Efforts to Reduce Infant and Maternal Mortality in Saskatchewan During the Settlement Period

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by
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FACULTY OF GRADUATE STUDIES AND RESEARCH

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ABSTRACT

This thesis examines how the problem of infant and maternal mortality was addressed in early twentieth century Saskatchewan. During the settlement process, the government had given little thought to the needs of women and childbirth, in particular, access to medical care to ensure for safe childbirth. As a result, the infant and maternal mortality rates were alarmingly high in Saskatchewan during this period. Women’s organizations, the medical profession and the provincial government all tried to address the maternity needs of prairie women to varying degrees and with limited results. Several historical developments occurring at the same time affected the type of response taken. These included the professionalization of both medicine and nursing, the medicalization of childbirth, and medical dominance in the field of public health. This thesis argues that the educational approach taken by the Saskatchewan government was not adequate or practical to deal with the maternity needs of homestead women. Farm women and members of women’s organizations knew that the only practical solution to the lack of health care services in rural areas was a system of trained midwives. However, the provincial government never considered this option as way of mitigating the high infant and maternal mortality rates in rural areas.

The primary research on which this thesis is based includes personal letters, emails and telephone interviews from people who responded to a letter I submitted to several small town newspapers requesting information on childbirth experiences during the settlement period. The McNaughton Papers housed at the Saskatchewan Archives Board also provided a wealth of information on Violet
McNaughton and her campaign for more midwives, doctors, nurses and hospitals in the rural areas of the province. Finally, annual reports from the Saskatchewan Bureau of Public Health and articles from the *Canadian Medical Association Journal* provided much insight into the medical community’s views on certain issues of the day.
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I gratefully acknowledge several contributions to this study. The Saskatchewan Archives Board was extremely helpful in conducting research into government documents and other areas. I would also like to thank those who responded to my request for information in local newspapers. They generously gave of their time and shared their stories, asking nothing in return. I thank the Faculty of Graduate Studies and Research at the University of Regina for helping to fund my research through scholarships. Lastly, I would like to express my great thanks to my supervisor, Dr. James Pitsula, Marilyn Bickford for all her assistance over the years, and the faculty of the History Department at the University of Regina for their unyielding patience and support through this challenging process.
DEDICATION

For all those homestead women who persevered and helped each other when there was no other help to be had.
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<td>Colonial Nurses Association</td>
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<td>CNATN</td>
<td>Canadian National Association of Trained Nurses</td>
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<tr>
<td>NCWC</td>
<td>National Council of Women of Canada</td>
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<td>ONA</td>
<td>Overseas Nursing Association</td>
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<td>RCW</td>
<td>Regina Council of Women</td>
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<td>SARM</td>
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<td>SGGA</td>
<td>Saskatchewan Grain Growers’ Association</td>
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<td>VON</td>
<td>Victorian Order of Nurses</td>
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<td>WGG</td>
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Chapter 1: Introduction

In the late nineteenth century a broad social reform movement emerged in Canada in response to a rapidly changing society. The changes brought on by urbanization, immigration and industrialization prompted a variety of reform activities from the struggle for prohibition to the provision of community health services. Maternal feminists argued that women had a duty to take their mothering qualities into the public sphere to save the family and clean up a corrupt society. As a result, women began to step outside of their traditional sphere and became involved with reform organizations. Initially, the female reformer focused her attention primarily on matters affecting women and children, and within this context, infant mortality was of particular importance. One in five Canadian babies died before the age of two at the beginning of the twentieth century.¹

Infant mortality was considered to be one of the most tragic effects of rapid industrialization and, from the beginning, it was conceptualized as essentially an urban problem. Although the infant mortality rates were high throughout the country, it was only the death rate of urban infants that prompted significant concern from public health reformers. The rate of infant mortality seemed to increase dramatically during the late nineteenth century as rapid urbanization created congested cities that became spawning grounds for disease. Aware that the infant mortality rate of the urban poor greatly exceeded that of the urban middle-class, reformers initially focused on measures that would alleviate the unsanitary conditions in working-class neighbourhoods.²

Like many other reform movements of the time, the infant welfare movement was international in scope. In the early twentieth century, organized efforts to reduce infant mortality began more or less simultaneously throughout much of the Western world. Infant welfare activists and public health officials borrowed heavily from the ideas and data published by their counterparts in other countries. With Great Britain, France and the United States in the forefront, they shared with the rest of the world a number of basic assumptions concerning the nature and causes of infant mortality. Initially, parental ignorance of proper care and feeding, along with the high concentration of disease-causing agents in urban slums, were believed to be the primary causes of infant mortality. As a consequence, public health officials and reform organizations approached infant mortality as a problem which required both environmental sanitation and parental education.3

