcare for a broad constituency of women.

In one such article from 1939, Ye, then practicing in the Nationalist capital of Chongqing, began by affirming the eugenic dimensions of biomedically sound mothercraft. Ye drew from statistical data on fertility and mortality to position China in a global ranking. According to Ye, China's infant mortality rate remained roughly 200 per 1,000, with 2,700,000 infants dying in China each year. This mortality rate grew even larger when young children

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[504] Ibid., 3-6.

[505] This is the same Ye Shiqin mentioned briefly in the introduction to this dissertation. Ye assumed the position of acting director of FNMS in Beiping in 1948 when Yang Chongrui left China to advise the World Health Organization. For a sample of her articles providing advice on health and hygiene, see Ye Shiqin, "*Tantan baidai* 谈谈白带,"Funü Shenghuo 《婦女生活》8, no.4 (1940):31-32; Ye Shiqin, "*Meidu yu ying'er* 梅毒与胎儿," Funü Shenghuo 《婦女生活》8, no.11 (1940):31-32. Ye also contributed to various other periodicals, including some medical journals in the 1940s.

between the ages of one and five were included. Ye further articulated the impact of inadequate, reproductive healthcare for women specifically by citing a maternal mortality rate in China that remained at roughly fifteen percent, with approximately 202,500 Chinese women dying each year during childbirth. Connecting the bodily suffering of women and children to widely circulated narratives, Ye argued that this trend had disastrous consequences for the health and strength of the *minzu.*[506]

But Ye argued that healthcare remained the responsibility of the state to its citizens. Juxtaposed with Ye's immediately preceding, quantitatively based assessment regarding the inadequacy of MIH in the Republic, such statements conveyed an implicit critique of state commitments to women's health that would have resounded with wartime readers of and contributors to *Women's Life.* Citing examples of state institutions, Ye argued that the responsibility for MIH lay with the government, because government institutions provided a "mechanism to benefit all the country's women and children." The expansion of clinics and health bureaus into rural and remote regions of the country should continue, she argued, "in order to ensure that all women and children throughout the country, whether of high or low status, whether rich or poor, may enjoy the benefits of healthcare."[507] With this rhetorical strategy, the implicit critique regarding the state's inadequate support of MIH merged with the critiques of the women's movement that had been circulating in *Women's Life.* In both cases, as Ye affirmed, efforts to address the particular needs of women required a simultaneous engagement with gendered difference and the categories of class, region, and urbanity that determined women's varied access to healthcare. The stark contrasts between women based on

[506] Ye Shiqin 葉式欽, "*Fuying weisheng* 婦嬰衛生," Funü shenghuo 《婦女生活》7, no. 8 (1939): 20.

[507] Ibid.

these categories of difference would have been particularly salient for Ye at the time she wrote this article, given her work as a medical practitioner trained in the East yet recently relocated to Sichuan.[508]

Ye connected the aims of the NHA to those of the women's movement as a medical practitioner aligned with both political projects. As a graduate of FNMS in Beiping, a member of the Sichuan Provincial Health Institute, and later, Director of FNMS, Ye actively participated in expanding the state's public health system even as she remained a regular contributor to feminist media and an advocate for women's suffrage and access to healthcare.[509] In this article and others authored by Ye during the war years, one can see a condensed view of the converging aims of philanthropy, national policy, and feminist activism on the issue of MIH. As Ye articulated here, the expansion of MIH services both geographically and across class divides aided the aims of these diversified players. However, Ye continued to prioritize women's wellbeing. She concluded by stating "First we must have healthy and whole mothers, then we can have health and whole children. Thus, the promotion of MIH work serves to advance the wellbeing of women and children while also ensuring the future of the *minzu* and country."[510] Thus, like other contributors to *Women's Life*, Ye affirmed state investments in the reproductive functions of China's women to leverage those investments toward feminist claims.

Also like many of her interlocutors, Ye's conception of MIH as feminist praxis developed through transnational encounters, producing a growing consciousness of both the categories that

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[508] For more on Ye's background, see "*Jiaoyu yu wenhua: Ye Shiqin daili guoli beeping gaoji zhuchan zhixiao xiaozhang* 教育與文化：葉式欽代理國立北平高級助產職校校長," Jiaoyu tongxun《教育通訊》6, no. 6 (1948): 24.

[509] Ibid.

[510] Ye Shiqin 葉式欽, "*Fuying weisheng* 婦嬰衛生," Funü shenghuo 《婦女生活》7, no. 8 (1939): 20.

divided women and the possibility of solidarities across classes and national borders. As noted briefly in Chapter One of this dissertation, Ye had worked as an apprentice to American Mary Breckinridge, a midwifery expert whose Frontier Nursing Service engaged similar dynamics of class, region, and urbanity to expand access to reproductive healthcare for women in Appalachia. Elsewhere in her writing, Ye drew parallels between her observations in Kentucky and those in China, emphasizing both the shared, particular healthcare needs of a transnationally imagined women as well as the forces operating in both the U.S. and China that produced differing levels of access.[511]

In the later 1940s, Nationalist censorship put an end to *Women's Life,* and the breakdown in relations between Communist and Nationalist parties contributed to divisions within the women's movement.[512] Yet certain areas of the women's movement continued to reflect socialist ideals, and other venues provided forums for feminist critique and activism. As Chinese feminists engaged with the postwar development of global institutions, Ye Shiqin published a passionate manifesto titled "Women in Power and World Peace" in a magazine titled *Political Commentary.* Here, Ye articulated the solidarities being imagined in certain parts of the Chinese women's movement as she forged connections across classes, parties, and nations while engaging multiple vectors of difference. Ye's inspiration for writing the piece came from an English newspaper article she read in London, which advocated women holding office in the

[511] Ye Shiqin 葉式欽, "*Kenta* (Kentucky) *zhuchanshi fuwu tuanji* 肯塔 (Kentucky)助產士服務團記," Zhuchan xuebao《助產學報》1, no. 1 (1949): 41-44.

[512] Edwards, *Gender, Politics, and Democracy,* 220.

British government. As she reflected on this article, Ye considered the implications for the broader world if women came to dominate the governments of multiple countries.[513]

Ye laid out her argument in a treatise organized around two questions: "Do women have the ability to hold power?" and "If women held power, how would they contribute to world peace?" In her examination of the first question, Ye began with Confucian ideals of gendered spheres and women's responsibilities within the home. While affirming a uniquely feminine capacity to nurture as fundamental to an imagined, global collective of women, Ye argued that this capacity would, in fact, be an asset to women in positions of political power. In response to unnamed male political figures who asserted that women lacked the natural capacity to lead, Ye argued, "In reality, this is a fallacious argument. Women possess the ability to hold office, and there is no shortage of examples."[514] Ye then pointed out women leaders in England, the Netherlands, Mexico, and the Soviet Union, in a choice that would have resonated with Communist-aligned women given the context of the Civil War. Thus, she concluded "In the realm of politics, men have held a monopoly, and women have had few opportunities to take part. Women's ability to govern has simply been ignored by many."[515]

In her examination of the question of women's impact on world peace, Ye engaged directly with those who emphasized women's reproductive responsibilities as a basis for excluding them from the realm of formal politics. Here, again, Ye reiterated that women's capacity to nurture would, in fact, prove an asset to their work in government, given that

[513] Ye Shiqin 葉式欽, "*Funü dangzheng yu shijie heping* 婦女當政與世界和平," Zhenglun 《政論》1 (1948): 23-24, 23.

[514] Ibid., 23.

[515] Ibid., 23.

women's shared "love for peace" would thwart men's propensity for violence and war. But Ye also asserted that many Chinese women had become enlightened, educated, and forward thinking in recent decades. Given this new reality and the urgencies of China's decades-long state of political fragmentation and armed conflict, she asserted that the country could not afford to disregard the ample numbers of gifted women fully capable of holding positions of power.[516]

Thus far Ye had drawn connections between the struggles of Chinese women and those of women around the world, imagining a collective woman rooted in shared capacities for nurturance. Thus, in Ye's framing, women's equality in the realm of politics rested on an embrace rather than denial of gendered difference. The emphasis on educated and forward-thinking women, however, suggested a collective bounded by class lines, even as it cut across nations and parties. But as her impassioned defense of women's suffrage continued, her imagined constituency expanded further.

Ye made explicit MIH's undergirding of feminist solidarities, with a focus on all women's shared reproductive capabilities that contributed to a general hatred of violence. "In ten years of experience as a gynecologist," she wrote, "I have gained an exceptionally clear understanding of women's deep-seated hatred for war. Women are the ones who give birth to the future generations of humanity. They endure the suffering of pregnancy and labor and have witnessed the loss of innumerable lives. Of course they cherish life more than men."[517] Further, she argued, based on her first-hand experience of aiding women in childbirth, "Because women endure the trials of birth, they have exceptional strengths in nurturing humanity. Men are not like this."[518] Here, Ye emphasized women's shared value for human life that at once connected a

[516] Ibid., 23.

[517] Ibid., 24.

constituency across borders of nation and class while differentiating women from men. This capacity for nurturing, she argued, came through women's bodily experiences of reproduction, not through the education and resources reserved for women of upper classes. As she proceeded to differentiate this expansively imagined woman from man, she argued that women's increased access to political power across borders would bring great benefit to the world. For Ye, men's utter lack of a feminine capacity to nurture in fact made it dangerous for them to wield the power they held. "Men take office with an attitude of disrespect for humanity, running amok all over the world. Because of this, the world progresses toward a dismal future. Can we consider this an accident?"[519]

Ye argued that the self-interest of men that dominated many governments had wrought devastation on humanity, an argument that found particular resonance in the immediate aftermath of the Second World War. In contrast to her endorsement of national narratives elsewhere, Ye critiqued patriotism itself, seeing solidarity among women around the world as having more positive benefit for humanity than allegiance to any particular state. "This so-called patriotic worldview," she argued, "comes forth from a heartfelt hatred of foreigners."[520] For Ye, this type of disregard for other individuals, which she explicitly linked to foreign invasions and conflicts between countries, resulted from men's dominance on the world stage. Feminist solidarity, she argued, could provide a remedy.

> The women of every country should together seize every opportunity to gain political rights. With a great sentiment of motherly love let us see each other in the international arena. Push forward to join with others and share joy with one another. Let us find joy in a foreign country's actions to protect its people's safety. The result will be that other countries will find joy in our benefit and safety. China will share love and benefits with

[518] Ibid., 24.

[519] Ibid., 24.

[520] Ibid., 24.

> other countries. The strong will be swift to help people. The wealthy will be swift to share with others. The virtuous will be swift to teach others. This way the hungry will have food. The naked will be clothed. And those in turmoil will find stability.[521]

Thus, Ye reframed the premise of exclusionary narratives to challenge men's dominance in the political sphere, while envisioning solidarities with women around the world. Within her overarching narrative emphasizing women's common propensity for "motherly love," Ye, here as elsewhere, engaged with socioeconomic differences to include the redressing of the poor in her grand vision of feminist utopia.

Other Chinese feminist engaged with these global dynamics through participation in and reporting on global organizations formed in the aftermath of World War II. Some Chinese feminists participated in the early work of the United Nations Commission on the Status of Women, founded in 1946. Though urban, educated women remained overrepresented in the Chinese delegation to the Commission,[522] the increasingly global vision of feminist activism circulated within and outside China paid special attention to disparities among women on the basis of class, education, and health. The reporting on the UN Commission in Chinese publications highlighted international movements to redress these structural factors, which found resonance amid the ongoing discussions in the Chinese women's press. Translations and summaries of the Commission's founding resolution connected this global movement to Chinese feminists' pursuit of comprehensive equality through an engagement with multiple vectors of difference. This continued re-imagining of the subject and scope of Chinese feminism further aided the envisioning of solidarities across national borders, as many Chinese feminists came to see differences of class, urbanity, health, and gender as transcending the borders of nation-states.

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[521] Ibid., 24.

[522] Jin Feng, *The Making of a Family Saga*: *Ginling College* (Albany: SUNY Press, 2009), 101-102, 256.

For example, a 1947 report titled "The Goal of Elevating Women's Rights" drew from the UN Commission's founding resolution to assert a feminist politics more capacious than suffrage. From the outset, the report argued that suffrage remained a necessary tool toward the pursuit of broader justice, rather than an end in itself. The global feminist movement highlighted in coverage of the UN Commission centered on improvements to the conditions adversely affecting women's economic status, education level, health, and effective nurturing of their children. The Chinese report and the original resolution emphasized an end to gender discrimination without respect to divisions of "nationality, race, language, or religion" while asserting that gender equality required social services to address economic disparities between women. The resolution further asserted that "regarding health, women and men should be treated in similar ways, but special attention should be paid to motherhood. Governments should make it a priority to provide mothers and children with benefits and protections."[523] This emphasis on social services evinced a conscious engagement with economic differences within gender categories, even as it maintained reproduction and nurturing as fundamental to a transnationally imagined woman. The long list of proposals that accompanied the resolution focused on working women and included paid maternity leave, nursing stations, childcare facilities, breaks from work, and rest areas. The list of goals for a refashioned, global women's movement also included "an effective plan established in law for health and social insurance" that included "special provisions for mothers and children," along with resources for free public education.[524] As

[523] "*Tigao nüquan de mubiao* 提高女權的目標," Tianjia《田家》14, no. 7 (1947): 15. A similar endorsement of the 1947 U.N. resolution appeared in *Women's Voice Bimonthly* in the same year. See "*Guoji nüquan yundong gaishu: Wushi yu guo funü yi huoyou xuanjuquan, dan wanquan de nannü pingdeng rengdai zhengqu* 國際女權*運動概述*:五十餘國婦女已獲有選舉權，但完全的男女平等仍待爭取," Fusheng banyuekan《婦聲半月刊》1，no. 11/12 (1947): 3-4.

[524] "*Tigao nüquan de mubiao,*" 15.

outlined in Chapter Seven, these commitments shaped the early MIH programs of the World Health Organization due, in part, to the critical involvement of feminists throughout the world, including Dr. Yang Chongrui.[525]

By the later 1940s, the interconnected dynamics of Chinese and global feminisms shaped not only feminist discourse in popular media, but also women's activism within the advisory and legislative bodies of the Nationalist Party and the Chinese state. The efforts to sway male political officials toward adopting a comprehensive and inclusive feminist agenda relied on a strategy that reframed exclusionary narratives without challenging their fundamental assumptions. In the arena of representative politics, feminist activists cited eugenic investments in motherhood as bases for claims to resources and legal protections for women. In tandem with similar discussions in the women's press, formal resolutions and petitions pointed not only to the state's interest in promoting scientific mothercraft, but also to the disparities among women through a reframing of the facts of MIH as evidence of state failure. Citing the very biomedical metrics and maternalist arguments that had been used to deny citizenship to Chinese women, feminists argued that these data evinced the state's failure to provide adequate education, healthcare, and economic resources to its most vulnerable subjects. The women representatives studied here thus leveraged pervasive notions regarding the political stakes of childbirth and mothering toward redressing gender inequities exacerbated by economic oppression and regional disparities.

This lobbying campaign proceeded within two representative bodies: the People's Political Council (PPC) and the National Congress of the Chinese Nationalist Party. The former body, established in 1938 to placate democracy advocates, held no substantive power to legislate,

[525] See Chapter Seven of this dissertation.

but rather advised the Nationalist government on policy during the war. The latter body more narrowly focused on the political platform of the Nationalist Party, again with no real power to enact policy.[526] However, both bodies did provide a forum for debating national policy, and ultimately pressured the government to adopt certain reforms. For the feminists studied here, many of their political aims became codified in the 1947 Constitution of the Republic of China. The Cantonese Dr. Wu Zhimei, also discussed in Chapter Five, remained among the most outspoken advocates for feminist causes within these bodies of the Nationalist state. I turn now to her lobbying efforts, which, in addition to suffrage,[527] centered on two policy goals: a public medical system and welfare programs for mothers and children.

Engaging Difference in Policy: The Campaign for a Public Medical System

The turn to rural women that had occurred in feminist media informed advocacy for a public medical system that would make healthcare accessible across disparities of urbanity and class. In their pursuit of this goal, feminists found a host of allies within the PPC. For example, the male politician Li Zhongxiang 李中襄 from Jiangxi province voiced support for a public medical system that would "free the masses from sickness and suffering."[528] Sean Lei has further noted the role of male representatives and public health officials in advocating for such a policy

[526] For more on these institutions of the Nationalist state, see W. L. Tung, *The Political Institutions of Modern China*, Second Ed. (The Hague: Martinus Nijhoff, 1968), 101-115; 188-90.

[527] The contemporary campaign for women's suffrage has been well documented by Louise Edwards. See Edwards, *Gender, Politics, and Democracy,* 195-231.

[528] Li Zhongxiang 李中襄, "*Tuixing gongyi zhidu yi jiechu minzhong jiku an* 推行公醫制度以解除民眾疾苦案," PPC 2, no. 2 (1941) in *Guomin canzhenghui shiliao bianzuan weiyuanhui* 國民參政會史料編纂委員會, eds., Guomin canzhenghui shiliao 《國民參政會史料》 (Taipei: *Guomin canzhenghui zai Tai lijie canzhengyuan lianyihui* 國民參政會在臺歷屆參政員聯誼會 1962): 283-84.

based on their observations of China's exceptionally rural population.[529] By 1941, the NHA had tentatively endorsed a plan for extending the reach of public health services into rural regions.[530] However, the government's slowness to act led many within the PPC, both within and outside the women's movement, to press for an expansion of public health services with increasing fervor.

In 1942, Wu Zhimei contributed to this effort through a formal petition within the PPC. Though Wu conceded that the Nationalist government had expanded public health services throughout much of the country, her critique began by highlighting persistent barriers to medical care that perpetuated the suffering of the rural poor. Wu's opening critique challenged homogenizing notions of the relationship between citizen and state. She began by highlighting the economic and physical disparities that precluded "common people" from responding to the pervasive narratives urging everyone to contribute to the war of resistance against Japan. Further, Wu argued that the low economic status of most Chinese compounded the physical suffering wrought by prevalent disease. The government's efforts had hitherto had little impact in providing them with medical care because it had failed to address the intertwined dynamics of economic and physical oppression. "The masses remain sick in isolated villages," she asserted, "suffering without access to healthcare or medicine. This is made worse by rampant inflation, which prevents local administrations from providing even basic nutrition. Thus, the health of the masses continues to decline…"[531] Affirming the widely held notion that healthy and hygienic

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[529] Lei, *Neither Donkey nor Horse,* 223-258.

[530] "*Duiyu zhengfu shizheng baogao zhi jueyiwen: weisheng baogao* 對於政府施政報告之決議文: 衛生告,"PPC 2, no. 2 (1941) in Guomin canzhenghui shiliao, 273.

[531] Wu Zhimei 伍智梅, "*Qing zhengfu jiji tuixing gongyi zhidu yi shuli minzu kangjian zhi jichu an* 請政府積極推行公醫制度以樹立民族康健之基礎案," Resolution No. 32065, PPC 3, no. 1 (Chongqing: December 31, 1942) (Nationalist Party Archives, Taipei).

citizens corresponded to a formidable nation-state, Wu refuted narratives that had laid the blame for deficient health with the individual habits of subjects. Rather, Wu highlighted material conditions—geographic distance, inadequate food, and poverty—that separated rural peasants from healthcare and differentiated them from the urban elite. Further, like many public health activists, her critique emphasized the bodily suffering of the masses and state failures to address their predicament over the imperative for individuals to make sacrifices for the survival of the state.[532]

Wu's reframing of public health as a state's responsibility to its subjects drew from the very data and assumptions leveraged by the militarist state to demand sacrifice. As Nicole Barnes has argued, the prioritization of the military during the war shaped a public health discourse that reduced men to soldiers and women to mothers/caregivers of soldiers.[533] These widely held notions appeared in Wu's 1942 proposal as evidence to support the necessity of readily accessible healthcare. Wu pointed to military reports from critical provinces that found less than eight percent of conscripts to be without physical deficiency. Despite this common ground with militarist politicians, Wu differed in her conclusions. The solution to this military problem was not an enforcement of discipline or indoctrination of national duty, but rather a massive state investment in an expanded, public medical system that would provide services to everyone in the country by addressing the particular needs and challenges of region, gender, urbanity, and class.[534]

Wu's proposal included a detailed plan for constructing such a system, which garnered

[532] Ibid.

[533] Barnes, "Protecting the National Body," passim.

[534] Ibid.

endorsements from twenty-two of her colleagues in the PPC. Her plan included a strengthening of county-level public health bureaus and hospitals and the enforcement of rigorous standards for medical personnel. Additional training institutions for doctors, nurses, and midwives would help staff new hospitals and MIH clinics in rural regions. The government should also sponsor domestic production of pharmaceuticals and prioritize expansion into underserved areas, including frontier regions.[535]

The PPC adopted Wu's proposal and submitted it to Executive Yuan. The Executive Yuan formally endorsed the proposal on December 31, 1942, and reported to the PPC that the proposal had been forwarded to the NHA for adoption and enactment.[536] However, the NHA's response in January 1943 made evident the limited power of the PPC to effect policy change as a mere advisory body in an authoritarian state. The NHA's response largely sidestepped Wu's original concerns regarding barriers to access, arguing that much of the proposal had already been put into effect in earlier years. According to the NHA, seventeen provincial and municipal bureaus of health had already been founded or planned, and an additional 800 county-level health bureaus had been or would soon be established. Through this growing network of bureaus, the NHA had gained increased oversight of medical personnel and the founding of additional hospitals and MIH clinics throughout the country.[537]

Throughout the war years, many public health advocates in the PPC expressed continued

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[535] Ibid.

[536] Jiang Zhongzheng 蔣中正, "*Xingzhengyuan gonghan: Guomin canzheng hui jianyi tuixing gongyi zhidu an* 行政院公函：國民參政會建議推行公醫制度案," (Chongqing: December 31, 1942) (Nationalist Party Archives, Taipei).

[537] "*Yuanhan: anzhun* 原函： 案准," Jiji tuijin gongyi zhidu 《積極推進公醫制度》, （Chongqing: December 12, 1942）(Nationalist Party Archives, Taipei).

dissatisfaction with what they perceived to be the limited efficacy of the NHA's endeavors. Several men in the PPC pressed for expanded public health services, based on the expected benefits to industry, worker productivity, and the threat disease posed to livestock.[538] Wu also continued to prioritize the expansion of medical care to underserved regions during her time in the PPC,[539] but she submitted her most forceful proposal at the Sixth National Congress of the Nationalist Party in 1945. Wu once again advocated for a public medical system while putting forth a more explicit indictment of the government's failure to live up to its responsibilities. Returning to her honed strategy, Wu cited quantitative data to outline a public health crisis exacerbated by a non-committal state and misdirected priorities.

> The health of our country's people remains at a low level. Ninety-percent of students have physical deficiencies. Only eight percent of men have the physical qualifications for active military service. As many as fifty-seven percent have not grown to a standard height. Thirty-five percent are under standard weight. The mortality rate in China is more than twice that of the strong countries of Europe and America.[540]

Wu's arguments here affirmed widely held notions regarding the inferiority of Chinese bodies and the significance of that inferiority for China's relative status in an international order of nation-states. As she continued, Wu affirmed that the particular plight of women and children remained relevant for these broad political concerns. Shoring up the now established correlation

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[538] See Wei Yuanguang 魏元光 , "*Gongwuyuan ji jiaozhi tebie yiyaofei ni qing you zhengfu zhigei yi zenggao gongzuo xiaolü er li jiankang an* 公務員 及教職特別醫藥費擬請由政府支給以增高工作效率而利康建案," PPC 3, no. 1 (1942) in Guomin canzhenghui shiliao; Li Zhi 李洽," "*Qing shezhi mengzang weisheng yuan yi zifang zhiren chuyi zengjia houfang shengchan an* 請設置蒙藏衛生元以資防治人畜疫癘增加後方生產案," PPC 3, no. 1 (1942) in Guomin canzhenghui shiliao.

[539] See for example, Wu Zhimei 伍智梅, "*Qing zhengfu congsu jiaqiang peizhi yishi weisheng rencai jiji tuixing gonggongweisheng sheshi yi bao min ming er gu guo an* 請政府從速加強培植醫事衛生人才積極推行公共衛生設施以保民命而固國本案," PPC 3, no. 2. (1943) in Guomin canzhenghui shiliao, 376.

[540] Wu Zhimei 伍智梅 , "*Qing jianli gongyi zhidu yi zengjin guomin jiankang an* 請建立公醫制度以增進國民健康案," Sixth National Congress of the Nationalist Party (Chongqing: May 5, 1945) (NATIONALIST Archives, Taipei).

between biomedical metrics of women's reproduction and the relative status of nation-states, she wrote, "The infant mortality rate remains nearly four times that of the West, and the maternal mortality rate is more than three times higher."[541] With an even more explicit affirmation of the foundational concepts of exclusionary narratives, Wu wrote, "Surely, these conditions are disadvantageous to national defense."[542]

However, when considered alongside the remainder of Wu's petition—and within the context of her life, activism, and other published work—these opening statements evince a strategy for advancing a more comprehensive, decidedly feminist agenda. Rather than refuting the primacy of the military or biomedically sound reproduction as integral to the strength of the state, Wu accepted these premises to support her critique the government. As she outlined, the government's failure to provide medical care to underserved women and children constituted not only a disservice to women, but to national defense and the citizenry as a whole. Thus, the government had failed to demonstrate a true commitment to its own stated priorities.[543]

Mirroring the contemporaneous debates in feminist periodicals, Wu's petition to the National Congress highlighted economic and physical differences among the population to complicate narrowly conceived and unidirectional notions of citizenship. She pointed to these differences as a blind spot of existing policies and to highlight the inefficacy of public health programs that failed to address differing levels of access and need. She asserted, "The population's masses differ in terms of wealth and poverty. This has made expansions to medical care extremely difficult…" Further echoing the arguments put forth in feminist media, Wu

[541] Ibid.

[542] Ibid.

[543] Ibid., see also Chapter Six of this dissertation.

argued, “Establishing a public medical system is the government’s responsibility to alleviate poverty and protect the health of citizens. It should give every citizen equal opportunity to healthcare and disease prevention.”[544] This “equal opportunity,” as she articulated, could be realized only through an engagement with the economic and geographic factors that produced differing levels of access. Based on this understanding of pervasive inequality and reciprocal duties of citizenship, Wu made clear that any just medical system would rest on state resources. “All funds should be provided by the government,” she asserted, “The people shouldn’t have to pay."[545]

Like the discourse in feminist media, formal petitions to the government also reflected the increasingly global consciousness of many Chinese feminists. Wu’s persistent framing of public health as the state’s duty to citizens drew from decades of foreign research and observation throughout Asia, Europe, and the Americas. Once again turning to quantifiable evidence, Wu argued that the Nationalist state had spent roughly one-point-five Chinese yuan (based on its worth in 1937) per person per year on public health. This paled in comparison to the sixty-five yuan per person per year spent in Great Britain, and the ninety-nine yuan spent in the United States. Wu concluded that if officials within the Nationalist state truly sought equal status with “strong countries” on the world stage, significant financial resources for public health should be guaranteed in the Republic’s constitution.[546]

In both the PPC and the National Congress, Wu’s arguments embraced women’s reproductive and caregiving functions as foundational to their citizenship and integral to national

[544] Wu Zhimei 伍智梅 , “*Qing jianli gongyi zhidu yi zengjin guomin jiankang an*.”

[545] Ibid.

[546] Ibid.

survival. Yet, Wu's feminist consciousness and experiences within and outside China led her to markedly different conclusions from exclusionary narratives despite this common ground. Wu rejected simplistic notions that high rates of maternal and infant mortality resulted from Chinese women's failures, based largely on the fact that most Chinese women did not possess the educational, financial, or physical resources necessary to perform the duties of scientific, republican mothercraft. Her arguments shifted the focus from individual responsibility to the state, and to the structural and material conditions dividing women. The solution was thus a redirecting of state priorities and resources to advance the health and wellbeing of the masses, especially women and children.

Engaging Difference in Policy: The Campaign for Social Welfare

Throughout the 1940s, the broader welfare of women and children also featured prominently in both exclusionary and feminist narratives, due in large part to wartime displacement that disproportionately affected women and children. For elite and middle-class women, advocacy and caregiving on behalf of war orphans and refugees became a gendered, state-sanctioned contribution to the war of resistance. As previous scholars have noted, these roles facilitated the performance of elite femininity and women's service to the state.[547] However, they also facilitated encounters between Chinese women of different regions and classes, which in turn spurred an increased emphasis in feminist circles on the plight of rural and working women. Within the structures of the Nationalist state, these feminists affirmed the primacy of women's and children's welfare to both the women's movement and the survival of the state, while reframing the discussion. Rather than highlighting "social welfare work" as

[547] See Li, *Echoes of Chongqing,* 37-38.

women's acts of service and sacrifice, these women leveraged the assumptions of exclusionary narratives vis-à-vis women and children to secure resources and legal protections.

Though several male political figures also championed increased resources for the welfare of women and children, feminists allied with suffragist campaigns made the issue a focal point of their lobbying in the PPC. From 1941-43, educator and Nationalist-affiliated women's bureau leader Liu Hengjing 劉衡靜 put forth several proposals in the PPC to advance the welfare of women and children, while also remaining among the staunchest advocates for women's suffrage and guaranteed representation within the Nationalist government.[548] These included proposals that the government provide financial support for mothers in need "in order to protect small children," that all factories be required to provide nurseries to women workers with young children, and that clinics and hospitals for children be founded "in order to rejuvenate the *minzu*."[549] Along with male allies and other feminists, Liu's proposals rested on two simultaneously held positions: reproduction and caregiving constituted women's shared duties of citizenship and that these duties could not be performed without material, state support to address economic and geographic disparities.

Like the campaign for a public medical system, the broader advancement of women's and

[548] Liu Hengjing (b. 1902) graduated from Beijing Women's Normal University and Columbia University (NY) with degrees in education. She returned to China in the mid-1920s to assume leadership positions in the Guangdong provincial government as well as the National PPC and Nationalist Party Women's Bureau. See Chen Yuhuan 陈予欢, *Minguo Guangdong jiangling zhi* 民国广东将领志 (Guangzhou: Guangzhou chubanshe, 1994), 80. For more on Liu's advocacy for suffrage and representation, see Edwards, *Gender, Politics, and Democracy*, 217-19; Helen M. Schneider, *Keeping the Nation's House: Domestic Management and the Making of Modern China* (Vancouver and Toronto: UBC Press, 2011), 71-73.

[549] Liu Hengjing 劉衡靜等, "*Qing guiding muqin fuzhu fa yi baohu you xiao er* 請規定母親扶助法以保護幼小兒," PPC 2, no. 2 (1941) in Guomin canzhenghui shiliao; Liu Hengjing 劉衡靜, "*Qing zhengfu congsu pushe chang tuo'ersuo yi dongyuan funü canjia gongye shengyu an* 請政府從速普設廠托兒所以動員婦女參加工業生育案," PPC 3, no. 1 (1942) in Guomin canzhenghui shiliao; Liu Hengjing 劉衡靜, "*Tiyi juban ertong baojian qing gongjue an* 提議舉辦兒童保健請公決案," PPC 3, no. 2 (1943) in Guomin canzhenghui shiliao.

children's welfare relied on impassioned lobbying by Wu Zhimei. In 1942, Wu brought these concerns to the Nationalist Party's Central Executive Committee through a formal petition. As before, Wu highlighted disparities between citizens and connected these feminist concerns to the interests of the party and state. Her petition comprised two main arguments: the Nationalist Party must prioritize social welfare in every region of the country to address the suffering of China's masses, and women should be a focus of these efforts as both orchestrators and beneficiaries. Wu pointed out that numerous schools, hospitals, orphanages, and philanthropic societies existed throughout the country, but that few of these had been established by the Nationalist government. This evinced a missed opportunity, she argued, to win the hearts of the masses and to demonstrate the Nationalist Party's commitment to their wellbeing through social welfare programs. Wu argued that such programs remained critical to the advancement of the Nationalist state's campaign of "political tutelage" and the ultimate (repeatedly delayed) enactment of constitutional government.[550]

The prioritization of women again fused Wu's feminist aims to the priorities of the state according to policy and propaganda. Foreshadowing the aforementioned 1948 manifesto of Ye Shiqin,[551] Wu pointed to Chinese women as an untapped resource of roughly 250,000 individuals who remained both underserved and invaluable. Like Ye, Wu's investments in a global feminist movement informed her policy positions and strategic lobbying. She pointed to the example of allied nations during World War I, whose victory, she argued, relied on both the military service of men and the social welfare work of women. Women, she argued, took over leadership

[550] Wu Zhimei 伍智梅, "*Wu Zhimei shang zongcai cheng* 伍智梅上總裁呈," Di wu jie zhongyang zhixing weiyuan hui quanti huiyi jilu 《第五屆中央執行委員會 － 全體會議記錄》 (Chongqing: November 9, 1942) (Nationalist Party Archives, Taipei).

[551] Ye Shiqin, "Funü dangzheng yu shijie heping."

positions in churches and philanthropic organizations to ensure that both soldiers and the masses maintained access to adequate food and clothing. In what was the sixth year of armed conflict, Wu urged the government not to disregard the female half of China's population. Women, if they are healthy and able, could prove critical in addressing China's military deficiencies.[552]

While strategically connecting social welfare and feminized labor to the survival of the state, Wu's petition also evinced the influence of international feminist discourses highlighting differences between women and broader views of justice. Her repeated mentions of "every locale" highlighted the regional disparities that plagued the efficacy of public health, education, and welfare policies. Her emphasis that "all" of China's 250,000 women be mobilized affirmed the prior myopia of both state policy and Nationalist-affiliated women's organizations. Without challenging gendered duties of citizenship, her arguments here and elsewhere resisted a homogenized category of woman by directing attention to the structural inequalities between women of different regions, classes, and levels of urbanity.[553]

Wu expressed this position more explicitly within the Sixth National Congress of the Nationalist Party in 1945. In a petition advocating the further institutionalization of the women's movement, Wu again asserted the utility of women's and children's welfare to the overall strength of the state. She began by quoting two policy positions adopted by the Nationalist government. Item number eleven from the Nationalist Party platform regarding domestic policy, according to Wu, read "Gender equality shall be affirmed as a key principle in the realms of law, economics, education, and society, and the development of women's rights shall be

[552] Ibid.

[553] Ibid.

supported."[554] Further, she highlighted a provisional draft of the Republic's constitution that read, "The Citizens of the Republic of China, irrespective of differences of gender, race, religion, or class shall be equal according to the law. Thus," she argued, "this party should organize women's bureaus at all levels of the party structure to ensure that the government carries out steps in accordance with this party platform."[555] Wu's argument rested not only on the government's stated principles, but also on its interests in a robust democracy. The expansion and institutionalization of the women's movement would strengthen democracy by educating women on their rights and responsibilities. This, she argued, would help produce a government that represented the interests of all people and thereby earned popular support.[556]

The emphasis on equality in the opening section of Wu's petition rested on a sustained engagement with multiple vectors of difference, as she outlined in detail. The founding of new women's bureaus, she argued, should focus on expansions into rural areas. Reflecting sensitivities to the class dynamics within the women's movement, Wu argued that educational and training programs should target not only "women workers, women officials, housewives, and *baojia* (community) members," but also "rural women."[557] With the regard to the latter, Wu noted that the promotion of political ideology would be meaningless without welfare programs to address the economic factors that compounded gender hierarchy. Wu's "method for providing social education and healthcare to rural women" depended on "improvements to the sanitation of local environments," widely available "courses in maternal and infant health," "the use of plays

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[554] Wu Zhimei 伍智梅, "*Qing jiaqiang fuyun zuzhi queli zhongxin gongzuo an* 請加強婦運組織確立中心工作案," Liu quandaihui ti'an 《六全代會提案》 (Chongqing: May 5, 1945) (Nationalist Party Archives, Taipei).