This thesis will examine how the problem of infant and maternal mortality was addressed in Saskatchewan during the settlement era: a period of approximately fifty years beginning in the 1880s and ending roughly around 1930. Aware that infant mortality was considered to be primarily an urban problem, I was curious to see how it was addressed in Saskatchewan, which also had a very high infant mortality rate, but was overwhelmingly rural. With many people living in sparsely populated, isolated areas, the central concern for these residents was obviously not the spread of disease in city slums, but the inaccessibility to medical care. Statistics reveal that the vast majority of infant deaths in Saskatchewan during this time occurred within the first day of birth, which points to a lack of medical attention before, during and directly after childbirth. In addition, because a high proportion of these deaths were

accompanied by maternal deaths, the maternal mortality rate in Saskatchewan was also shockingly high in the early twentieth century. This thesis will argue that the educational approach taken by the Saskatchewan government was not adequate or practical to deal with the maternity needs of homestead women in the early twentieth century. Farm women and members of women’s organizations knew that the only practical solution to the lack of health care services for mothers and infants in rural areas was a system of trained midwives. They lobbied the government to pass a Midwives Act to legalize midwifery, however, for a variety of reasons the provincial government never considered this option as a way of mitigating the high infant and maternal mortality rates in rural areas. These included: a short sightedness on the part of the government to the needs of homestead women; professionalization of medicine and nursing, the hospitalization of childbirth, and medical dominance in the field of public health. This study will begin by putting the infant mortality movement into a national and international context by analyzing the social and political environment in which it emerged. It will also describe how theories of disease causation shaped medical attitudes and initiatives to reduce infant mortality in the early twentieth century.

The Concern Over National Deterioration

Public health activists in Europe and the United States had been aware of the high infant mortality rates since around the mid-1800s, but widespread interest in infant mortality only surfaced after the turn of the century. One important reason for the increased interest was the concern over national deterioration that gripped much of the Western world at the end of the nineteenth century. Shaped by ideas of political economy and post-Darwinian evolutionary theory, concern over the quantity and quality of national populations began to
emerge. It was believed that eliminating the causes of infant death would not only increase population but would also increase national efficiency, since diseases in infancy often condemned thousands to sickly, unproductive lives.\textsuperscript{4}

During the nineteenth century most political economists agreed with the Malthusian theory that excessive population would eventually lead to the exhaustion of resources, resulting in war, epidemic, disease, and other natural checks on overpopulation. This began to change in Great Britain, after the publication of an influential book by J.R. Seeley, \textit{The Expansion of England}, in 1883. Seeley argued that if the British population did not increase fast enough to fill the empty spaces of the empire, others would. The threat he was referring to was not from the indigenous populations, but from rival master-races from the United States or Germany. Britain’s declining birth rate suddenly became a matter of national importance, for population equaled power.\textsuperscript{5}

Around the same time, concern about the physical and mental condition of future generations began to emerge as well. Ideas about ways to improve the population stemmed from scientific discussions following the publication of Darwin’s \textit{Origins of Species} in 1859. Darwin’s cousin Francis Galton took his ideas one step further by claiming that you could improve the quality of human populations by controlling the process of selection. He developed the concepts of positive eugenics; encouragement of reproduction by desirable couples, and negative eugenics; discouragement of reproduction by the ‘undesirables’, as a way to control racial progress. Eugenics developed within a particular economic and political context, which revolved around the idea of efficiency. The pursuit of national efficiency was primarily a response to fears of British decline as a

\textsuperscript{4}Ibid., 101.
military and commercial power.\(^6\)

By the turn of the century, anxiety over the falling birth rate, combined with concern over the physical debility and ill-health of British military recruits during the Boer War, provoked enough public and official alarm over national degeneration to inspire the creation on an Inter-departmental Committee on Physical Deterioration in 1903. Publishing its report in 1904, the Committee claimed that, contrary to what the eugenists believed, no evidence existed of inherited racial physical decline. They did, however, devote considerable attention to infant mortality, suggesting that eliminating the causes of infant death would not only increase population but would also increase national efficiency. They believed that education and environmental conditions were the key factors in ameliorating infant death and childhood illnesses.\(^7\)

France was equally alarmed by the increasingly high rates of rejection of military recruits and by the publication of statistics indicating rising mental and physical degeneracy amongst the French population. France, in fact, many have been the first country to record such concern and to link it to infant mortality. Some historians claim that public officials became obsessed with its declining birth rate following the devastating loss in the Franco-Prussian War. Consequently, as a means of building their demographic strength, they turned increasing attention toward saving infant lives and pioneered infant welfare programs which were eventually adopted by other countries.\(^8\) According to Deborah Dwork, the poor health of military recruits and the policy of national efficiency did not create the infant welfare movement in Europe at the beginning of the twentieth century, but these factors highlighted the problem and provided a

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\(^7\)Ibid., 18-20.

\(^8\)Meckel, *Save the Babies*, 101-102.
stimulus for reform. Healthy babies were needed not only for the maintenance of empire but also for production under the changing conditions made necessary by imperialist competition. The result was an outpouring of concern over the bearing and rearing of the next generation of soldiers and workers. This newfound appreciation of infant life inspired national and international organizations devoted to the study and prevention of infant mortality and conferences to discuss strategies for its amelioration.  