[555] Ibid.

[556] Ibid.

[557] Ibid.

and competitions to spread information about public health," as well as "establishing vocational training centers for women."[558] Thus, as Wu outlined, the government's stated goals of "gender equality" could be realized only through simultaneous engagement with the health needs particular to women and the economic and geographic divisions that produced differing levels of access.

Conclusion

Efforts to shape the policies of the Nationalist government from within representative bodies faced several challenges. Some historians have argued that various figures in the Nationalist government aimed ultimately to use constitutional structures to shore up authoritarian power.[559] Chiang Kai-shek's push for rapid implementation of a rubber-stamp National Assembly met resistance from those who advocated a robust legislative branch of government to restrain presidential power. In 1946, representatives from Nationalist, Communist, and various smaller parties participated in a People's Consultative Congress focused on amending the yet-to-be implemented Constitution of the Republic of China. Archives and secondary literature provide little insight into women's voices during these deliberations, other than to note their significant presence. However, the document that emerged as the 1947 Constitution of the Republic bore the influence of feminist claims made within the PPC and the National Congress of the Nationalist Party. As Louise Edwards has shown, rights of suffrage and guaranteed quotas for women in legislative bodies gave representation to a constituency of women with particular,

[558] Ibid.

[559] Zhao Suisheng, *Power by Design: Constitution Making in Nationalist China* (Honolulu: University of Hawaii Press, 1996), 143-5; passim.

shared interests.[560] But, as shown in this chapter, suffrage rights or legislative quotas in isolation do not adequately reflect the subject or scope of feminism in this arena.

The impact of feminist lobbying on the 1947 Constitution was not only to establish "woman" as a constituency worthy of guaranteed representation, but to write into law the differences within and between genders that constituted this political category. The constitution tethered legal womanhood to reproductive and affective labor, while repudiating homogenizing policies that showed disregard to class, region, or urbanity. Without refuting motherhood and caregiving as women's civic duty, the constitution provided protections for the health, education, and economic security of vulnerable women and children. Article 13 ("Fundamental National Policies") Section 4 ("Social Security") most directly reflected maternalist solidarities that embraced intersectional differences. Item 156 guaranteed "social welfare policies for women and children" and the "protection of motherhood" as the "foundation for the existence and development of the nation," while Item 157 guaranteed "infant health protection enterprises" and access for all to medical treatment "in order to advance the health of the nation."[561] Thus, the constitution affirmed essentialist notions of gendered citizenship rooted in the idiom of MIH, while also guaranteeing resources to address intra-gender differences of urbanity, education, and class.

The policies advocated by feminists within the PPC were never fully realized as such on the Chinese mainland. The government held elections for a National Assembly in 1948. However, Chiang Kai-shek's continued persecution of communists along with growing CCP

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[560] Edwards, *Gender, Politics, and Democracy,* 195-96, 221-28, 235-37.

[561] Art.13, Sec. 4, Items 156, 157, Const. of Republic of China (December 25, 1947). See also items 7, 26, 153, 155. An official English translation of the ROC Constitution includes "infant health protection enterprises" in Item 157. This diverges somewhat from the original Chinese, which does not specifically mention "infants." See Charles C. H. Wan, trans., *The Constitution of the Republic of China* (Nanking: Chinese Ministry of Information, 1947), 18.

territory and support led Communists to boycott these elections. The collapse of the Nationalist government's legitimacy added fuel to revolutionary fervor, culminating in the Nationalist retreat to Taiwan and the establishment of the People's Republic of China in October 1949. This "national emergency" legitimized the suspension of the ROC Constitution in Taiwan, including the provisions won by 1940s feminists.[562] But, as the next chapter demonstrates, the public debates and formal petitions of the 1940s shaped the divergent legacies of Nationalist-era MIH in the PRC and in Taiwan.

The significance of contingent, 1940s-era maternalist solidarities lies in their illuminating of more complex models of feminist praxis in the first half of the twentieth century, and of alternative paths not taken to expand medical services to rural women and children. "Equality" and "difference"—though salient categories—remained interconnected and indivisible. With a global view of feminism and transnational allegiances, the feminists surveyed here saw an engagement with intersecting difference as critical for the pursuit of meaningful gender equality. Debates in media and policy produced the dual effect of rooting Chinese women's claims to citizenship—and the very category of woman itself—in shared reproductive and affective capacities, while also repudiating the notion that all women held equal resources to perform these gendered duties of citizenship. The resulting policies pointed toward a constitutionally based method for redressing rural women's systemic oppression, a path interrupted by a renewed commitment to authoritarianism on both sides of the Taiwan Strait.

Further, the discourse in feminist media and activism points to the dual effects of MIH, as an idiom of difference with both disciplinary and productive effects. The notion that all women shared a unique yet varied capacity to reproduce and nurture undergirded both exclusionary

[562] Edwards, *Gender, Politics, and Democracy,* 229-31.

narratives for withholding full citizenship to women and feminist claims to rights and resources. The dynamism between these two discourses occurred not over the facts of Chinese women's ineffectual reproductive labor, but rather, the logical conclusion to which those facts pointed. While exclusionary narratives emphasized Chinese women's failures, feminist claims argued that data on maternal and infant mortality evinced the failure of the state to support women's health and welfare, in comparison to the international examples with which many Chinese feminists had grown familiar.

Chapter 7: Diverging Legacies:

Chinese Maternal and Child Health in the Cold War World

Like maternal and infant health (MIH) throughout the Nationalist decades, the more expansive and increasingly prevalent field of maternal and child health (MCH)[563] remained integral to the developing political order of the Cold War Era from the late 1940s to the early 1960s. The Chinese Communist victory of 1949 developed in relation to broader trends in the Cold War Pacific, having a profound impact on both international relations and global health. As nationalism and anti-colonialism swept through the Global South, European influence continued to wane. The decisive defeat of the Japanese Empire by the Allies (and the subsequent occupation of Japan by U.S. forces) left the United States and the Soviet Union the remaining powers of what Prasenjit Duara called "the imperialism of free nations."[564] Before the Sino-Soviet Split of the late 1950s and early 1960s, the line dividing U.S.- and U.S.S.R.-allied spheres in the Pacific cut through Korea, the East China Sea, and the Taiwan Strait.

Amid this context, the constellation of actors that had given rise to the reproductive health landscape of pre-revolutionary China unwound and realigned. In the immediate aftermath of World War II, maternalists throughout the world, including Yang Chongrui, shaped the early

[563] By the postwar period, the more capacious moniker "maternal and child health (MCH)" or *fuyou weisheng* had largely subsumed "maternal and infant health (MIH)" or *fuying weisheng* in both Chinese- and English-language public health discourse. Also, the notion of "healthcare" or *baojian* seems to have gained greater currency in Chinese discourses, though *weisheng,* which I have translated as public health, continued to be used.

[564] Prasenjit Duara, "The Imperialism of 'Free Nations: Japan, Manchukuo, and the History of the Present," *The Global and Regional in China's Nation-Formation* (New York: Routledge, 2009); see also Chapter Two of this dissertation.

MCH policies of global health organizations to adopt a commitment to the broadly conceived wellbeing of women and their children. After the Communist Revolution in China, most feminist doctors influential during the Nationalist decades remained on or returned to the mainland to partner with the Ministry of Health and the All-China Women's Federation, strategically maneuvering with varying degrees of success to continue work in MCH amid a radically altered political context. Wu Zhimei fled to Taiwan with the Nationalist Party, though she largely retired from public life amid the suppression of the White Terror before her untimely death from illness in 1956.[565] After a brief period of uncertainty, Taiwan became critical to the early operations of newly founded global organizations including the World Health Organization (WHO), the United Nations International Children's Emergency Fund (UNICEF), and the Population Council. The efforts of these non-governmental organizations came to depend not only on the investments and cooperation of Taiwanese health workers, but also on U.S.-based officials and academics, who came to view the Taiwan Strait as critical for the broadly conceived commercial and strategic interests of the U.S. during the Cold War.

Within this context, intertwined measures of mortality and reproduction continued to provide an idiom of difference structuring political relations, though, as outlined in earlier chapters, this idiom could be manipulated toward a variety of aims. The science of reproduction reflected the distinct if overlapping political interests of varied parties. In the postwar era, MCH continued to serve as an index of development that helped to demarcate boundaries within and between nation-states, thereby shaping policies aimed at modernization. For newly formed

[565] "Wu Zhimei shishi xiaoxi 伍智梅逝世消息," *Zhongyang Ribao* 中央日報, November 13, 1956; Li Youning 李又寧, "Wu Zhimei yu Guomindang 伍智梅與國民黨[Wu Zhimei and the Nationalist Party]," in *Zhonghua minguo jianguo bashinian xueshu taolun ji*《中華民國建國八十年學術討論集》 vol. 1, eds. Zhonghua minguo jianguo bashinian xueshu taolunji bianji weiyuanhui (Taipei: Jiandai Zhonguo Chubanshe, 1991), 413-47.

international organizations, the varied health of women and children drew distinctions between developed and developing worlds, establishing a relation of difference that animated and legitimated their global operations. These distinctions between worlds became integral to the worldviews of U.S. academics and policy makers, who sought to shore up U.S. interests globally by guiding less developed nations along a teleological path from third-world misery to first-world prosperity. In Nationalist Taiwan,[566] the discourses and practices of biomedical MCH positioned state-sanctioned public health as superior to both vernacular medicines and the earlier hygienic regimes of Japanese colonialism. In Communist China, official narratives emphasized reforms to midwifery and mothering as novel movements that differentiated the old society from the new, while also highlighting disparities between the rural peasantry and the urban elite that informed the policy priorities of socialist state-building.

This chapter argues that interwar precents shaped the divergent legacies of MCH in Communist China, Nationalist Taiwan, and the early Cold War world. This cumulative development of reproductive health schemes across the divide of the Chinese Revolution can be seen in the persistence of personnel, institutions, and strategies, despite radically altered political rhetoric and conditions. On both sides of the Taiwan Strait, health officials remained committed to the now honed strategy of using midwives to engage populations in rural and remote areas, a

[566] The nomenclature used in primary documents from this period obscures the political realities of postwar, Sinophone East Asia and may be confusing to some readers. Both the Communist People's Republic of China (PRC), which governed the mainland, and the Nationalist Republic of China (ROC), which governed Taiwan and surrounding minor islands, claimed sovereignty over all of both China and Taiwan throughout the Cold War era. Thus, despite a retreat to Taiwan and a radically altered political landscape, government documents from Taiwan during this period refer to the Nationalist government and the state it governed as "China." Given Taiwan's close relationship to the U.S. and allied countries during this period, many other diplomats, public health workers, and governments also recognized and referred to the Nationalist state in Taiwan as "China." In this chapter, I refer to the post-1949 Nationalist state as "Taiwan" or the "Republic of China (ROC)," and the mainland-based Communist state as "(mainland) China" or the "People's Republic of China (PRC)." Both states referred to Taiwan as a province of a larger, contested "Chinese" state, thus many of the government organizations that oversaw the entirety of the territory governed by the ROC are referred to as "provincial."

method increasingly exported through international health networks to countries throughout Asia and the Pacific. When the focus of reproductive health globally shifted in the later 1950s from concerns over mortality to fears of excess fertility, these same female health workers proved critical to engaging rural women in large-scale projects of "family planning" or "planned birth", serving as liaisons between global population anxieties and the quotidian concerns of rural women across capitalist and socialist blocs in the Pacific.

MCH in the Postwar World: Afterlives of the LNHO and the Rockefeller IHD

From its founding, the WHO relied heavily on the personnel and precedent of interwar and wartime public health endeavors in China. In 1946, an Interim Commission under the auspices of the United Nations began planning a new global organization for managing health and successfully oversaw the amalgamation of the *Office International d'Hygiene Publique*, the Heath Division of the United Nations Relief and Rehabilitation Association (UNRRA), and the League of Nations Health Organization (LNHO). Andrija Štampar, who had been among the key orchestrators of the westward expansion of public health in Nationalist China, served as chairman of the Interim Commission and later president of the First World Health Assembly.[567]

From the earliest envisioning of a new, global health organization, MCH figured among its most pressing concerns. Initially, the Interim Commission identified four critical areas for the management of global health: malaria, tuberculosis, venereal diseases, and MCH. At the Fifth Session of the Interim Commission in March 1948, delegates articulated the particular

[567] James A. Doull and Morton Kramer, "The First World Health Assembly," *Public Health Reports* 63, no. 43 (Oct. 22, 1948): 1379-1403, 1386-88.

importance of MCH programs based on a shared perception of children as important "resources" for the political and economic development of nation-states. A report of the session read,

> Among nations, there is a general recognition that children are their greatest asset in terms of human resources, and that to assure for them physical and mental health, it is essential that they be born in satisfactory conditions, have the advantage of adequate food, shelter, clothing, and maternal care, as well as an opportunity for education and normal family life.[568]

After the official founding of the WHO one month later, the First World Health Assembly of June 1948 codified the primacy of MCH as integral to the global expansion and centralized management of public health. Given the overlapping investments in MCH between the WHO and the newly founded UNICEF, these two organizations worked together to develop global programs in MCH throughout the latter half of the twentieth century.[569]

The vision of MCH adopted by the 1948 assembly reflected a number of earlier, wartime developments. First, the choice of "MCH" reflected a global trend toward an expanding purview of women's and children's health, from an earlier emphasis on mothers and infants to a more capacious field that reflected a long view of reproduction, from fertility and conception to childhood development and adolescence.[570] Further, the official program in MCH drew from the earlier transnational activism of maternalist feminists to emphasize not only biomedical measures of health, but also the broader economic and social wellbeing of women and children.

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[568] "Fifth Session of the Interim Commission," *WHO Chronicle* 2, no. 3 (March 1948), 39.

[569] Ibid.; Doull and Kramer, "The First World Health Assembly," 1386-88.

[570] By the later twentieth century, this field would be expanded further under the moniker "reproductive health," defined by the WHO as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes." This contemporary, broader field includes, in addition to the treatment and prevention of STIs, an emphasis on reproductive choice and men's impact on the health and welfare of mothers and children. See Jane Fisher, Jill Astbury, Meena Cabral de Mello, Shekhar Saxena, eds., *Mental Health Aspects of Women's Reproductive Health: A Global Review of the Literature* (Geneva: WHO, UNFPA, 2009), 1; James A. Doull and Morton Kramer, "The First World Health Assembly," 1379-1403.

The official program explicitly endorsed the "protection of the health of adolescents—particularly girls—and expectant and nursing mothers employed in gainful occupations and prohibition of the gainful employment of children."[571] Further, the program integrated concerns particular to working women by calling for expectant mothers to receive maternity leave with the "continuation of adequate wages for the duration of leave."[572] According to the WHO's vision, mothers would also have access to medical care both at home and in hospital, and receive "consultation on the hygiene of pregnancy and on feeding, care, and upbringing of children."[573] The inclusion of this broad view of women's and children's health occurred, in part, through the direct participation of maternalist voices in the early work of the WHO. Specifically, Dr. Marion Yang Chongrui of China joined the WHO's Expert Committee on Maternal and Child Health that also included Indian nursing expert T. K. Adranvala and American engineer of New Deal women's and children's programs Dr. Martha May Eliot.[574]

At its first meeting, the committee's proposals mirrored the earlier work of the LNHO and the Rockefeller Foundation in its emphasis on aid to national governments and fellowships for native medical practitioners to study in the West. By the meeting of the Second World Health Assembly in October 1949, the committee had reportedly received requests for these types of assistance from a number of countries throughout the world. Aside from the continuities in prioritizing aid and education, the committee's guiding principles reflected the continued conceptual labor of MCH for articulating categories of difference, now integral to newly

[571] Doull and Kramer, "The First World Health Assembly," 1387-88.

[572] Ibid.

[573] Ibid.

[574] "Maternal and Child Health" *WHO Chronicle* 3, no. 3 (March 1949): 45-6.

conceived divisions of the world. A report on MCH programs from the Second World Health Assembly read,

> The potentialities of work in maternal and child health are apparent from the fact that infant mortality varies today from below 30 per 1000 live births in some countries to over 300 in others…It is sometimes forgotten that the most widespread and most serious ill-health is not due specifically to tuberculosis, malaria, cholera, typhus, or indeed to any other single factor, but to a concatenation of circumstances, which result from dirt and ignorance. Food production does not improve only by destruction of weeds. Health will not improve greatly by only attacking disease.[575]

Thus, the metrics of MCH helped shape emerging notions of developed and developing worlds, as this distinction came to replace notions of colonizer and colonized in the postwar era. The state of women and children, specifically their health, made clear the areas of the globe most in need of the WHO's aid and expertise. Depending on the case and actor, these metrics of difference could be used to highlight the superiority of more developed areas of the world or to point out structural inequities that shaped relationships of domination and exploitation. For the WHO, quantifiable metrics of mortality provided incontrovertible evidence of differing levels of development, not only legitimating the WHO's existence but focusing its efforts in terms of gender, age, and geography.

Further, as the quote above demonstrates, many in the WHO agreed that the work of MCH entailed more than "attacking disease." The conditions that gave rise to high rates of mortality could not be easily reformed through the providing of funds and medicine alone. Rather, the "concatenation of circumstances" that produced crises in MCH throughout the Global South resulted from a widespread lack of hygiene and an even more dire lack of knowledge. Thus, the MCH program adopted at the Second World Health Assembly emphasized education

[575] "Second World Health Assembly," *WHO Chronicle* 3, nos. 8-9-10 (October 1949): 188-9; see also "Maternal and Child Health."

of both medical personnel and interventions at the level of individual households.

> Successful work for maternal and child health is based on teaching people what they can do for themselves. It can co-operate with the agricultural and animal husbandry departments to ensure that improvements in nutrition take place in the homes; with departments of education, social welfare and sanitation to improve the standard of living.[576]

Based, in part, on the spheres of predecessor organizations, the WHO further divided the world into six regions. The former Pan American Sanitary Organization (PASO) became a WHO regional organization for the Americas, while the Pan Arab Sanitary Bureau became integrated into the WHO as a regional office governing the Eastern Mediterranean.[577]

In Asia and the Pacific, the international public health landscape took shape in tandem with developing Cold War alliances. Rockefeller representatives participated in the formation of the WHO as part of American delegations to the World Health Assemblies. However, the Rockefeller IHD continued to operate as such in East Asia into the early 1950s. In the early postwar era, the institutions founded and supported by the Rockefeller foundation and its once affiliated China Medical Board remained in contact with their American partners, even after 1949.[578] The outbreak of the Korean War sharpened Cold War divisions in the Pacific that severed ties between China and the U.S., ultimately contributing to the demise of the Rockefeller IHD. The U.S. government placed restrictions on the movement of people and funds to the People's Republic of China. With the loss of its major investments in China and the growing dominance of U.N. institutions, the Rockefeller IHD formally disbanded in 1951. Many of its

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[576] Ibid.

[577] Neville M. Goodman, "First World Health Assembly," *The Lancet,* August 4, 1948, 265; see also Michael McCarthy, "A Brief History of the World Health Organization," *The Lancet* 360, no. 9340 (October 12, 2002): 1111-1112.

[578] Mary Augusta Brazelton, "Western Medical Education on Trial: The Endurance of Peking Union Medical College, 1949-1985," *Twentieth-Century China* 40, no. 2 (2015): 126-45, 129.

personnel, including John Black Grant, continued their work under the auspices of the WHO, while other divisions of the Rockefeller Foundation, including the Population Council, would continue to influence public health policies throughout the world.[579]

The WHO had previously established a Western Pacific Regional Office (WPRO) in British Hong Kong. In 1951, the WPRO relocated to occupy the same geographic seat as the disbanding Far East Bureau of the Rockefeller IHD in Manila.[580] This regional office oversaw WHO projects with the Republic of China in Taiwan, which many states and the U.N. itself continued to recognize as the legitimate government of a unified China until the 1970s. Though the Republic of China briefly left the WHO in the immediate wake of the Chinese Communist victory, it soon rejoined the organization to become a critical site for cooperative ventures between the WHO, UNICEF, and American aid organizations in the Pacific by the mid-1950s.[581]

U.S. Interests in the Early Cold War

For many in the intertwined circles of U.S. business, government, and philanthropy, the Chinese Communist Revolution resulted in the devastating loss of decades-long investments that exacerbated growing fears of global communism. Perplexed by this perceived catastrophe, many U.S. academics and policy makers developed theories to explain global processes that produced differing levels of stability and development throughout the world. As Nils Gilman has argued,

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[579] For more on the founding of the Population Council, see Matthew Connelly, *Fatal Misconception: The Struggle to Control World Population* (Cambridge, MA: Belknap, Harvard University Press, 2008), 155-62.

[580] Though both organizations chose Manila as headquarters for Pacific operations, the WHO office occupied a newly constructed building. See "Founding of the Western Pacific Regional Office," *World Health Organization: Western Pacific Region.* http://www.wpro.who.int/about/in_brief/history/en/ (accessed November 15, 2016).

[581] For more on the ROC's brief absence from the WHO, see "Government of Republic of China in Formosa withdraws from WHO," *WHO Chronicle* 4, no. 4 (June 1950), 194.

in many cases, these often collaborative endeavors between social scientists, scientists, business interests, and policy makers reflected anxieties about conditions within the U.S. that gave fodder to international critics and ideological foes. These various parties sought to identify how, when, and why societies became "modern," and how U.S. actors might intervene to accelerate or channel these processes. This "modernization theory," in many ways, provided more of a conceptual field with moving targets rather than a clearly defined teleology, as conditions within the U.S. fueled an ongoing debate regarding the precise meaning and pathway of "modernity" and how or whether it should be enacted globally.[582]

The debates among actors moving between academia and government ultimately produced a loose consensus that famine, pestilence, and suffering in the third world fostered anti-Western resentment and provided a breeding ground for socialist revolutionaries. This shared assumption connected U.S. postwar ventures to the civilizing missions of the interwar period, as we have seen in the case of China. Despite a more hardened anti-communist ideology, postwar ventures shared with interwar programs foundational assumptions that aligned the interests of U.S. foreign policy with those of corporate capitalism, philanthropy, and state-building in Asia, Africa, and Latin America. Further, these postwar ventures, with a more developed goal of "modernization," continued the practice of large-scale investments in impoverished regions of the world, based on a belief that with U.S. guidance and support, third-world misery could be transformed into first-world prosperity, thereby thwarting socialist revolution and fostering zones amenable to the aims of varied yet intertwined U.S.-based actors.[583]

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[582] Nils Gilman, *Mandarins of the Future: Modernization Theory in Cold War America* (Baltimore: Johns Hopkins University Press, 2003), 3-5; see also Michael E. Latham, *Modernization as Ideology: American Social Science and "Nation Building" in the Kennedy Era* (Chapel Hill: University of North Carolina Press, 2000), 2-4.

[583] Latham, *Modernization as Ideology*, 2-6.

The management of reproduction proved integral to both articulating countries' relative positioning along the path of modernization and identifying the sources of third-world misery. In the early 1950s, philanthropic organizations and public health officials throughout much of the world continued to prioritize reductions in maternal and infant mortality amid shifts in scientific circles that would ultimately shape later programs in public health. Even by the late 1940s, a limited number of figures within the U.S. government and academy began to voice concerns that investments in public health globally had been perhaps too successful, upsetting the balance between fertility and mortality that kept population growth at bay. In 1944, demographer Dudley Kirk wrote, "The day is rapidly passing when a handful of Europeans, equipped with superior weapons and a complacent and somehow contagious faith in white supremacy, can expect indefinitely to dominate the half of the world that is occupied by the colored peoples."[584] As in earlier decades, reproduction continued to provide a key field for identifying differences between races and states, however, in Kirk's article, the emphasis shifted from excess mortality to excess fertility. "In regard to demographic matters," he argued, "the different countries of the world may be considered on a single continuum of development…In areas relatively untouched by Western influences, the typical demographic situation today is one of high birth rates and high death rates…"[585] The dissemination of capitalism, medicine, and philanthropy, Kirk argued, had

> …ameliorate[d] the effects of these disasters. Before the war, the British in India, the Dutch in Java, the Japanese in Korea, we ourselves in the Philippines and Puerto Rico, had softened the impact of calamity, and had made effective the normal high rate of natural increase. This is the typical 'colonial' situation today, characteristic of most of the Far East, the Mohammedan world, and much of Africa and Latin America.[586]

[584] Dudley Kirk, "Population Changes and the Postwar World," *American Sociological Review* 9, no. 1 (1944): 28-35, 35.

[585] Ibid., 29.

[586] Ibid., 29.

Though imperialist ventures had succeeded in thwarting mortality, Kirk argued, they had inadvertently contributed to an impending Malthusian crisis. Though economic development in the first world had produced a "small family pattern" that began to reduce birth rates along with death rates, inferior economic development in the Global South had not yet produced this reduction in fertility. "The list of countries facing the likelihood of future population decline is a roster of the nations that have led the world in material progress," Kirk argued.[587] In less developed countries, "the youth of their popualtions, and the inevitable lag in the decline of fertility from its present levels posit substantial future growth of population in these areas for some years to come."[588] Thus, as Kirk argued, patterns of reproduction provided a key index for a society's overall development relative to other nation-states. Further, the "white man's burden" had shifted to a new responsibility of managing third-world fertility.

Kirk belonged to Princeton University's Office of Population Research, an early and influential institute that foreshadowed growing investments by U.S. philanthropists and government organizations in the field of demography. The influential group of demographers at Princeton also included Frank Notestein, who had demonstrated significant interest in the case of China. In addition to producing earlier studies based on the data of John Lossing Buck, Notestein participated in a Rockefeller-sponsored survey of China in 1948 and early 1949, witnessing first-hand the ascendancy of Chinese communism. The Chinese Revolution, which sent shockwaves throughout U.S. circles, reportedly had a profound impact on Notestein and the group of demographers at Princeton who began advocating fertility management as a means for promoting economic growth and thwarting communism in less-developed countries.[589] Surprisingly,

[587] Ibid., 30.

[588] Ibid., 30.

Notestein's ideas about the relationship between fertility management and economic development based on the Chinese case would also provide inspiration for later architects of planned-birth policies in both Taiwan and the People's Republic.[590]

The ideas propagated by Princeton demographers gained support throughout government, academia, and philanthropy, as the historical conditions of the early Cold War fostered a demand for technocratic solutions. Similar offices for population research sprang up at other universities, including the University of Michigan Population Studies Center, founded in 1961, which would become particularly influential in the management of fertility in the U.S. sphere of influence in Asia.[591] Under the influence of later U.S. Secretary of State and then Rockefeller Foundation trustee John Foster Dulles, John D. Rockefeller, III became particularly interested in the implications of fertility management for economic growth and the global war against communism. In 1952, a conference held in Williamsburg, Virginia brought together experts in demography, economics, and public health, including then Rockefeller IHD Far East Director Marshall Balfour. From this conference emerged the Population Council, a new venture in service of longrange U.S. aims to modernize the third world. Unsurprisingly, these endeavors came to focus on Asia, the region possessing the highest levels of population density and in which the Rockefeller Foundation had long maintained large-scale operations. In 1959, Notestein became president of this new organ of the Rockefeller Foundation that would play a key role in

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[589] Susan Greenhalgh, "The Social Construction of Population Science: An Intellectual, Institutional, and Political History of Twentieth-Century Demography," *Comparative Studies in Society and History* 38, no. 1 (1996): 26-66, 40. See also Simon Sreter, "The Idea of Demographic Transition and the Study of Fertility: A Critical Intellectual History," *Population and Development Review* 19, no. 4 (1993): 659-701.

[590] Thomas Scharping, *Birth Control in China, 1949-2000: Population Policy and Demographic Development* (New York: RoutledgeCurzon, 2003), 29-30.

[591] Ronald Freeman, John Y. Takeshita, and T. H. Sun, *Fertility and Family Planning in Taiwan: A Case Study of Demographic Transition* (Ann Arbor: University of Michigan Population Studies Center, 1964), 14.

shaping reproductive health throughout the world but especially in Taiwan.[592]

The ideology of modernization bound reproduction to economic development and the relative status of nation-states. Thus, in many ways, the tenets of modernization theory linked the interventions of U.S.-based and global organizations in the new order of the Cold War to earlier U.S.-based civilizing missions of the interwar period. However, as seen in both the cases of Nationalist Taiwan and Communist China, the enactment of schemes to modernize reproduction depended not only on these persistent conceptual frameworks, but also on continuities of methods, institutions, and personnel that ultimately aided the management of both mortality and fertility in rural areas of sinophone East Asia.

MCH in Nationalist Taiwan

The public health landscape in Nationalist Taiwan drew from the remnants of successive colonialisms, culminating in the penetration of the island by the Nationalist state in the late 1940s. The increasingly universalized metrics of health that categorized women according to modes of birthing and mothering shaped the fraught ethnic politics of localized public health endeavors allied with an assimilationist, predominantly Han government. MCH programs disproportionately targeted native and aboriginal populations in Taiwan, shoring up their acceptance of Nationalist rule and bringing them into regular encounters with the varied organs of the newly arrived Nationalist government. In addition to the linguistic divisions that separated Mandarin-speaking newcomers from existing populations most fluent in Japanese, Hoklo, or Austronesian languages, biomedical metrics of reproduction also structured relations between

[592] Connelly, *Fatal Misconception,* 155-62; Alison Bashford, *Global Population: History, Geopolitics, and Life on Earth* (New York: Columbia University Press, 2014), 287-300; see also Alexandra Dundas Todd, "The Prescription of Contraception: Negotiations between Doctors and Patients," in Phillip K. Wilson, ed., *Childbirth: Reproductive Science, Genetics, and Birth Control* (New York: Garland Publishing, 1996), 389-418, 391-93.

"people from outer provincces (*waishengren*)" and those who had lived in Taiwan before the Nationalist occupation, figured as "people of this province (*benshengren*)."[593]

Like much of Taiwanese politics, public health in general and MCH in particular remained shaped by Taiwan's critical place in U.S. foreign policy in the Cold War Pacific. In the immediate wake of World War II, many in the U.S. government favored abandoning support of the Nationalist regime. However, the founding of the PRC in 1949 and the subsequent outbreak of hostilities in Korea shaped a renewed commitment to the defense of Nationalist Taiwan as part of a broader sphere of U.S. influence. By 1954, the Nationalist ROC and the U.S. government formally entered into a Mutual Defense Treaty, later amended to guarantee U.S. defense of not only the main island of Taiwan, but also surrounding minor islands claimed by the Nationalists. Within this context, public health endeavors in Taiwan drew from the aid of global organizations as well as several U.S.-government agencies and U.S.-based philanthropies. By the late 1950s, the foreign parties directly invested in Taiwanese MCH included the WHO, UNICEF, the Sino-American Joint Commission on Rural Reconstruction (JCRR), the U.S. Agency for International Development (USAID), and the Population Council. The precise nature of the work of these varied agencies shifted in the early postwar decades to accommodate vicissitudes in Cold War ideology, making the science of reproduction a politically and culturally contingent field of knowledge and practice.[594]

As the Rockefeller IHD and the WHO transitioned to a new postwar program in the Pacific, Marshall Balfour of the IHD, who later played a role in the founding of the Population

[593] For more on these categories, see Scott Simon, "Multiculturalism and Indigenism: Contrasting the Experiences of Canada and Taiwan," in Tak-Wing Ngo and Hong-zen Wang, eds., *The Politics of Difference in Taiwan* (New York: Routledge, 2011), 14-34, 20-21.

[594] Matthew Connelly, *Fatal Misconception,* 155-62.

Council, provided a report on the state of health and medicine in Taiwan for the Rockefeller Foundation in 1949. According to Balfour, the Japanese had built an impressive infrastructure of public health institutions and personnel. Following the German-Japanese school of public health, police power had supported this public health scheme, strengthened by formal colonial subjugation. Balfour reported,

> While the public health policy under the Japanese cannot be described as humanitarian, human beings were regarded as an economic asset to be safeguarded. The public health measures and medical care were aimed at maintaining a healthy labor force. Consequently, death rates decreased from 33 to 20 during the Japanese period and a natural increase in the population has been the result. Whether or not such colonial administration is admired, the fifty year[sic.] record shows a marked growth of population under conditions of enforced order, epidemic control, and a favorable agricultural and industrial development.[595]

For Balfour in 1949, population growth provided evidence of Taiwan's favorable position among regions in Asia. Balfour's positive assessment of Japanese achievements further cited an estimated 6,000 doctors on the island at the end of World War II. As Balfour noted with specific reference to Japan, this figure reflected a ratio comparable to developed countries of one doctor per one thousand inhabitants. In stark contrast to mainland China, where a dearth of biomedically trained personnel had plagued public health efforts for decades, Balfour reported that a surplus of qualified doctors left many unemployed in Taiwan. Balfour further observed some 600 nurses, "numerous" midwives, and thousands of hospital beds on the island.[596]

Despite the foundation laid by the Japanese, public health had faced a number of setbacks both in the final years of the war and in the years immediately thereafter. As the Japanese neared defeat, health and medical services reportedly suffered. Since the Nationalist government had

[595] Marshall C. Balfour, "Taiwan: Public Health and Medical Care," 1949 (RAC, RF Records RG2 Series 601 Box 464 Folder 3110).

[596] Ibid.

taken control of the island, the situation had further deteriorated. "Under Japanese control," Balfour reported, "plague was eliminated, cholera and smallpox were rare. Since 'liberation,' cholera and smallpox recurred in serious fashion in 1946-47."[597] Aside from the preoccupations of the Nationalist regime, Balfour argued that local Taiwanese resented the exchange of one colonial ruler for another. According to Balfour, "The Taiwanese were ill prepared for responsibility; being independent and separatist-minded, they have not welcomed the Chinese from the mainland."[598] Thus, Balfour's early survey of Taiwan's public health landscape pointed to Japanese efficacy, Nationalist incompetence, and indigenous intractability.

The authoritarian and anti-indigenous oppression by the Nationalist regime did little to assuage the concerns of foreigners or advance public health in the years surrounding the retreat to Taiwan. After the infamous massacre of indigenous people by Nationalist forces on February 28, 1947, the Nationalists ruled Taiwan under an authoritarian regime of martial law until 1987. In 1949, Robert Briggs Watson of the IHD wrote that many Chinese public health workers who had followed the Nationalist regime to Taiwan received little support for their efforts to build on the institutions of Japanese colonialism. Many had since abandoned their work, with others considering the option of an attempted return to the mainland. According to Dr. Watson, "since the [Chinese National Institutes of Health] have been unable so far to get funds to Taiwan, I guess they will move back. They never should have left in the first instance."[599] Thus, in the months surrounding the founding of the PRC in October 1949, many foreign and Chinese medical personnel grew pessimistic regarding the future of public health under a Nationalist

[597] Ibid.

[598] Ibid.