The fear of national degeneration travelled easily across the Atlantic in the early twentieth century. In North America the discourse on infant mortality was conducted as part of a larger discourse on national deterioration and race suicide. The phrase ‘race suicide’, popularized by Theodore Roosevelt, referred to both the numerical decline of the Anglo-Saxon race with respect to other more fertile groups, and the decline of humanity in general. Advocates of eugenics, whose influence during this period was pervasive, strongly believed that human inequalities were hereditary and that immigration was contributing to the multiplication of the unfit. Scholarly studies lent credence to the eugenic position by arguing that the introduction of immigrants into American society was “diluting the purity of the nation’s racial stock.” An elaborate classification system was even devised to rank national and ethnic groups according to a combination of geographic, physiological, and moral criteria. Generally speaking, lighter skinned people from more northern latitudes were preferred to darker skinned people from more southern latitudes.

The fact that sympathy toward eugenicist ideas was widespread among

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9Dwork, War is Good for Babies and Other Young Children, 20.
12Valverde, The Age of Light, Soap, and Water, 110.
infant welfare activists is not surprising. For many of those involved in the various reform movements of the early twentieth century, eugenics was perceived as a legitimate science and was granted great respect. Carol Lee Bacchi contends that the one unifying theme that underlay the entire social reform movement and made sense of its diverse strands, was concern over the future of the Anglo-Saxon race. From the perspective of the infant welfare activist at the time, not only were they involved with an international movement to try to save infant lives, but also a scientific endeavor to advance human welfare by improving the quality of humanity. Consequently, linking infant mortality to the pseudoscience of eugenics became an important preoccupation within the movement.13

Advocates of eugenics discounted environmental reforms as a method of reducing infant mortality and insisted that the only way to improve the race was through selective breeding. They believed the principal cause of racial degeneration was that people with hereditary defects were multiplying faster than those with desirable traits. The recommended solution was to encourage the ‘fit’ to have more children and pass legislation which prevented the ‘unfit’ from breeding. This commitment to race regeneration placed a premium on women’s traditional role as mother and, as a result, a powerful ideology of motherhood emerged in the early twentieth century. It was now the duty and destiny of women to guarantee the health of a new generation.14 Motherhood was to be given a new dignity and made in every way desirable, for the elevation of motherhood was the one certain method by which infant mortality could be checked. Middle and upper-class women who were pursuing new opportunities

13 Meckel, Save the Babies, 117.
in education and employment, rather than marrying and having children, were accused of shirking their national responsibility and abandoning their racial duty.\textsuperscript{15}

In Canada, the infant welfare campaign in the early years of the twentieth century was initially in the hands of organized womanhood and subsumed within a much broader social reform movement. It took the impact of the Great War to transform a loose coalition of reformers dedicated to saving infant lives into a full-fledged movement under state control.\textsuperscript{16} The heavy losses of World War I triggered a quantum leap in the concern about conserving human life which was made evident by the changing emphases of the federal government’s Commission of Conservation. Before the war, the Commission had focused its attention primarily on the conservation of national resources such as forests and fisheries. During and after the war, however, more emphasis was put on the conservation of human life and less on trees and animals.\textsuperscript{17} Suddenly, theories of race degeneration became much more pervasive within Canadian politics and society. Many English-Canadian writers at the time commented on how the ‘best’ young Canadians were dying in the war while the ‘worst’ languished and reproduced at home. A number of historians have also noted how several women’s organizations during this period seemed preoccupied with the issues of Social Darwinism and race regeneration.\textsuperscript{18} Thus, as was the case in Europe and the United States, in Canada eugenics and theories of racial degeneration played a prominent role in the national discourse on infant mortality and provided the spark necessary to turn a relatively small campaign into a concerted movement

\textsuperscript{15}Davin, “Imperialism and Motherhood,” 14, 20.  
\textsuperscript{16}Comacchio, \textit{Nations Are Built of Babies}, 44.  
\textsuperscript{17}Valverde, \textit{The Age of Light, Soap, and Water}, 24.  
\textsuperscript{18}Angus McLaren, \textit{Our Own Master Race: Eugenics in Canada, 1885-1945} (Toronto: McClelland & Stewart, 1990), 37, 43.
of national importance.

The Era of Reform

The period from the 1890s to the 1920s was a transitional one in North America. These decades saw not only great economic development but also increasing social ferment. With the economic shift toward industry and finance, urban living became the rule rather than the exception. Rapid urbanization had created a whole host of problems that North American society had not yet experienced. One important aspect of the growth of a modern industrial society was the development of an urban working class. The correlative of that was the development of an urban middle class, certain sectors of which initiated a reform movement to curb industrial society’s most glaring problems and injustices.\(^{19}\) A wide range of organizations for social, moral, political, and economic reform found their voice during this period.

In the United States, this broad reform movement acquired the name Progressivism at the beginning of the twentieth century. Progressives believed that continued growth and advancement were the nation’s destiny, but they also believed that the “natural laws” of the marketplace were no longer sufficient to create the order and stability that the growing industrial society required. Purposeful human intervention was needed and most believed that government should play an important role in the process. Progressives placed a premium on scientific knowledge and envisioned a new civilization in which the expertise of scientists and engineers would be put into the service of improving society. This belief was realized with the emergence of social work as a profession in the early twentieth century.\(^{20}\)

At its core, the American Progressive movement was an urban middle

\(^{19}\)Valverde, *The Age of Light, Soap, and Water*, 15.

\(^{20}\)Brinkley, *The Unfinished Nation*, 557, 560.
class response to problems associated with rapid urbanization. Rural migrants new to the city were deeply affected by the experience of urban life, with its overcrowding, poverty, filth, crime, intemperance, prostitution, and ethnic diversity. To many, the city seemed not merely a new way of life but a threat to civilization itself. According to Richard Hofstadter, Progressives were all after the same elusive thing: the moral social order of a town within a city. He claims that Progressivism, at its heart, was an effort to realize traditional ideals under new circumstances.\textsuperscript{21} While many reformers had a genuine concern for the welfare of the victims of industrialization, most historians agree that the primary motive behind the Progressive movement was fear of disorder among the lower classes rather than altruistic reform.

Underlying and accompanying the social reform movement was what came to be known as the Social Gospel. The Social Gospel was part of a widespread attempt in Europe and North America to revive and adapt Christianity to meet the scientific and social challenges of a rapidly changing world. Many Christians believed that Christianity simply had to be made more relevant to the social conditions of the times. This led to an attempt by religious leaders to save Christianity by transforming it into an essentially social religion. The orthodox Christian preoccupation with man’s salvation was replaced with an emphasis on social salvation. This modernist version of Christianity denied the transcendence of God and insisted upon his immanence in the world. In its most fully developed version, the Social Gospel espoused that indeed the only goal of Christianity was the reform of society to create the Kingdom of God here on earth.\textsuperscript{22}

The Social Gospel played a much more prominent role in the social reform

\textsuperscript{22}Ramsay Cook, \textit{The Regenerators: Social Criticism in Late Victorian English Canada} (Toronto: University of Toronto Press, 1985), 4, 105, 147-175.
movement in Canada than it did in the United States. At the beginning of the twentieth century, reform-minded individuals within the Protestant churches were eager to ensure that their brand of Christianity adapted to the changes occurring in modern Canadian society. These men assumed a new leadership role within the Protestant churches and shifted its cultural emphasis from the preservation of traditional theology to an outward social action designed to address the ever increasing problems of the nation. In their book *A Full-Orbed Christianity*, Nancy Christie and Michael Gauvreau argue that because of the enormous public authority the Protestant churches enjoyed prior to World War Two, they became the gravitational centre for social reform in Canada. They assert that unlike Progressive reform in the United States, which became increasingly divorced from Christianity, the Protestant Churches in Canada provided the funding, personnel, and organizational structure necessary for the creation of social reform. As the American Social Gospel movement became more marginalized with the rise of the social sciences in American universities, the near absence of sociology in Canadian universities allowed the churches to fill the void and serve as the main avenue by which modern social science entered Canadian culture. And because social service departments were underdeveloped in Canada at the time, the Protestant churches became the dominant institution in the area of social investigation. Christie and Gauvreau argue that clergymen were the key actors in shaping the new cultural mindset and were in every sense the Canadian counterparts to the American Progressive leaders.

While the leadership of Protestant reformism may have been male, the force behind its platform was provided by the mobilization of vast numbers of

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24 Ibid., 35, 76, 166.
middle-class women. The new social evangelism directed religious sentiment towards an acceptance of outward social action as the definitive mark of an individual's membership into the Kingdom of God. Those who embraced the tenets of the Social Gospel felt obligated to take positive action to create a better world. It therefore provided both the incentive and the justification for women to enter the public sphere and get involved with reform organizations. However, the respectable female reformer was expected to confine her activities to those issues affecting women and children. Maternal feminists argued that women had an intuitive empathy with the weak and dependent and, as such, the female reformer was encouraged to accept the role of ‘mother of society.’ Christie and Gauvreau claim that voluntary organizations such as the National Council of Women (NCW) and their local associations, working in close alignment with the Protestant churches, were largely responsible for laying the groundwork of the modern welfare state. And, rather than being a predominantly urban-based phenomenon like Progressivism, small town and rural reform organizations, fuelled by the force of the Social Gospel, became the life-blood of the social reform movement in Canada until the 1930s.