[599] Watson to Tenant, March 10, 1949 (RF Archives, RG 2 Series 601 Box 464 Folder 3110, RAC, Sleepy Hollow, NY).

regime in Taiwan. For many, hopes for the development of public health were further diminished by the founding of the PRC in 1949, its accompanying diplomatic tensions, and the ROC's formal departure from the WHO roughly five months later.[600]

However, the early 1950s saw a gradual strengthening of Taiwan's relations to the United States, its allies in the Pacific, and, ultimately, newly founded international organizations including the WHO and UNICEF. As Taiwan grew more critical to U.S. efforts to thwart the spread of communism, former graduates of Rockefeller training programs in the mainland gained positions within the "provincial" health administration under the new Nationalist regime. The list of public health workers that relocated to Taiwan in the late 1940s and 1950s included J. Heng Liu, a prominent figure in global health that linked Chinese operations to the intertwined mission of the Rockefeller IHD and the WHO. In the early 1950s, Liu began regular conferences that included both Taiwanese practitioners and representatives of international health organizations, with the aim of building on the legacy of Japanese colonialism to develop public health in Taiwan.[601]

While the ROC's relationship to global health organizations remained in flux, a number of international and local developments affirmed the critical place of women's reproductive health to Taiwan's position in a new global order. Beginning in the early 1950s, John Black Grant, who had initially envisioned the Rockefeller IHD's midwifery reform program in the 1920s, worked as an emissary of the WHO throughout Asia and the Pacific. During a 1950 visit to Taiwan, Grant reportedly advised Taiwanese health authorities to station nurses and midwives

[600] "Government of Republic of China in Formosa withdraws from WHO," 194.

[601] John R. Watt's article on healthcare in Taiwan provides both a secondary source of information on these developments in Taiwan and a primary source demonstrating the effects of modernization theory on U.S. philanthropy in the region. See John R. Watt, "Advances in Health Care in Taiwan: Lessons for Developing Countries," *Kaohsiung Journdal of Medical Sciences* 24, no. 11 (November 2008): 563-67, 564.

in local health stations, based on the exceptional utility of MCH and women practitioners to reach individual households in remote and rural areas.[602] Through Grant's international networks, this particular tack for generating public health schemes shaped endeavors elsewhere in Asia. For example, in the early 1950s, midwives from Taiwan trained earlier in institutions on the mainland traveled to Thailand as ambassadors of a transnational project to combat maternal and infant mortality.[603]

Contemporaneously, politically engaged women in Taiwan emphasized the importance of childcare services and healthcare, in a move that connected women's concerns to the ideology of an authoritarian state purportedly in the midst of a national crisis. As Doris Chang has argued, these endeavors demonstrated continuities with the history of both Nationalist ideology and feminist activism on the mainland. Influenced heavily by the positioning of Soong May-ling as model maternalist exemplar, some women in Taiwan founded organizations that advanced social welfare programs under the guise of state ideology. Beginning in 1950, the Provincial Women's Association began to advocate for programs that would enhance the health and wellbeing of rural women on the island, whom they had observed toiling in rice paddies while their undernourished children suffered in tropical heat. Citing the government's own emphasis on the links between a strong race and a strong state, the provincial women's association successfully lobbied for childcare and nutrition programs in rural areas, supported by funds from the provincial

[602] Ibid., 563-64.

[603] Waijiao Bu 外交部, *Lü tai huaqiao song shen fuwu xueli zhengjian* 《旅泰華僑送審服務學歷證件》(1951-1954)(Academia Historica); Grant's continued movement until his death in 1962 among the sphere of U.S. influence in the Pacific, including Taiwan, Japan, and the Philippines, further cemented the perpetuation of these networks as a legacy of his interwar operations in the Pacific. See also John Black Grant obituary, *New York Times,* Oct. 18, 1962 (Necrology File for John Black Grant, Bentley Historical Library); For more on the history of midwifery and obstetrics in Thailand/Siam, see Quentin (Trais) Pearson, "'Womb with a View': The Introduction of Western Obstetrics in Nineteenth-Century Siam," *Bulletin of the History of Medicine* 90 (2016): 1-31.

government of Taiwan.[604]

As public health in Taiwan drew nearer to the global work of the WHO, the organization officially welcomed the ROC's full participation as the recognized government of "China." After a clear indication of the ROC's intention to rejoin the negotiation, J. Heng Liu traveled to Geneva and New York in 1952 to negotiate Taiwan's re-entry to the organization.[605] Through the lobbying of I.C. Fang, a Chinese doctor who became the first director of the WPRO in Manila, the Nationalist government fulfilled membership obligations and the WHO formally reinstated its membership. From 1951 to 1971, the ROC government of Taiwan participated in the WHO as the sole representative of "China."[606]

Public health advocates in Taiwan began a sustained partnership with the WHO and UNICEF that would later incorporate American aid agencies and academics to become the cornerstone of MCH throughout ROC territory for the next several decades. In March 1952, the WHO, UNICEF, and the health administration of Taiwan entered into a formal agreement of cooperation to advance biomedical midwifery and scientific mothercraft from a new, centralized clinic in the city of Taichung. Though the initial endeavor remained but a modest, localized "demonstration center," all parties involved took advantage of ambiguous language in the agreement to expand the reach of the center's operations and extend cooperative arrangements into the 1970s. The primary objective of the Taichung program centered on demonstrating

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[604] Doris Chang, *Women's Movements in Twentieth-Century Taiwan,* (Urbana: University of Illinois Press, 2010), 66-69.

[605] M.C. Balfour to Robert Briggs Watson, July 8, 1952 (RF Archives, RG 2 Series 100 Box 8 Folder 45, RAC, Sleepy Hollow, NY).

[606] I. C. Fang to Grant, April 21, 1953 (RF Archives, RG 2 Series 100 Box 7 Folder 45, RAC, Sleepy Hollow, NY); see also "Who Representative Office in China," WHO WPRO, http://www.wpro.who.int/entity/country_focus/country_offices/co_history/chn_history/en/ (accessed November 16, 2016).

"modern methods of maternal and child care within the economic and social resources of China (Taiwan) and in harmony with its cultural background, as an integral part of the national health services."[607] Further, the cooperative endeavor would facilitate training for practitioners in these methods and broader curative and preventive health services. In addition to the renewed commitment to midwifery as a means of reaching rural populations, the agreement affirmed a now honed strategy of using MCH to spur public interest in public health more broadly. The formal agreement included the stated objectives of developing "the group approach to socio-medical problems and to stimulate community participation in the health services," as well as surveying "the utilization of the services by the community" as related to "the reduction of mortality, the economy of the country, and any other indices as may be practicable."[608]

Much about the endeavor, from the continued promotion of midwives to the facilities themselves, demonstrated the adaptation of global projects to local conditions. An initial team of foreign experts affiliated with the WHO, comprising one doctor, one public health nurse, and one nurse-midwife, arrived in Taiwan in August of 1952 supported by funds and logistical aid from UNICEF and the provincial government. The center's facilities, though regarded as primitive by some, remained a concession to local conditions. One doctor writing in June 1956 reported,

> the premises are ill adapted for MCH work...nevertheless there is an air of informality about them that is of value. A more efficient chrome and glass clinic might frighten mothers away and the fact that the demonstration clinics are held in worse premises that their own health stations ought to encourage students.[609]

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[607] Agreement between the Government of China (Taiwan) and the World Health Organization and the United Nations International Children's Emergency Fund for the Operations of a Maternal and Child Health Educational and Services Demonstration Project," 1952 (CHINA - 3 1955-1970 MCH MM-Projects WPRO China, WHO Archives, Geneva), 1-2.

[608] Ibid., 1-2.

[609] T. S. Chen to Dennis Pirrie, June 22, 1956, *Shijie weisheng zuzhi fuyou weisheng zhuanjia gongzuo baogao*《世界衛生組織婦幼衛生專家工作報告》（1957） (Academia Historica, Taipei).

Beyond this concession as a means not to "frighten mothers," an early official report on the center deleted this description of the facilities at the request of provincial health authorities, who "[could] not agree that the premises holding demonstration clinics is[sic.] really so bad as what he described."[610]

The complexities of Taiwan's ethnic and cultural dynamics presented challenges that led some WHO representatives to call for further adjustments. Chief among these remained multiple language barriers, which presented a particular point of frustration for WHO emissary Vera Watson. In 1952, Watson wrote that weekly Mandarin classes remained of limited utility, as many of the midwives and nearly all of the villagers spoke Taiwanese. Despite interpreters, the barrier separated WHO staff not only from native practitioners but also from the local people about whom they sought to collect data through home visits. Watson advised that future WHO personnel be given Taiwanese classes in Geneva or Manila before arrival in Taichung, but archives bear no evidence that this came to fruition in the 1950s or 1960s. The MCH center arranged for regular, on-site English classes for locals in an attempt to bridge linguistic divides.[611]

Watson further noted local conditions and customs that shaped early efforts to expand MCH on the island. After lauding a midwife who forded a river with a bicycle at 3:00 a.m. to attend a birth, Watson chastised another who worked too slowly and preferred to aid wealthier women who welcomed her rather than poorer women perceived to harbor the greatest need for her services. Watson noted that no mothers were visited on the fourth or fifth days after delivery,

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[610] C.H. Yan to I. C. Fang, March 20, 1957, *Shijie weisheng zuzhi fuyou weisheng zhuanjia gongzuo baogao* 《世界衛生組織婦幼衛生專家工作報告》(1957) (Academia Historica, Taipei).

[611] Vera Watson, "Informal Supplementary Report," September 19, 1952. 《世界衛生組織婦幼衛生專家工作報告》(1957) (Academia Historica, Taipei).

due to superstitious, phonetic connections between local words for "four" (*si* in Mandarin) and "death" (*si*) as well as "five" (*wu)* and "mistake" (*wu*). Watson felt that the local custom to eat a diet of only meat and fish for the first month after delivery may ultimately be of medical benefit, given the increased take of protein. Further, Watson argued that the local custom of nursing a child until the age of four or five could and should be discouraged through general economic development.[612]

The fault found with local midwives and birthing practices affirmed notions not only of peculiar social customs but also the inadequacy of earlier public health programs. Despite Marshal Balfour's earlier observations regarding the efficacy of Japanese public health practices, WHO representatives in the 1950s came to view Japanese-trained midwives and Japanese-founded institutions as inferior. Thus, in its early days, the Taichung center focused on "refresher-courses" for existing midwives in Taiwan, much like earlier refresher courses in Beiping that had sought to reform midwives inadequately trained by missionaries.[613]

The early work of the Taichung center brought to Taiwan increasingly universalized notions of difference rooted in women's varied capacity to reproduce and nurture according to biomedical metrics. In its early years, the Taichung clinic mostly treated women from "outer provinces" who had fled the Communist revolution along with the Nationalist government. However, biomedical metrics of health, hygienic childbirth, and sound nurturing rendered stark the divisions between these *waisheng* women and rural *bensheng* women, affirmed by scientific fact. Public health officials quickly identified indigenous women in remote areas as those most in

[612] Ibid.

[613] "Plan of Operations for the Refresher-Training of Private Practicing Midwives for the Refresher-Training of Private Practicing Midwives in Taiwan Province of the Republic of China," 1952 (CHINA - 3 1955-1970 MCH MM-Projects WPRO China, WHO Archives, Geneva); see also Chapter Two of this dissertation.

need of biomedical intervention. Emphasizing that the true need remained in poor villages inhabited by "aborigines," public health workers soon began monthly field excursions to promote biomedical MCH in isolated and poor villages. Beginning in 1953, the Taichung center extended its reach outward, conducting public demonstrations in hygienic methods of childbirth and mothering within a four-*li* radius in the southeastern region of Taichung. In 1955, the geographic reach of the center doubled to include a perimeter of 8-*li.* By 1957, the reach of these demonstrations extended yet again to include an 8-*li* radius of the Taichung Municipal Hospital in the city center. The architects of these demonstrations envisioned them as bringing indigenous people into a developing provincial health system while providing midwifery students opportunity to develop skills for "improvised conditions."[614]

Staff at the Taichung center soon developed a grand vision for a network of fifty health stations scattered throughout the island, each staffed with one nurse-midwife and one doctor. These local health stations further facilitated encounters between rural *bensheng* women and ever-expanding structures of national and global health. According to a 1955 report from the Taichung center, local health stations conducted "house to house surveys" that collected records for every family within a designated area. MCH personnel used these records to monitor the health of all "ante-natal mothers, post-natal mothers, new born babies, infants, pre-school and school children" within their respective spheres.[615] Much of this work explicitly targeted indigenous people of the island, as the biomedical metrics that dictated those in greatest need

[614] Ibid; see also *Taiwan sheng fuyou weisheng yanjiu suo tuixing fuyou weisheng shifan gongzuo chengguo ji jianglai kuozhan jihua*《台灣省婦幼衛生研究所推行婦幼衛生示範工作成果暨將來擴展計畫》(Taichung, August 1965) (Academic Historica, Taipei).

[615] Vera Watson, "Maternal and Child Health Demonstration Project: Final Report and Evaluation of Nursing Activities, August 1952 – July 1955," (Taichung: July 1955), 1 (WHO Archives, Geneva).

fostered the construction of local health stations in mountainous and remote regions.[616]

The extension into indigenous and rural communities did little to improve perceptions of MCH in Taiwan. Rather, the data collected by locally operating midwives only affirmed categories of difference shaped by gender and biomedical knowledge, both in terms of expertise and as a measure of sound reproduction, as they intersected with other locally salient categories of ethnicity and urbanity. According to the 1955 report, local MCH workers affiliated with the Taichung center had now determined that large numbers of women continued to rely on "unqualified personnel," who attended roughly half of all births in Taiwan. The continued prevalence of lay and Japanese-trained midwives resulted, it was argued, from the fact that the WHO-affiliated Taichung center remained the only facility on the island that provided sound training to nurse-midwives. Thus, the extension of the Taichung services provided data to shore up continued and expanded international ventures in Taiwan. Vera Watson reported to the WHO in 1955,

> What is most necessary is more midwives. What is necessary is to raise the standard and level of people undertaking deliveries. The need for international staff for the MCH projects will not be so great in the future, but the need for international staff for an entirely new project—such as a Midwifery Education project should be considered by the government.[617]

Watson's report concluded by echoing a familiar refrain regarding the lack of adequately trained personnel, the dangers of lay practitioners, and thus the necessity of further expansions to the Taichung program.[618]

The perceived need for greater intervention led MCH workers to solicit partnerships with

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[616] Ibid.

[617] Ibid.

[618] Ibid.

additional foreign agencies, beyond the WHO and UNICEF. The Taichung center, like the *de facto* independence of Taiwan as a whole, came to depend upon the support of the U.S. government and remained imbricated within U.S. endeavors to maintain a sphere of influence in the Cold War Pacific. U.S. government programs, including the United States Information Service, USAID, and the Sino-American JCRR, provided direct support to the Taichung center and the broader development of MCH in the ROC beginning in the 1950s.[619]

As the MCH project continued to expand outward from Taichung and into rural areas, aims to strengthen and extend Nationalist authority aligned with humanitarian motives and the foreign policy aims of the U.S. government to shape the course of MCH projects. In 1952, the JCRR worked with rural health expert S. C. Hsu 許世鉅, a graduate of the Rockefeller-founded Peking Union Medical College in Beijing, to develop a program to provide funding specifically for MCH services in rural areas. The proposal for this program cited earlier official correspondence, noting that the funds requested by the provincial health authorities from the JCRR would be used to "invite international experts in women's and children's health to come to Taiwan to partner with the province in its plans for maternal and child health work."[620] According to the plan, a great deal of this money designated for women's and children's health thus went to lodging and transportation costs for foreign experts.[621]

One of the earliest uses of this designated funding targeted Kinmen (Quemoy), a small

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[619] Ibid.

[620] Zhongguo nongcun fuxing lianhe weiyuan hui 中國農村復興委員會 to Taiwan sheng zhengfu weishengchu 台灣省政府, September 26, 1952《Zhongguo Nongcun fuxing weiyuanhui buzhu Taiwan sheng fuyou weisheng gongzuo jingfei 中國農村復興委員會補助臺灣省工作經費，1952-1958》(Academia Historica, Taipei); see also John W. Garver, *The Sino-American Alliance: Nationalist China and American Cold War Strategy in Asia* (New York: Routledge, 2015, 1997), 232-4.

[621] Ibid.

group of islands just off the coast of the mainland province of Fuijian. The ROC government in Taiwan asserted control over these islands, so close to PRC-territory that they remain visible from the Chinese mainland. In the mid-1950s, these small islands became flash points in cross-strait relations, erupting into military skirmishes in both 1954 and 1958. When the PRC shelled the islands in 1954, Secretary of State and former Rockefeller trustee John Foster Dulles traveled to Taiwan to respond to the ROC's urging for greater defense by the U.S. The event helped to bring about a forma Mutual Defense Treaty between the ROC and the U.S. that explicitly affirmed U.S. defense of both the main island of Taiwan and minor islands to which the Nationalists laid claim.[622]

The priorities for the public health program in Kinmen demonstrated a continued use of MCH as an "entering wedge" through which to shore up both fledgling public health enterprises and the reach of political influence. In 1958, the same year as a second U.S. confrontation with China over Kinmen, provincial health authorities in cooperation with the JCRR began dispatching midwives to rural areas of the islands, even as Nationalist sovereignty remained contested with military force. The plan for MCH on the islands deployed now familiar language regarding hierarchies of female bodies, qualitative differences in the manner of reproduction, and a dearth of medical personnel. "Kinmen has but three stations for MCH. Because villages are scattered, each station can only poorly address the work of birth in a single village. In remote villages, many still adopt the methods of 'old-style' delivery, often causing difficulties in birth. Thus, the need to replace these methods with training work in professional midwifery is

[622] Steven M. Goldstein, *China and Taiwan* (Malden, MA: Wiley, 2015), 26-28; see also Michael Szonyi, *Cold War Island: Quemoy on the Front Line* (New York: Cambridge Unversity Press, 2008), 42-43.

urgent."[623] Based on now well established notions of differential reproduction that necessitated intervention, health officials in Taiwan worked with foreign philanthropists to enfold Kinmen within the ROC through the continued, rural expansion of biomedical midwifery and broader MCH.[624]

Provincial public health authorities continued to rely on midwives trained in the central Taichung institute to extend the reach of the public health system into the 1960s. Based on the demonstrated efficacy of this strategy both on the mainland and now in Taiwan, the government and its foreign partners implemented a large-scale plan to further extend biomedical midwifery services into every district governed by the ROC in 1965. The plan continued to emphasize the need to reduce mortality rates, understood as resulting primarily from a persistent lack of biomedical care for women and children.[625] However, according to several sources, this program accelerated a decline in mortality rates already underway. Maternal mortality in the ROC declined from 197 per 100,000 in 1952 to 40 per 100,000 in 1972.[626] This reduction coincided with a decline in infant mortality rates from 35 per 1,000 in 1960 to 16.9 per 1,000 in 1970.[627]

But the constellation of actors now invested in the management of reproduction in Taiwan had identified new problems to be addressed, reportedly produced by the very decline in

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[623] Zhongguo nongcun fuxing lianhe weiyuanhui 中國農村復興聯合委員會 to Jinmen xian zhengfu 金門縣政府, March 24, 1958 《Zhongguo Nongcun fuxing weiyuanhui buzhu Taiwan sheng fuyou weisheng gongzuo jingfei 中國農村復興委員會補助臺灣省工作經費，1952-1958》(Academia Historica, Taipei).