The Infant Mortality Movement

The infant mortality movement of the early twentieth century must be viewed within the context of international developments in medicine and the evolution of public health care systems. Capitalism’s innate potential for self-destruction was revealed in the early stages of industrialization when its effects on public health became all too apparent. Since the self regulating free market structure could no longer be counted upon, many believed that intervention was needed to prevent the system from “quite literally devouring its own young.”

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25 Buckley, "Ladies or Midwives?" 133.
26 Christie and Gauvreau, A Full-Orbed Christianity, 114, 203.
infant welfare campaign cannot be properly understood apart from the discovery of the preventive concept in medicine, and the development of public health as one of the essential services of the modern industrial state.\(^{27}\)

Infant mortality was central to the development of public health policy in North America and preoccupied early public health activists in a way that many other forms of mortality did not. One important reason for this was the fact that it came to be regarded as a particularly sensitive index of community health and well-being. Infant mortality was also seen as an emotionally charged issue which reformers found useful in securing government funding for related programs.\(^{28}\) But perhaps the most important reason for the heightened concern with infant mortality was the realization that the infant death rate was not declining at the same pace as the general death rate. The publication of comprehensive national mortality statistics had a significant impact on American public health reformers at the turn of the century.\(^{29}\)

The first phase in the infant mortality movement coincided with the first phase in the urban public health movement: environmental reform. The “sanitary idea” emerged in the second half of the nineteenth century in response to the rising death rate that accompanied rapid industrialization.\(^{30}\) It was believed that cleaning up unsanitary urban environments would dramatically diminish deaths from communicable diseases. The concept promoted the development of engineering and waste management technology, and led to the creation of municipal health boards and new positions such as medical health officers and sanitary inspectors. Public health activists believed that housing inspection,


\(^{28}\)Meckel, *Save the Babies*, 5.

\(^{29}\)Ibid., 103-104, 111.

sewage disposal, and water and food purification standards would go a long way toward improving public health and saving lives.\textsuperscript{31}

The bacteriological revolution also contributed greatly to the evolution of public health systems in the latter half of the nineteenth century. As scientists uncovered the microbiological origins of many communicable diseases, public health officials were able to use these discoveries to control the spread of disease in urban centres. Bacteriology subsequently became the main weapon in the battle for public health, and infant mortality in particular, for initial efforts to lower infant mortality rates were focused primarily on preventing the spread of disease in the urban slums. By 1900, diagnostic testing had become the norm in city health departments and, increasingly, vaccines were discovered to prevent many of the diseases which took such a toll on infant life.\textsuperscript{32}

Thus, the first stage in the campaign to reduce infant mortality emphasized environmental reform and lasted roughly forty years, from 1850 to 1890. Like public health reform in general, the campaign to prevent infant mortality was initially an urban reform activity centered in the larger cities. Public health activists believed that infants died in such great numbers because of hereditary debility and exposure to morbific influences. Statistics showed that the babies of the urban poor suffered disproportionately from premature deaths. Health officials then tried to identify those factors which made the children of the working-classes significantly less able to resist infections and disease.\textsuperscript{33} At the time, heredity was considered to be a key factor in the high infant mortality rate among the poor. It was widely accepted that sickly parents produced sickly kids, who were either predisposed to the diseases from which their parents suffered or

\begin{footnotesize}
\textsuperscript{31} Comacchio, Nations Are Built of Babies, 24.
\textsuperscript{32} MacDougall, Activists and Advocates, 11-13.
\textsuperscript{33} Meckel, Save the Babies, 5, 19.
\end{footnotesize}
were simply unable to fight off morbidic influences because of an inherited weakened constitution. The high infant mortality rate of the infant poor was therefore a reflection of the generally high morbidity and mortality experienced by the adult urban poor. It followed, then, that if the infant death rate was to be diminished, the health of all the urban poor had to be improved. As a result, during the first phase of the infant mortality movement, public health reformers sought to lower the infant mortality rate by improving general health through environmental reform.\textsuperscript{34}

The second phase of the infant mortality movement began around 1880 and stretched through to the second decade of the twentieth century. Frustrated over their inability to reduce infant mortality through general environmental reform, public health activists started to narrow their focus from the conditions in which infants lived, to what they were fed. Influenced by developments in the science of bacteriology and the emerging profession of paediatrics, and aware that the cause of a high proportion of infant deaths was from digestive disorders, reformers refocused their attention to improving the quality of the urban milk supply and on making clean and wholesome milk available to those babies at highest risk.\textsuperscript{35}

Doctors concerned over the high infant mortality rate started to pay increasingly close attention to infant feeding in the late nineteenth century. English and German ideas on artificial infant food as a critical determinant of infant health traveled quickly to the United States and prompted American physicians to investigate the theory further. In 1890 the eminent American paediatrician L. Emmett Holt, wrote that digestive disorders were caused primarily by faulty nutrition rather than poverty and confinement in dirty, ill-

\textsuperscript{34} Ibid., 22.
\textsuperscript{35} Ibid., 5-6.
ventilated homes. He concluded that it was the nature of what infants were fed that actually produced the illness.\textsuperscript{36} Statistical data from the United States and Europe supported his findings that artificially fed babies died from infant diarrhoea, which was considered to be the most obvious and ‘preventable’ cause of infant mortality at the time, in far greater numbers than breast-fed infants. This led to a conclusion that correlated contaminated milk with a high infant mortality rate.\textsuperscript{37}

Paediatric promotion of the belief that improper nutriment was the primary cause of infant diarrhoea exerted a powerful influence on public health reformers. While environmental reform and improving the health of the general population remained part of the program to reduce infant mortality, reformers shifted their emphasis in the late nineteenth century toward improving the quality of urban milk supplies. The initial stage of the pure milk campaign focused primarily on protecting urban milk supplies from adulteration, dilution, and spoilage through governmental regulation. However, regulating the urban milk supply did not address the more serious problem of bacterial contamination. Although anti-adulteration regulations and milk inspection were initiated in many cities, the quality of commercial milk remained appallingly impure due to unsanitary methods of production.\textsuperscript{38}

While public health reformers became increasingly aware of the importance of improving the hygienic conditions in which milk was produced, they also recognized how difficult it would be to monitor and regulate the numerous sources from which a city’s milk supply typically came. Reformers argued that addressing the milk problem required a more immediate solution. One such

\textsuperscript{36}Ibid., 40, 45.  
\textsuperscript{37}Dwork, \textit{War is Good for Babies and Other Young Children}, 52.  
\textsuperscript{38}Meckel, \textit{Save the Babies}, 63, 69, 77.
measure involved the establishment of clean milk depots in working-class districts for the specific purpose of reducing infant deaths from digestive disorders among the urban poor. The depots would provide pure milk to working-class mothers free of charge or for a subsidized rate and operated primarily in the summer months when deaths from such diseases reached epidemic proportions.  

Prior to this point, the campaign to reduce infant mortality had primarily been dominated by public health officials and medical communities. After 1900, however, reform organizations and charity workers became increasingly involved. The pure milk campaign served as the perfect opportunity for volunteers to play a more active role in infant welfare work. The depots were organized and staffed by local reform groups and physicians dedicated to the cause. An organizational network quickly developed amongst infant welfare activists involved with the milk depots that soon evolved into a multifaceted movement. As a result, infant mortality moved to the forefront of the social reform platform in the early twentieth century and inspired a campaign to ameliorate it that dwarfed all previous infant welfare efforts.

What had made milk reform so central to the infant welfare movement was the promise it seemed to hold as a well-defined and relatively simple way to lower the urban death rate. Aware that infant mortality rates among the urban poor accounted for a high proportion of total city death rates, and frustrated by their inability to change the environmental conditions associated with poverty, infant welfare activists looked to an alternative solution. If the single most important cause of infant mortality was bacterial infection from contaminated milk, then improving the quality of commercial milk should theoretically result in a

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39 Ibid., 78-79.
40 Ibid., 79-80, 91.
significant reduction in infant mortality. However, while infant mortality due to summer diarrhoeal illnesses did decline slowly, infant mortality rates in general remained very high. Statistics revealed that, along with digestive disorders, congenital problems and respiratory diseases were also causing a high number of infant deaths.\textsuperscript{41} Thus, just as pure milk depots proliferated across North America in the early twentieth century, public health officials were beginning to realize the limitations of that solution.

The third phase in the infant mortality movement generated, by far, the most publicity and reform activity. Beginning around the turn of the century and lasting until the 1930s, this final stage witnessed a number of crucial developments within public health, social welfare, and medical professionalization. Infant mortality was once again reconceptualised and yet another strategy was adopted to combat it. Increasingly questioning the efficacy of narrowly focusing on milk reform, infant health reformers redefined infant mortality as a problem of motherhood and began to focus on improving women’s abilities to carry, bear, and rear healthy children.\textsuperscript{42} By this time, the medical profession had effectively taken the reins of leadership in the infant welfare campaign. Physicians believed that only they had the skills and the professional expertise to address the issue of infant mortality. They concluded that a lack of knowledge of hygienic principles was the primary cause of infant death and the solution they advocated was scientific motherhood. The growing medical appreciation of the role of prevention, and the selling of this basic principle to the public, would therefore become the focus of the campaign.\textsuperscript{43}

Milk depots were a common first step in combating infant mortality in both

\textsuperscript{41}Ibid., 90.
\textsuperscript{42}Ibid., 6.
\textsuperscript{43}Comacchio, \textit{Nation’s Are Built of Babies}, 15.
Europe and North America. However, the actual effect that they had on reducing the urban infant death rate was negligible. Despite the great number of nursing bottles dispensed, only a tiny fraction of the milk consumed by urban infants came from the pure milk stations. It soon came to be realized that a great deal more was needed to reduce infant mortality than could be supplied by a few scattered milk depots in the working-class neighbourhoods of large cities.\textsuperscript{44} Physicians were also well aware by this time that concentrating primarily on milk work left largely unaddressed the other causes of infant mortality. Although digestive disorders did account for the greatest proportion of urban infant deaths, respiratory and infectious diseases also killed a significant number of babies.\textsuperscript{45}