[624] Ibid.

[625] Fan Guangyu 范光宇, *Taiwan sheng fuyou weisheng yanjiu suo*《台灣婦幼衛生研究所》（Taichung 台中: Dadi Yinshuachang 大地印刷廠 1969）, 1.

[626] Watt, "Advances in Health Care in Taiwan," 564.

[627] Tung-liang Chiang, "Health Care Financing in Taiwan," in Siân M. Griffiths, Jin Ling Tang, and Eng Kiong Yeoh, eds., *Routledge Handbook of Global Public Health in Asia* (New York: Routledge, 2014), 627-41,629.

mortality rates that they had so ardently pursued. By the early 1960s, the findings of U.S.-based demographers spurred action by U.S.-government agencies and the Population Council, which became particularly interested in Taiwan. Despite an earlier, pre-revolutionary debate regarding the appropriate quality and quantity of the Chinese population, many within the Nationalist state continued to believe that birth control remained antithetical to the ideals of Sun Yat-sen and counterproductive for the ultimate goal of reclaiming the mainland. Nonetheless, others, including the director of rural health programs for the JCRR, S. C. Hsu, and Kwoh-ting Li 李國鼎, who served as both economic minister and finance minister, came to share with the Population Council and U.S.-based academics a belief that reductions in fertility remained critical for Taiwan's economic development. This narrative of "demographic transition," as it was often labeled, drew from statistical information regarding reproduction to render evident both differences between developed and underdeveloped countries as well as the path through which backward societies became modern.[628]

As these varied actors mobilized to bring about Taiwan's "demographic transition," they built family-planning programs on the very infrastructures and methods that had been used to advocate hygienic childbirth. A pilot program in family planning affiliated with the Taichung MCH center began in 1959, under the euphemistic moniker "The Pre-Pregnancy Health Program." Through its local MCH representatives, this division of the Taichung institute penetrated roughly 100 of the 361 townships in Taiwan, providing contraceptives to an estimated 44,000 women. In 1961, the Population Council, in consultation with representatives from the

[628] Lu Xinmi 盧忻諡 Liang Feiyi 梁妃儀, Cai Dujian 蔡篤堅, Taiwan jiating jihua zhi dianji qihang: yi Zhou Lianbin jiaoshou koushu fangtan weizhu zhou de tansuo《台灣家庭計畫之奠基啟航：以周聯彬教授口述訪談為主軸的探索》（Taipei: Xingzhengyuan weishengshu guomin jiankangju 行政院衛生署國民健康局, 2007）, 1-8.

JCRR, provided support for an initially modest program targeting Taichung and surrounding rural areas. Spurgeon Keeny, the Asia field representative for the Population Council (formerly a representative of UNICEF), traveled throughout Asia to spur the development of family-planning programs in varied countries, most notably South Korea and Taiwan. In 1963, Keeny began working with S.C. Hsu of the JCRR, the UNICEF liaison in Taiwan Y.C. Chen, and then director of the Taichung institute C.L. Chen 程怡秋 to expand the Taichung pilot program into a large-scale family planning venutre.[629]

Like earlier programs to reduce mortality on both the mainland and in Taiwan, the grand designs of these men rested on the labor and interest of women, including nurses, midwives, and those they served. As Keeny summarized for the readers of his regular newsletters,

> The gist of it is that a proposal is to be worked out to add family planning to the duties of 44 nurses recently employed to help clean up the villages threatened with cholera, to hire at least enough more to bring the total to 100, to ask another 120 health stations to start work on family planning and to recruit leaders to organize and supervise work, especially in the poor villages devoted to coal mining, salt making, and fishing. The main need is for leadership with drive and a readiness to stay in the field. To find doctors who are willing to do this may be impossible even with subsidies. The job will mostly be done by the women as usual.[630]

Thus, the plan of using nurse-midwives to reach rural areas shifted from the implement for reducing mortality to one of managing fertility. That these health workers were female became increasingly critical for frank discussions of birth control. Tessie Huang 黃彩雲 , a native of the mainland province of Hebei trained in the United Kingdom, became critical for the

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[629] Spurgeon Keeny, Newsletter No. 1 (1963), in Spurgeon M. Keeny, *The Keeny Newsletters: A Window on the Early Family Planning Programs of Asia* (Poughkeepsie: Hudson House, 2009), 1-4; see also Spurgeon Milton Keeny, Jr., "Foreword: Spurgeon Milton Keeny: A Remarkable Life," in in Spurgeon M. Keeny, *The Keeny Newsletters: A Window on the Early Family Planning Programs of Asia* (Poughkeepsie: Hudson House, 2009, ix-xv.

[630] Keeny, Newsletter No. 1, 3.

implementation of family planning on the island. As the female health worker overseeing all of Taichung's rural midwives, she brought the needs and concerns of Taiwan's women to bear on the grand designs of Keeny, Hsu, and Li, and earned renown through internationally circulated reports of the Taichung program in both academic circles and populatr publications. As Keeny himself noted, the success of any program would depend on bonds between women and intimate knowledge of family dynamics surrounding reproduction. Based on the dialogue between midwives, local women, demographers, economists, and health officials, the program advanced by prioritizing women who had already had three or more children and actively sought means for preventing additional births.[631]

Family planning programs spread from Taichung throughout Taiwan in the 1960s and 1970s, in tandem with the steady decrease in mortality rates soon followed by a reduction in fertility. However, the extent to which this reduction in fertility stemmed from the acts of widespread family planning remains unclear. Figures collected by the provincial Department of Civil Affairs in Taiwan showed a steady decrease in fertility rates since 1958, well before the introduction of family planning. As Guo Wenhua 郭文華has argued, if the upsurge in Taiwan's population resulting from the massive mainland inmigration is excluded, Taiwan's population increase rates had already leveled by 1960. Thus, these endeavors, which connected global geopolitical concerns and large amounts of external capital to individual households and villages in rural Taiwan, likely accelerated processes already underway.[632]

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[631] Ibid., 4; see also Fan Guangyu 范光宇, *Taiwan sheng fuyou weisheng yanjiu suo,* 21-24; "Champion of Birth Control," *Life,* October 6, 1967, 39-48, 42.

[632] Kuo Wen-hua 郭文華, "*Meiyuan xia de weisheng zhengce: 1960 niandai Taiwan jiating jihua de tantao* 美援下的衛生政策：1960 年代臺灣家庭的探討," in Li Shangren, ed., Diguo yu xiandai yixue 《帝國與現代醫學》 (Taipei : Lian jing chu ban shi ye gu fen you xian gong si 聯經出版事業股份有限公司, 2008)：325-65; see also Ronald Freedman, John Y. Takeshita, and T. H. Sun, "Fertility and Family Planning in Taiwan: A Case Study of the Demographic Transition," *American Journal of Sociology* 70, no. 1 (July 1964):16-27, 16-17.

The data collected by local and foreign researchers through this project proved at least as impactful as the implementation of family planning, as they were framed as evidence of the validity of modernization theory. Data collected by University of Michigan researchers in 1964 affirmed the conclusions of a WHO report published five years earlier. Whereas earlier government and philanthropic narratives of both mainland China and Taiwan had emphasized depravity to legitimize interventions in reproduction, postwar reports, including the 1959 WHO report, cited metrics of MCH to frame Taiwan as a land in transition. The report situated Taiwan in the middle of a teleological, universalized process of modernization, based on its orchestrated demographic transition. WHO nursing educator Merle Farland noted growing industrialization and urbanization on the island, while also pointing out that "the population of Taiwan is still predominantly agricultural," with "approximately 75% of the people living in rural areas." Further, Farland noted, over 94% of children in Taiwan received elementary education, and, thanks to well-developed communication and transportation infrastructures, "there are very few villages which cannot be reached by bus or train."[633] All told, Farland found a standard of living in Taiwan that remained the second highest in Southeast Asia. However, as Farland outlined, sanitation remained "far from satisfactory." Specifically, Farland highlighted the state of women and children, pointing out that pregnant mothers and infants constituted "two sections of the community showing definite signs of malnutrition,"[634] which affected approximately half of pregnant women. These problems were exacerbated by the JCRR's discovery that an estimated forty-six percent of childbirths "were conducted by unqualified personnel."[635] Throughout this

[633] Merle Farland, "Final Report - Maternal and Child Health, China (Taiwan)," (August 1952-August 1959) (WHO Archives, Geneva), 2.

[634] Ibid., 2-4.

[635] Ibid., 2-4.

report, Farland affirmed an undergirding assumption that the management of reproductive health remained intimately wed to industrialization, urbanization, and economic development. Further, Taiwan's perceived potential for advances in all of these areas rested on the existing infrastructures of Japanese colonialism that differentiated the ROC from many of its neighbors in the Pacific.[636]

The data collected by local midwives and public health officials on mortality and fertility shored up a growing consensus that Taiwan remained a nation in transition from the high mortality and high fertility common in the third world to the low rates of both in the first world. Earlier data showing Taiwan's deficiencies compared to developed nations had been cited to legitimate further expansion of reproductive health programs. However, in the 1960s, the mixed picture of Taiwan's reproductive health situation became evidence of the efficacy of global health interventions and their relationship to broader economic development. Population scientists from the University of Michigan argued that the fact that fertility had been declining since the colonial period ultimately affirmed the overall benefits of sustained economic development. That mortality and fertility had significantly decreased further since World War II evinced the impact of more recent trends of "urbanization, non-agricultural employment, highly productive agriculture oriented to a market, education, literacy, circulation of mass media, [and] internal written communications."[637] Those integral to the operations of the Taichung center's population program believed these "significant measures of development and modernization" demonstrated a radical transformation of economic and social relations that had already set

[636] Ibid., 26-30.

[637] Freedman, Takeshita, and Sun, "Fertility and Family Planning in Taiwan: A Case Study of the Demographic Transition," 16-17.

Taiwan on the path from third-world misery to first-world standards of living. This understanding of reproductive patterns rooted in modernization theory found further support from localized studies that showed that "modern fertility behavior [remained] most characteristic of population groups in the most modernized sector."[638] When large-scale family planning programs coincided with further reduction of fertility in Taiwan in the later decades of the twentieth century, both local and foreign public health workers and demographers praised integrated campaigns for economic development and family planning that had successfully brought Taiwan more in line with first-world fertility. These opinions held until the early twenty-first century, when concerns shifted once again to the economic fears stemming from exceptionally low fertility rates in Taiwan, Japan, and much of the West.[639]

MCH in the Early People's Republic of China

The 1949 founding of the PRC signaled a drastic shift in the political system and governing ideology of China, soon followed by dramatic reductions in mortality rates and expanded access to healthcare. These developments suggest a radical rupture in public health that divides the ineffectual efforts of the Nationalist era from the successes of the PRC. However, as recent works in the history of medicine have shown, many of the public health advances of the socialist period drew from Nationalist precedents.[640] Though existing scholarship on MCH has tended to emphasize Nationalist failure as a foil for Communist successes, socialist-era projects

[638] Ibid.

[639] Wan-I Lin and Shin-Yi Yang, "From Successful Family Planning to the Lowest of Low Fertility Levels: Taiwan's Dilemma," *Asian Social Work and Policy Review* 3 (2009): 95-112.

[640] See, for example, Sean Hsiang-lin Lei, *Neither Donkey nor Horse: Medicine in the Struggle over China's Modernity* (Chicago: University of Chicago Press, 2014), 223-225.

to reduce maternal and infant mortality also relied heavily on models, personnel, and institutions developed during the Nationalist period. These prerevolutionary roots were obscured by design. The political context of the early PRC period demanded that those critical to the work of reducing mortality minimize or disavow their work in the Nationalist decades, thereby burying a history of reproductive health that spanned the second and third quarters of the twentieth century, ultimately providing infrastructures for the implementation of later "planned birth" policies. Some American agencies, including the Rockefeller-founded China Medical Board, continued to send financial support to their Chinese institutions throughout 1949 and 1950. But many affiliated with the Rockefeller Foundation predicted an abrupt end to the now decades-long investment in Chinese public health as the Chinese Communist Party gained control of the mainland. In September 1949, Chinese doctor T. S. Sze 施肇基 (then in England with the support of the Rockefeller Foundation) wrote to Marshall Balfour of the IHD that "All old friends of China are, I imagine, anxious about developments in China right now…Little as we have accomplished in the past in the way of giving some health service to the people, even they are in flames now! And what future?"[641] Similarly in October, Elizabeth Tennant of the Rockefeller Foundation responded to a request for funding from the Nurses' Association of China by lamenting, "I am afraid China is not in for very happy times ahead. Their path of course has never been smooth."[642] The outbreak of the Korean War in 1950 fully severed the ties between Chinese institutions and U.S.-based philanthropists. In December 1950, the U.S.

[641] T.S. Sze to Marshall Balfour, September 8, 1949 (RF Archives, RG 2, Series 601 Box 464 Folder 3110, RAC, Sleepy Hollow, NY).

[642] Tennant to Cora E. Simpson, October 20, 1949 (RF Archives, RG2 Series 601 Box 464 Folder 3110, RAC, Sleepy Hollow, NY).

government banned all financial transactions with Communist China, thereby ending the aid of U.S.-based organizations to their Chinese subsidiaries.[643]

The Cold War division of the Pacific posed a dilemma for many who had orchestrated Nationalist-era public health reforms. Many prominent doctors and public health advocates had to negotiate shifting political terrain and choose between positions in newly formed international organizations, the People's Republic of China, British Hong Kong, or Nationalist Taiwan. In the early 1950s, many of these actors remained publicly noncommittal, maintaining ties with foreign organizations while using word-of-mouth communications to explore the intentions of the nascent Communist government. For example, a Chinese doctor named Winston Yung conveyed in a letter to Robert Briggs Watson of the Rockefeller IHD that C. K. Chu, who then held a position in the WHO, had privately expressed his intent to resign from the WHO if he were offered a position in Beijing. By the time this news reached Geneva, M.C. Balfour had already been informed indirectly through other messages from J. Heng Liu and I. C. Fang.[644]

Within China, Communist leaders faced a dilemma of their own that centered on the tensions between embracing "Western" medicine and disavowing Western imperialism. Drawing from trends in the later Nationalist period, the PRC incorporated Chinese medicine as integral to its public health system while retaining biomedical treatments as the most efficient means of treating infectious disease. This official syncretic position vis-à-vis medicine ran against an impassioned repudiation of the actors and institutions that had promoted biomedicine throughout China. With the United States and its allies officially enemies of the PRC, many of the

[643] Mary Brown Bullock, *An American Transplant: The Rockefeller Foundation and Peking Union Medical College* (Berkeley and Los Angeles: University of California Press, 1980), 208; see also Brazelton, "Western Medical Education on Trial," 129.

[644] Robert Briggs Watson to M. C. Balfour (through Dr. Warren), July 1, 1952; M. C. Balfour to Robert Briggs Watson, July 8, 1952 (RF Archives, RG 2 Series 100 Box 8 Folder 45, RAC, Sleepy Hollow, NY).

institutions and personnel across the public health landscape became politically suspect. Some institutions were closed. Others, like PUMC, were nationalized by the People's Liberation Army. This process, accompanied by speeches from PRC officials, established an official ideological position that repudiated U.S. imperialism while embracing the utility of biomedical institutes and experts for state-building.[645]

The Rockefeller-founded First National Midwifery School (FNMS) of Beijing continued operations in this new political context, buoyed by the socialist state's strong support for "new-style midwifery." Dr. Ye Shiqin葉式欽, who had held various positions in the Nationalist health system, continued as director of the school in the early years of the PRC. As noted in the introduction to this dissertation, FNMS joined several other local public health organizations in Beijing to organize events under the auspices of the "patriotic hygiene" campaign during the Korean War. Shortly thereafter, FNMS merged with Beijing Medical College (北京医学院, now known as Beijing University of Medical Sciences 北京医科大学). Thus, it continued to exist, though in a different form.[646]

At the national level, many of the key players in public health had been trained through Rockefeller fellowships and institutions. The shifting political landscape in China presented both opportunities and challenges for those who had been key orchestrators of Nationalist-era MIH programs. The repudiation of imperialism—including its varied informal manifestations in China—made the political affiliations and backgrounds of missionary-trained, foreign-funded

[645] Brazelton, "Western Medical Education on Trial."

[646] This fact challenges Tina Phillips Johnson's assertion that FNMS was disbanded in 1949. Shoudu yiyaojie ding mingri juxing aiguo shiwei lüxing 首都医药界定明日举行爱国示威游行, *Renmin Ribao* 《人民日报》, January 20, 1951; see also Tina Phillips Johnson, *Childbirth in Republican China*: *Delivering Modernity* (Lanham, MD: Lexington Books, 2011), 169.

medical practitioners suspect. On the other hand, the Communist state's explicit commitments to women's equality, health, and welfare shaped and resulted from a public health system led by women doctors. Li Dequan 李德全, who had studied at PUMC and been involved, to a limited degree, in Nationalist-era MIH programs, became the first Minister of Health in the PRC. In September of 1950, Yang Chongrui accepted Li's invitation to leave her post in the WHO and return to China, where she joined the PRC's Ministry of Health as the first director of its Maternal and Child Health Bureau.[647]

In the early years of the PRC, state support of "new-style midwifery" aided Yang's longtime goal of universalizing biomedical midwifery and mothercraft. Through allied efforts between local chapters of the All-China Women's Federation, public health bureaus, hospitals, and training centers, the biomedical midwifery training scheme first developed in the Nationalist decades penetrated the most rural and remote regions of the PRC. In this respect, Yang's commitments remained compatible with official ideology, especially once the promotion of biomedicine became incorporated into state campaigns of rural development and patriotic hygiene in the early 1950s.[648]

Thus, in many ways, the socialist state continued a Nationalist-era project that emphasized biomedical midwifery, though cases from the socialist decades highlight the unevenness of Nationalist-era developments across the Chinese mainland. For the early decades of the PRC, childbirth and infant care remained gendered practices tended by women. The varied

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[647]"Woguo jindai fuyou weisheng shiye chuangshiren—Yang Chongrui zhuidaohui zai jing juxing 我国近代妇幼卫生事业创始人 杨崇瑞追悼会在京举行," *Renmin Ribao* 《人民日报》, August 8, 1983; see also Zuo Qi 左奇 and Yan Renying 严仁英，eds., *Yang Chongrui boshi: Zhongguo fuyou weisheng shiye de katuozhe* 《杨崇瑞博士：中国妇幼卫生事业的开拓者》(Beijing: Beijing yike daxue chubanshe, 2002), 63.

[648] For more on these campaigns in the 1950s, see Ruth Rogaski, *Hygienic Modernity: Meanings of Health and Disease in Treaty-Port China* (Berkeley and Los Angeles: University of California Press, 2004), 285-299.

ways in which women gave birth continued to shore up politicized notions of difference, even as they shifted to a new political landscape with new actors and ideologies. Pervasive narratives drawing stark divisions between "old" and "new societies" structured criticism of "old-style" midwifery in the early PRC, framed as a symptom of the pre-revolutionary era that needed to be eradicated.

For example, an article from November 1951 written to promote biomedical reforms to midwifery recounted the horror of a difficult birth, placing blame for the death of both mother and infant with an old-style midwife. In a rural village in Jiangsu, a twenty-seven-year-old woman named Fan Tianying 樊天英 had sought the aid of the local midwife, Gao Yaxian 高亚贤. Gao used crude tools in an ineffective attempt to speed labor. When the infant emerged arm first, Gao reportedly exclaimed, "This is a difficult birth. I should save the adult, not the child."[649] Despite Fan's objections, Gao grabbed a sharp instrument and began to dismember the fetus, even reaching inside the woman to evacuate the uterus. Fan slipped into a coma. Locals requested emergency treatment from a gynecologist at a hospital, but the doctor arrived too late. Due to internal injuries from the midwife's instruments and a loss of blood, Fan died within a matter of hours. An investigation determined that if Gao had not attempted to dismember the fetus, Fan would have survived. At the urging of members of the village, local authorities subjected Gao to an unspecified punishment.[650]

The report from Jiangsu emphasized that this horror was not an isolated incident, but rather the realities of childbirth in much of China, resulting from the ineffectual leadership of the

[649] Li Kangzuo 李康佐, "Nongcun chanfu he ying'er siwanlü henda gedi ying chongshi xunlian jiechanpo gongzuo 农村产妇和婴儿死亡率很大 各地应重视训练接产婆工作," *Renmin Ribao* 《人民日报》, November 12, 1951.

[650] Ibid.

Nationalist regime and the backwardness of feudal society. In fact, nearly identical accounts of difficult childbirth—which bore the same details regarding an emergent fetal arm and maternal death—circulated in other Chinese publications.[651] According to statistics collected during a mere three months, 106 infants had died in this single village in Jiangsu. To address this pervasive problem, the author, Li Kangzuo李康佐, recommended that child welfare groups, women's federations, and public health offices unite to found gynecological clinics and training centers.[652]

Despite the novel framing of such a plan, Li's proposed program drew from Nationalist-era precedents in a number of ways. First, the vision put forth for MCH affirmed the role of female midwives in attending childbirth. Second, the program affirmed biomedical methods of sterilization and hygiene as the most effective tools against contagion and death. Li's proposed program also provided a path for 'old-style' midwives to continue their practice, provided that they undergo biomedical training. Some have noted this emphasis on retraining "old-style" midwives as a notable shift from Nationalist-era programs, but this shift primarily indicated a change of tone rather than a major diversion from existing policies. As has been shown throughout this dissertation, Nationalist-era midwifery education programs emphasized both the recruiting of new midwives and the retraining of existing midwives. The degree to which public health authorities rejected or retrained lay midwives varied depending upon institution and locale. The program Li advocated in 1951 emphasized that "old-style" midwives should be incorporated into new public health schemes, while maintaining that those who refused formal

[651] John Watt, *Saving Lives in Wartime China: How Medical Reformers Built Modern Healthcare Systems Amid War and Epidemics, 1928-1945* (Leiden: Brill, 2013), 283-5.

[652] Li Kangzuo 李康佐, "Nongcun chanfu he ying'er siwanlü henda gedi ying chongshi xunlian jiechanpo gongzuo.

biomedical training should be prohibited from practicing.[653]

Local cases shed further light on the links between MCH, communist ideology, and historical memory. The unevenness of Nationalist-era reproductive health schemes provided plenty of cases with inadequate services to support a narrative of Nationalist failure. A May 1952 report in the People's Daily drew from localized observations in northwestern Yunnan province to make generalizations about the broader state of women and children before the Revolution. Official publications reported that midwives had been stationed at each of the more than forty villages of ethnic minorities in Lijiang, with the result of "guaranteeing women's safety in reproduction."[654] The declaration of this achievement followed what quickly become a prevalent template for narrating life before and after "liberation," also noted by Gail Hershatter in her recent study of rural women in the early PRC.[655] Many reports of socialist successes came paired with a repudiation of the pre-revolutionary past. The report from Lijiang read,

> In the past period of reactionary Nationalist rule, the people here—both Yi and Han—experienced extraordinary poverty. The standard of living lagged behind, and when women gave birth all used old methods of delivery. Parturient women suffered great pain. In the event that a woman experienced difficulty in birth, more often than not, both woman and child died.[656]

This prevalent problem, it was argued, met its remedy only when the new Communist-affiliated provincial government sent a medical relief team to aid in the wake of an earthquake.[657]

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[653] Ibid.

[654] "Yunnan Lijiang zhuanqu shaoshu minzu zhong kaishi tuiguang xinfajiesheng 云南丽江专区少数民族中开始推广新法接生," *Renmin Ribao* 《人民日报》, May 19, 1952.

[655] Gail Hershatter, *The Gender of Memory: Rural Women and China's Collective Past* (Berkeley and Los Angeles: University of California Press, 2011), *passim.*

[656] Ibid.

[657] Ibid.

Local women in Lijiang reportedly welcomed a crash course in antiseptic midwifery, with fifty-four local women participating from the outset. All of the students in this early training program had already given birth to several children. However, none of their children had survived. Only through the training course in "new-style midwifery" did these women come to understand that their children had all died as a result of the infection caused by unhygienic childbirth practices.[658]

The reiteration of the Revolution as a radical break from the past shaped women's recounting of their birthing experiences in Lijiang, at least as reported in official publications. One woman in Lijiang, identified as Xue Shanying 薛善英, had given birth to six children, none of whom survived beyond one month after their birth. After receiving the knowledge of hygienic birth, Xue once again mourned the loss of her infants. Tearfully, she was quoted as saying, "In the past, my lack of understanding of new-style delivery caused the deaths of all six of my little babies." Now, in the new society, she eagerly pursued the biomedical knowledge propagated by varied organs of the socialist state, with the hope that she might have children survive in the future.[659]

According to the report in the *People's Daily,* none of the women in the Lijiang training course could read or speak Mandarin. However, their eagerness to learn new methods of childbirth more than made up for these barriers. On the day of their graduation, each in succession stood before a likeness of Mao Zedong, swearing an oath to both the People's Republic and its leader. When they returned to their home villages, they reportedly became eager evangelists for the new government, emphasizing the contrasts between old and new societies

[658] Ibid.

[659] Ibid.

and the impact of the Revolution for the quotidian lives of rural women. To further affirm the narrative of change, the report ended with the self-reflection of an old woman, who found satisfaction in knowing that the lives of future generations would be filled with less suffering than she had experienced before the revolution.[660]

This case of northwestern Yunnan, where the Kunming-based health regime had had little influence due, in part, to military conflicts along the Burma border, obscured continuities in the province that linked Communist-era endeavors to Nationalist-era precedents. Elsewhere in the province, programs begun under the auspices of Nationalist-era health authorities continued across the 1949 divide, building on pre-revolutionary origins to further extend into rural and remote regions of Yunnan. In Kunming, the provincial women's and children's health program established in 1948 through the joint efforts of local practitioners and foreign philanthropists became critical for early PRC endeavors to promote new-style birth in surrounding areas. According to official sources, the percentage of deliveries overseen by "new-style" midwives through these programs in Kunming had reached 69.01% by 1951, rising further to 85.8% in 1952.[661] The school founded by Xiong Jin in Jiangxi province also continued across the 1949 divide, ultimately transforming into the Gannan Medical University, which still exists in Ganzhou to this day.[662]

The case of Gansu provides the clearest case of continuity, given the long career of Chen Guiyun in the province from the 1930s to the 1970s. In the years surrounding the revolution, the

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[660] Ibid.

[661] *Yunnan sheng weisheng ting* 云南省卫生厅, Yunnan weisheng tongzhi 《云南省卫生通志》4, no. 2（1999）,318-320.

[662] See Gannan yixue yuan xiaoshi 《贛南醫學院校史》, vol. 1 1941-1985 (Ganzhou: *Gannan yixue yuan* 贛南醫學院, 2011).

clinic and training center overseen by Chen Guiyun expanded to include more beds and larger facilities through the investments of both Nationalist and Communist states as well as private philanthropists. The further development of MCH in the 1950s brought established institutions and personnel in Lanzhou into the broader national project orchestrated by various organizations within the socialist state. In 1956, provincial leaders founded a Gansu Maternal and Child Healthcare Committee, which brought together medical professionals, provincial officials, and members of the women's federation. At the time of its founding, the committee continued longstanding goals for MCH in the province, with the stated purpose of promoting "new style birth and new methods of childrearing."[663] These continued efforts depended on expanding the faciltiies of Nationalist-era clinics and training schools, including the Gansu Provincial Maternity and Child-care Hospital that grew out of the provincial midwifery school in 1942.[664]

As reproductive health in Gansu transitioned to the political conditions of the early PRC, Chen Guiyun remained a prominent figure in local public health while gaining increased prominence in provincial and national politics. As a representative to the Gansu Provincial Assembly in 1958, Chen praised recent advances in MCH while noting that much work remained to be done.

> The strengthening of the party's leadership is the main reason that we have achieved positive results. The party has persevered in establishing political order, eliminating superstition, liberating thought, and giving the masses a necessary measure of awareness and the goal of struggle. Despite these strengths, there remain many deficiencies.[665]

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[663] "Gansu sheng fuyou baojian weiyuanhui gei sheng weishengting de pifu yiji sheng weishengting de baogao," August 10, 1956 (Gansu Provincial Archives, Lanzhou).

[664] Ibid., See also Chapter Four and Chapter Eight of this dissertation.

[665] Chen Guiyun 陈桂云, "Chen Guiyun daibiao zai sheng erjie yici rendaihui shang de fayan (sheng baojian yuan) 陈桂云代表在省二届一次人代会上的发言（省保健院）" 1958 (Gansu Provincial Archives, Lanzhou).

Here, Chen's description of MCH before and after the Revolution affirmed the integral place of MCH for pervasive scripts differentiating between "old" and "new" societies. Her couching of vague criticism within politically expedient language characterized much of her work in the early PRC, a practice common to women activists operating within socialist state structures that Wang Zheng has called a "politics of concealment."[666] For Chen, this rhetorical strategy enabled her to continue her work on behalf of women's health and evade the political persecution that many of those around her endured in the 1950s.

Chen's longtime companion, Yang Yongni, met a different fate. As Chen rose in prominence, Yang's past affiliations brought her under intense scrutiny during the Communist Party's political purges of the 1950s. In particular, the "anti-counterrevolutionary" or *sufan* movement that began targeting former Nationalist party personnel in the mid-1950s found Yang to be an enemy of the revolution. In January 1959, the local, official organization carrying out the "purge of counterrevolutionary elements" prepared a detailed record of Yang's life and background. According to the report, Yang had attended a missionary school in her native Sichuan during her youth under the name Yang Qiongxian 楊瓊仙, before relocating to Beiping in 1930 where she met Chen Guiyun at FNMS. The most problematic aspect of her background remained her official entry into the Nationalist party under a pseudonym in 1943. When Chen had left the country in 1946-7 for a study tour of the United States, Yang had reportedly supported Nationalist causes in Lanzhou. For these reasons, in 1959 at the age of 52, Yang was labeled a member of the "counterrevolutionary class."[667]

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[666] Wang Zheng, *Finding Women in the State: A Socialist Feminist Revolution in the People's Republic of China 1949-1964* (Berkeley and Los Angeles: University of California Press, 2017), 17-18.

[667] Zhonggong Gansu shengwei xuanjiao sufan wuren xiaozu 中共甘肃省委宣教肃反五人小组, "Guanyu Yang Yongni an de pifu 关于杨永霓案的批复," (January 23, 1959) (Gansu Provincial Archives, Lanzhou).

As a firsthand witness of the political persecution that befell her companion, Chen became an increasingly outspoken defender of socialist state campaigns. In a 1935 article, Chen had asserted the importance of her work in MIH within the rhetoric of the Nationalist state. Then, she wrote, "If families improve, then China's status in the world, along with the intentions of the New Life Movement and individual hygiene will improve. If we can make children understand these things in their youth, then in the future China will absolutely be able to regain the status it had long ago."[668] In contrast, Chen emphasized the importance of socialist state campaigns in the 1960s. In a 1960 speech published in the *People's Daily,* Chen framed the advances in her work in MCH within the broader triumphs of the Great Leap Forward. She began with lengthy praise for advances in transportation, economic development, education, agriculture, science, and technology that resulted from the "proper leadership of Chairman Mao and the Chinese Communist Party."[669] Chen then segued to her own field, by stating that "Medicine and public health work are also in a similar state of continued and rapid progress."[670] That Chen lavished praise upon the Communist government and tied her own field to these broader campaigns comes as no surprise, especially given the recent persecution of her longtime companion. However, when compared with her earlier depictions of her work in Nationalist periodicals from the 1930s, we see a continued commitment to women's reproductive health, enabled by strategic deployment of radically different, contextually dependent political rhetoric.[671]

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[668] Chen Guiyun 陳桂雲, "Ertong jiaoyu yu huanjing 兒童教育與環境，" *Shaanxi jiaoyu yuekan*《陝西教育月刊》 8, no. 2 (1935).

[669] Chen Guiyun 陈桂云, "Jibing saochu shenti zhuang—shenghuo meimanle yang yang—Chen Guiyun weiyuan de fayan 疾病扫除身体壮　生活美满乐洋洋 陈桂云委员的发言," *Renmin Ribao* 《人民日报》, April 16, 1960.

[670] Ibid.

[671] Ibid.

Further, the continuation of Chen's work in the socialist state depended upon a renunciation of the pre-revolutionary past, in which she used the idiom of MIH to differentiate between old and new societies. In this 1960 speech, she presented a personal narrative that contrasted with her pre-revolutionary words and the record of her career under the Nationalists. Her recounting of her life across the 1949 divide drew from a state-supplied script of "turning over" or *fanshen,* which Chen used as a heuristic device for both her political consciousness and her medical practice. She asserted,

> For several decades, I have continually engaged in the work of maternal and child healthcare. From the old society to the new society, I have experienced a tremendous change, like crossing to heaven and returning to earth, which has had an exceptionally profound impact. Before liberation, I used borrowed money to build a so-called maternal and infant health clinic that had less than ten rooms. At most, it only had nineteen hospital beds. I was the only doctor. At that time, the reactionary government, though they had a so-called public health organization, showed no interest in the health of women and infants. They cared nothing for the suffering of the masses. After liberation, under the brilliant leadership of the Party and Chairman Mao, maternal and child healthcare has developed greatly. Especially since the Great Leap Forward began in 1958, the development has progressed even faster.[672]

The pervasiveness of the language of "turning over" and Chen's proximity to the consequences of unorthodox speech make clear the political expediencies shaping her praise for the Communist state. Further, they affirm MCH's critical place for gendered narratives that differentiated between the feudal past and revolutionary future, thereby aiding Chen's praise for the Communist regime. While minimizing her Nationalist-era work, Chen pointed to quantifiable metrics that affirmed the dramatic advances of the 1950s. According to Chen's report, well over 90% of women in Lanzhou received maternal and child health services after 1959.[673]

[672] Ibid.

[673] Ibid.