In the late nineteenth and early twentieth centuries, a number of European studies were published which provided evidence that much of the bacterial contamination of milk took place in the home and suggested that breastfeeding and better maternal care might be the only way to lower the infant mortality rate. As early as 1892, French physician Pierre Budin was among the first to contend that providing pure milk to uninstructed mothers was an inadequate approach to combating infant mortality. Concerned with the limitations of merely providing pure milk, Budin designed and implemented a program of follow-up instruction for maternity patients called the “consultation de nourrissons.” In his consultation with new mothers, Budin stressed the importance of breastfeeding and provided information on infant hygiene. For those mothers unable to breastfeed he emphasized the value of sterilizing and keeping cool the milk they fed their infants.\textsuperscript{46}

Arthur Newsholme, chief medical officer to Great Britain’s Local

\textsuperscript{44}Ibid., 46, 51.
\textsuperscript{45}Meckel, \textit{Save the Babies}, 95.
\textsuperscript{46}Ibid., 93, 96.
Government Board between 1908 and 1918, was another physician who exerted a great deal of influence within the infant mortality movement in both Europe and North America. He believed that domestic contamination of food and milk was a far more important factor in producing epidemics of summer diarrhoea than commercial contamination. He argued that maternal education in the basics of domestic hygiene and stressing the need to breastfeed for aseptic reasons would do more to lower the infant mortality rate than any other single action. But perhaps the most widely quoted book on the subject of infant mortality in the early twentieth century was George Newman’s *Infant Mortality: A Social Problem*. Newman characterized infant mortality as a complex social problem with many interrelated causes. He contended that “more than any other single agency, infant mortality depends on infant rearing.” By suggesting that infant mortality was mainly a problem of motherhood, Newman and other infant health care advocates refocused attention away from external factors and toward individual behavior.

The shift in focus from milk reform to maternal reform did not involve a total abandonment of previous reform activities. Those interested in reducing the infant mortality rate continued to campaign for improvements in the commercial milk supply and to dispense pure milk to the urban poor. However, such milk work was increasingly viewed as an insufficient response to infant mortality unless it was part of a larger program of maternal education. Mothers were considered to be handicapped in their childrearing duties by an ignorance that could only be remedied through expert tutoring in scientific motherhood. This new approach to the infant mortality problem called for a professional and public commitment to mass education. An important aspect of the educational program

48 Ibid., 93.
was to raise public awareness of the extent and seriousness of the problem.\textsuperscript{49}

Initially, the maternal education campaign focused on encouraging women to breastfeed their babies and on instructing those who could not in hygienic methods of artificial feeding. It came to be realized that providing clean milk to poor mothers was futile unless they were also taught now to handle and prepare it. Vital to this effort was the transformation of milk depots into well-baby clinics in which the emphasis shifted from providing pure milk and caring for sick babies, to examining well babies and educating mothers on keeping them that way. The well-baby clinics continued to dispense pure milk to the urban poor; however, their primary function was to assist mothers through advice and education on how to properly care for their infants.\textsuperscript{50}

Although voluntary organizations formed the core of the campaign against infant mortality, increasingly it came to be seen that only the state had the authority and resources to pursue and coordinate effective reform. Therefore, much of the voluntary reform effort during the third phase of the movement was directed at pressuring the government to play a bigger role in the effort to reduce infant mortality in Canada. Consequently, governments at all levels did gradually expand their participation in the infant welfare campaign. Medically designed information on proper childrearing methods was delivered to women through state-sponsored advice literature and well-baby clinics. In some cities, follow-up care was also provided in the form of home visits by public health nurses. Provincial health departments also attempted to target mothers outside the cities by conducting infant welfare conferences at exhibitions and fairs. Educational exhibits were set up demonstrating correct methods of feeding and pointing out

\textsuperscript{49}Comacchio, \textit{Nations Are Built of Babies}, 4, 25, 112.
\textsuperscript{50}Meckel, \textit{Save the Babies}, 119, 124-125.
the common factors leading to infant death.\textsuperscript{51}

As the infant mortality movement gained momentum, a current of doubt began to surface around the time of the First World War, which challenged the sufficiency of a reform program that placed so much emphasis on maternal care. Mounting statistical evidence revealed that a large and increasing percentage of infant deaths occurred during the first two weeks after birth. Since the overwhelming majority of these deaths were attributed to prematurity and congenital debility, they could not be ascribed to improper feeding and care, nor diminished by efforts to reform mothers. Infant welfare activists had been aware for some time of the connection between the health of the mother and the survival of the infant once born. Despite this fact, they chose to concentrate almost exclusively on preventing deaths attributable to postnatal environment and care. The decision was based on the belief that the prevention of such deaths could be more readily achieved. At this time, the causes of neonatal death and the physiology of gestation were still shrouded in medical uncertainty. In addition, eugenicists continued to argue that stillbirths and neonatal deaths were unpreventable and simply nature’s way of weeding out the unfit. Nevertheless, while the prevention of infant death due to gastrointestinal disorders remained central to the movement, after 1914, increasing attention was given to reducing the neonatal death rate as well. Thereafter, the infant mortality campaign became synonymous with the health and well-being of both mother and child.\textsuperscript{52}