Chen's words here and elsewhere reveal the extent to which continued MCH advocacy depended on a strategic political positioning, while also illustrating how that political positioning led to a burying of Nationalist-era MCH programs by their very actors. Whether the result of political expediency or through the performative reiteration of a state script that shaped the formation of memory, "liberation" bifurcated histories and shaped the recounting of both sides of the temporal divide. The dramatic expansion in MCH services in the 1950s, the subsequent reduction in mortality rates, and ultimately, the relief brought to many women through access to contraception became antitheses of life before revolution. Thus, as healthcare in China continued to improve, the perception of the Nationalist era grew dimmer, ultimately producing a history that largely obscured the pre-revolutionary roots of socialist China's widely celebrated programs to advance women's reproductive health.

As in Taiwan, the priorities of MCH programs shifted in China during the late 1950s and 1960s, from an emphasis on "new-style delivery" to a promotion of "planned birth." A brief history of this shift challenges any misconception of the socialist state as a monolithic entity with uniform aims. In the early 1950s, pronatalist positions dominated policies regarding MCH, though they remained contested. Against a wide-ranging intellectual debate surrounding population that had persisted since the early Republican decades,[674] Mao Zedong himself labeled Malthusianism a pessimistic ideology emanating from the capitalist West that failed to recognize the great resource that was China's large population.[675] These dominant notions regarding women's reproductive labor ultimately brought about the political downfall of Yang Chongrui,

[674] See Thompson, "The Birth of the Chinese Population."

[675] Tyrene White, *China's Longest Campaign: Birth Planning in the People's Republic, 1949-2005* (Ithaca, NY: Cornell University Press, 2006), 19-21.

who was purged from her position in the Ministry of Health based on her earlier promotion of birth control. In 1957, she was labeled a rightist and an enemy of the revolution.[676]

A September 1949 speech from Mao, given less than a month before the founding of the PRC, made clear both this early pronatalist line of the party and its partial roots in U.S. critiques. In this speech, which explicitly targeted U.S. thinkers, Mao asserted, "The absurd argument of Western bourgeois economists like Malthus that increases in food cannot keep pace with increases in population was not only thoroughly refuted in theory by Marxists long ago but has also been completely exploed by the realities in the Soviet Union and the Liberated Areas of China after their liberation."[677] This passionate assertion came in rebuttal of an American White Book that drew from the observations and arguments of Frank Notestein, later director of the Rockefeller Population Council. In Mao's speech, the Soviet example provided a basis for a rejection of Notestein's ideas, even as the speech itself belied the role of U.S. demography in shaping official positions vis-à-vis brith control.[678]

Beginning in the later 1950s, feminists engaged with various organs of the socialist state lobbied for increased access to contraception and abortion as a means of freeing women from local patriarchy and the social responsibilities of the old society. Though the use of birth control had been permitted among married couples in Communist areas since the 1940s, the Party maintained restrictions on sterilization and abortion in accordance with an officially pronatalist position. By the early 1950s, access to contraception, too, became increasingly restricted,

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[676] *Ershi shiji zhongguo nüxing shi* 二十世纪中国女性史, vol. 8: *Shengyu geming* 生育革命. DVD. Directed by Feng Xuesong 馮雪松(Beijing: China Central Television, 1999).

[677] Mao Zedong, "Banruptcy of Idealist Conception of History," September 16, 1949 in *Selected Works of Mao Zedong,* vol. 4 (Beijing: Foreign Language Press, 1961), 451-59, 453; see also Scharping, *Birth Control in China, 1949-2000*, 30-31.

[678] Scharping, *Birth Control in China, 1949-2000,* 30-31.

meeting resistance from educated women within the Party bureaucracy. Through the maneuvering of women within the Women's Federation and other organs of the state, combined with new population estimates that demonstrated a much larger population than had been estimated, some cadres within the party came to support birth control by the early 1960s. Through the collectivization campaigns of the 1950s and the emphasis on a planned economy, birth control proponents within various organs of the state attached the issue to socialist ideals, arguing not for the liberal notion of "family planning," but rather "planned birth" policies rooted in socialist economic philosophies.[679]

In Chen Guiyun's writing from the early 1960s, we see both the utility of binding birth control to socialist economics and the continuities linking Nationalist-era MIH to socialist-era planned birth. In a speech to the Gansu Provincial Assembly in 1964, Chen, who had for decades deployed pronatalist rhetoric to advance MCH, advocated planned birth based on its sound basis in a socialist approach to government.

> Planned birth is a critical policy for our country's construction of a socialist society, because of its relationship to the broad questions of constructing a socialist society. In a socialist country like ours, the economy and the building of industry all develop according to a plan. Every aspect of this construction has a plan. Materials and goods should all have a plan. If population and birth are not planned, then it will impact the entire project of constructing our country and impede the timely development of industry.[680]

[679] White, *China's Longest Campaign,* 32-35; Greenhalgh, *Just One Child,* 46.

[680] Gansu sheng jingji weiyuanhui 甘肃省经济委员会, "Chen Guiyun daibiao de fayan 陈桂云代表的发言," Gansu sheng di san jie renmin daibiao dahui 甘肃省第三届代表大会, 1964 (Gansu Provincial Archives, Lanzhou).

Like other women within the socialist state, Chen thus advocated for a change of policy with regard to birth control by tieing this concern to the dominant ideology of the state, thereby divorcing it conceptually from its purportedly bourgeois associations in the past.[681]

Chen's outspoken praise for state programs and the obfuscation of her pre-revolutionary work shielded her from the purges of the 1950s. However, she, too, ultimately became the subject of persecution, in a period of tumult that also thwarted the initial movement toward "planned birth" in China.[682] By the mid-1960s, her past affiliations with missionaries and the Rockefeller Foundation had attracted political scrutiny. A provincial Women's Federation report from late 1964 pointed to these aspects of her background as politically problematic, while still noting her enthusiastic support of state policies, including the movement toward "planned birth."[683] During the subsequent Cultural Revolution, a 1971 report by a provincial revolutionary committee purported to provide a more thorough "investigative report of Chen Guiyun's political history problem."[684] Though Chen reportedly fired a janitor at one of her hospitals to satisfy calls for purges, Red Guards attacked Chen's hospital in Lanzhou, subjecting her and her companion, Yang Yongni, to physical violence. Less than two years after the death of Mao, Chen herself died of illness at the age of 82, two days after giving a tour of her hospital to CCP officials in 1978.[685]

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[681] Ibid.

[682] See White, *China's Longest Campaign,* 41-46; Greenhalgh, *Just One Child,* 48-49.

[683] Gansu sheng funü lianhe hui 甘肃省妇女联合会, "Chen Guiyun xianshi biaoxian 陈桂云的现实表现," December 11, 1964 (Gansu Provincial Archives, Lanzhou).

[684] Though not open to researchers, this document remains listed on the catalog of the Gansu Provincial Archives in Lanzhou. See Zhongguo gongchandang Gansu sheng geming weiyuan hui 中国共产党甘肃省革命委员会, "Guanyu Chen Guiyun zhengzhi lishi wenti de shencha baogao de pifu 关于陈桂云整治历史问题的审查报告的批复," September 20, 1971 (Gansu Provincial Archives, Lanzhou).

[685] *Gansu wenshi ziliao xuanji* 《甘肃文史资料选辑》Vol. 23 (Lanzhou: Zhongguo renmin zhengzhi xieshang huiyi gansusheng weiyuanhui wenshi ziliao yanjiu weiyuanhui 中国人民政治协商会议甘肃省委员会文史资料研究委员会，1985), 70-1.

Conclusion

When "planned birth" efforts resumed in the 1970s, the implementation and enforcement of these policies relied on a "large-scale grass-roots organization" (to borrow Thomas Scharping's phrase) including midwives who had proven integral to earlier reductions in maternal and infant mortality.[686] As this chapter has shown, this strategy became integral to "family planning" campaigns in Taiwan during the same decades, despite regional conflicts and their global resonances that divided the ROC and PRC. Through the networks of global health workers, who included Chinese actors, the strategy for retraining local women as biomedical midwives and *de facto* birth control ambassadors also appeared in places such as South Korea and Thailand during the 1950s and 1960s.

In addition to linking dynamics on either side of the Taiwan Strait to shifts in global health, these commanlities also point to the divergent legacies of earlier, Nationalist-era MIH programs in the Cold War era. The scheme developed through the varied efforts of foreign philanthropists, Chinese health authorities, and feminist physicians in the 1920s, further honed through the particular needs of interior provinces during the 1930s and 1940s, only gained momentum in the 1950s and 1960s as it proved critical to reducing mortality and ultimately, managing fertility. In the PRC, a more centralized bureaucracy and newfound political stability helped to remedy the unevenness of Nationalist-era programs even as state efforts relied on similar strategies and the same personnel and institutions. In Nationalist Taiwan, health workers within the Nationalist government and the foreign organizations with whom they partnered found the training and dispatching of midwives well-suited to the textured geographic, linguistic, and

[686] Scharping, *Birth Control in China*, *1949-2000*, 177; see also, White, *China's Longest Campaign,* 108-109.

ethnic terrain of the island. In both cases, the science of reproduction developed in dialogue with local conditions and geopolitical dynamics, variably constructing a pathway from the 'old society' to socialism or from third-world misery to first-world prosperity. Despite varied and shifting contexts, MCH, with now established links between demographic measures of mortality and the individualized acts of childbirth and mothering, continued to provide an index of development and an idiom of difference that linked childbirth and motherhood to the global Cold War and grand ambitions for managing life on earth.

The links between Nationalist-era and socialist-era endeavors on the mainland become clearest through a focus on Chinese women physicians whose lives spanned the Revolution of 1949. Wth varying degrees of success, women like Ye Shiqin, Yang Chongrui, and Chen Guiyun reframed their work in MCH for a radically altered political context, demonstrating a commitment to reproductive health that superceded allegiance to any particular state. Through a temporal frame that spans the Revolution, the political framing of their work appears as a strategic effort to bind the reproductive concerns of the women they served to the varied ideologies of Communist and Nationalist regimes. Only from the vantage point of the early PRC can we fully understand the rhetoric they espoused during the Nationalist decades.

Chapter 8: Conclusion

Today, in Lanzhou, the Gansu Provincial Maternity and Child-care Hospital features prominently in a district of hospitals and clinics that visually bind biomedical childbirth and mothercraft to China's re-emergence as a global economic power. Towering high in the skyline surrounded by cranes and construction signs, the maternity hospital forms the core of a complex of buildings that provide material evidence of successive campaigns to manage women's reproduction. The hospital stands between a planned-birth office and an alley called "Mother and Child Street," lined with shops selling diapers, formula, and bottles. From this spot in Lanzhou, one can see cumulative, material effects for childbirth and motherhood from the marketization of the economy, the massive campaign to limit births, and an even earlier project to reduce maternal and infant mortality.

The entrance to the hospital features placards that affirm the critical place of women's reproduction in national myth. Photographs of mulitiple generations of Chinese women make clear the perceived links between women's reproductive health and the futurity of the nation-state. Alongside these photographs, messages affirm these stakes of women's healthcare by asserting, "Mothers are the cradle of the nation, children are the hope of the motherland." In local histories, the hospital stands as a monument to the triumph of socialist state-building that transformed China from a feudal land of disease and misery to among the foremost players in geopolitics and the global economy.[687]

[687] *Gansu wenshi ziliao xuanji* 《甘肃文史资料选辑》Vol. 23 (Lanzhou: Zhongguo renmin zhengzhi xieshang huiyi gansusheng weiyuanhui wenshi ziliao yanjiu weiyuanhui 中国人民政治协商会议甘肃省委员会文史资料研究委员会，1985), 60-3.

Other photographs near the entrance to the hospital point to fissures in this narrative, belieing the multifaceted assemblage of actors and interests that produced both the Lanzhou hospital and the reproductive health landscape of modern China. In addition to noting that the hospital itself opened seven years prior to the Communist Revolution, photographs of the hospital's longtime director, Chen Guiyun, inadvertently tie the present to the prerevolutionary past and developments within China to a broader story of global health in the twentieth century. The hospital that now reaches to the sky in urban Lanzhou emerged as an expansion of the MIH program begun at the provincial midwifery school in 1935, which rested on the aligned investments of foreign philanthropists, the Nationalist state, provincial authorities, and local practitioners, including Chen Guiyun and her largely erased companion, Yang Yongni.

This dissertation has sought to recoup these buried histories of MIH by attending to global and pre-revolutionary dynamics that shaped the cumulative development of reproductive health across the 1949 divide. Amid the shifting dynamics of imperialism and nationalism during the interwar period, public health linked the interests of new imperial powers and new nation-states, as the terms of legibility dictated by international organization, namely population and territory, came to depend on foreign capital, expertise, and military cover. In women's reproductive health, these dynamics became fused with the woman question, in discourses that connected China's status among nations and the biopolitical management of the population as a whole to the everyday tasks of childbirth and mothering. The linking of these political and social dynamics produced scientific measures of women's shared yet varied capacity to reproduce and nurture—figured in maternal/infant mortality rates and/or categories such as "old-"and "new-style" birth—that at once animated foreign interventions in China and Nationalist interventions in the interior.

These intertwined national and global projects depended on local health practitioners, who included significant numbers of female doctors, nurses, and midwives. In western provinces, the grand designs of philanthropists and national officials yielded to local conditions, as health workers adapted national models to suit the particular needs of local women. The extension of biomedical midwifery and mothercraft thus had diversified effects. It at once extended foreign influence and state surveillance to individual households in remote and rural areas of China, while bringing the concerns and customs of women in particular regions to bear on the implementation, and ultimately, the design of public health policy.

The broad political and cultural investments that elevated women's reproductive and affective roles also had dual effects for the Chinese women's movement. It at once circumscribed the realm of women's political engagement to the domain of childbirth and nurturing, while imbuing those roles with new political significance and thereby fostering new discourses and venues for women's activism. The scheme to rely on female midwives and the broader feminizing of nurturing drove rapid increases in the number of women medical practitioners in China. For some of the practitioners, the resources and priorities of the state and its foreign partners provided venues and vocabulary through which they could advance explitly feminist aims. These resources and networks further linked Chinese feminisms to an international maternalist movement, as Chinese women physicians like Wu Zhimei, Yang Chongrui, and Ye Shiqin studied and worked throughout the world supported by the Chinese government and foreign philanthropists.

These international travels fostered a global feminist consciousness further shaped by dynamics within China during the later 1930s and 1940s. Particularly during the war years, many women medical practitioners, often from privileged backgrounds and from the coastal east,

encountered peasants and refugees in rural areas of the interior. These conditions led to a refashioning of the subject and scope of the Chinese women's movement that played out in feminist publications, the representative organs of the Nationalist government, and public health policy. In many cases, activism by and on behalf of a broadly imagined collective of "women" drew from the very metrics of population and reproduction that had been used to delimit women's roles, making political claims that simultaneously asserted women's shared concerns and the structural factors that produced women's differing levels of access to scientific mothercraft's prerequisite education, means, and healthcare.

Through a timeframe that spans the regime change of 1949, the cumulative development of reproductive health infrastructures throughout the twentieth century comes into stark relief. The management of both mortality and fertility on both sides of the Taiwan Strait depended on concepts, strategies, personnel, and institutions that emerged during the Nationalist decades on the mainland. In the wake of the Revolution, the assemblage of actors invested in Chinese women's reproductive health realigned, with most feminist physicians maneuvering to claim a position in the PRC, and global health organizations adapting their endeavors to accommodate the Cold War context and allying with health officials in Taiwan. Beyond Sinophone East Asia, the broader field of global health came to bear the legacy of pre-revolutionary endeavors in China, as retraining midwives became critical to efforts in other regions and the MCH programs of international organizations reflected transnational maternalist politics authored in part by Chinese physicians.

For Chinese history, this dissertation demonstrates that a history of reproductive health in twentieth-century China must account for dynamics beyond the People's Republic, in both geographic and temporal terms. Further, even within the authoritarian context of both Nationalist

and Communist regimes, the state cannot be conceived of as a monolithic, bounded actor advancing a clearly defined set of aims. In the Chinese case, policy bore the influence of a variety of actors both foreign and Chinese. Within a single bureau, like the National Health Administration, or, in other iterations, the Ministry of Health, varied actors advanced distinct aims even as they drew from shared assumptions and deployed similar rhetoric. In the particular case of Chinese women health advocates, we see a project to advance women's reproductive health that spanned the rupture of Revolution, using varied organs and ideologies of government often to further explicitly feminist aims. Though their consistent efforts bound women's reproduction to the political, economic, and eugenic aims of other figures within and beyond the state, the motives animating their practice remain irreducible to "nationalism" or a pursuit of "modernity," despite the dominance of these categories in the rhetoric of their day and scholarship produced in the present.

This dissertation also brings Chinese history into dialogue with a broader historiography of imperialism and medicine in the non-Western world. From a global view, a more textured political terrain of public health can be seen in China than has been accounted for in existing historiography. For many actors, nationalism and a desire to modernize China made public health a powerful tool for expanding, disciplining, and perfecting the population subject to Chinese governments. However, these projects, critical for the Chinese nation and state, remained imbricated within global dynamics, intertwined with the aims of new imperial powers in the mid-twentieth century. Even as nationalistic campaigns promoting hygiene emphasized elevating China's status on the world stage, they remained compatible—in fact integral—to foreign efforts to enhance U.S. strategic and commercial interests in the Pacific. This linking of

national and international scales can be seen across the rupture of 1949, particularly in the case of Taiwan.

Though much of the historiography on public health beyond the West has emphasized disciplinary dynamics, the intertwined projects of new imperialism and nation-state building in China had unexpected effects. In the middle third of the twentieth century, biomedical public health's disciplining of bodies within and across national borders also produced agentic subjects who used public health infrastructures and idioms to frame and legitimize distinct political aims. By accounting for the diversified scales, motives, and effects surrounding reproductive health in China, we see agentic engagement with disciplinary regimes of health and medicine irreducible to revolt or resistance.

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