While this shift in focus to include maternal health broadened the scope of the infant mortality movement, it did not involve any significant departure in the strategy to combat it. Maternal education was still considered to be the most

\textsuperscript{51}Comacchio, \textit{Nations Are Built of Babies}, 4, 49, 54.
\textsuperscript{52}Meckel, \textit{Save the Babies}, 158-161, 166.
effective approach in preventing infant death whether from prenatal and natal complications or postnatal causes. Therefore, governments and social welfare agencies continued on with the educational program and merely expanded their operations to include prenatal clinics and the promotion of maternal health. The prenatal clinics adopted the same preventive educational and supervisory approach of the well-baby clinics, the only difference being that the information provided was aimed at preventing birth complications among pregnant women.\textsuperscript{53} Thus, in this final stage of the infant mortality campaign, physicians came to view infant mortality and maternal mortality as inseparable, and their solution was to be found in the same objective: maternal education.\textsuperscript{54}

This thesis will begin by attempting to portray what the experience of childbirth was like for Saskatchewan women at this time. This study focuses on the women of the first generation of mass agricultural settlement in western Canada: those women who came with their families from Europe, the United States and Eastern Canada to homestead and begin a new life on the Canadian prairies.\textsuperscript{55} By looking at letters, diaries, oral histories and memoirs of homestead women I will reveal many of the challenges they were forced to overcome in their preparations for childbirth as well as the tragic losses they had to endure. Although infant and maternal mortality was prevalent throughout the region, the focus of this research is primarily on childbirth in rural Saskatchewan, not in the cities and towns.

The initial phase of research involved writing letters to the editors of several small town newspapers in Saskatchewan. I asked them if they would

\textsuperscript{53} Ibid., 168-169.
\textsuperscript{54} Comacchio, \textit{Nations Are Built of Babies}, 88.
\textsuperscript{55} I categorize these women as the “homesteaders”, recognizing of course that indigenous people had lived on the North American prairies for thousands of years before the Europeans arrived.
include in their next issue a letter requesting help from their readership on information pertaining to childbirth experiences during the homestead era.\textsuperscript{56} I was overwhelmed by the response I got in the form of letters, emails and phone calls from as far away as Victoria, British Columbia. The oldest respondent was Beulah Pettyjohn from Eastend, Saskatchewan who had just turned one hundred and three. The majority of people who responded to my request were older women sharing information about their mother’s childbirth experiences. I was granted approval from the Research Ethics Board to include any information I received by this method in the thesis.\textsuperscript{57} Another valuable source of information was the collection of local histories located in the Prairie History Room at the Regina Public Library. The many oral histories and memoirs housed at the Saskatchewan Archives Board also provided me with a wealth of information on the life and day-to-day experiences of homestead women.

The following chapter looks at the response from women’s organizations, both locally and nationally, to the infant and maternal mortality problem. Women were well aware of the high infant and maternal death rate on the prairies in the early twentieth century and did not passively accept the lack of medical services and facilities available to them. Starting in 1914, Violet McNaughton, the President of the Women’s Section of the Saskatchewan Grain Growers Association (SGGA), led a campaign she called “medical aid in reach of all.” It was an all encompassing campaign for midwives, nurses, doctors and hospitals in the rural districts of Saskatchewan. The National Council of Women (NCW), along with its local branches, was also very involved in the infant mortality movement at this time. They were particularly concerned about the lack of

\textsuperscript{56}See Appendix 1 for a copy of the letter as it appeared in the newspapers.
\textsuperscript{57}See Appendix 2 for Approval Form from the Research Ethics Board and Appendix 3 for the Participant Consent Form.
medical care for prairie women and were among the first to try to do something about it. The McNaughton Papers and records of the Regina Council of Women (RCW) were the major sources of information for this chapter.

Chapter four examines how governments responded to the high infant and maternal mortality rates in Saskatchewan during the settlement period on a local, provincial and federal level. It includes an overview of the institutional framework of public health in Canada at the time, and addresses some of the difficulties the new province faced in establishing necessary services. The funds and the trained personnel had to be found and the structures for services had to be developed. This chapter also looks at the types of programs the provincial government adopted to ameliorate the problem. Because Ontario provided national leadership in the health and welfare fields at the time, many of the strategies the Ontario government used to combat infant mortality were implemented here in Saskatchewan, whose population distribution and circumstances differed significantly. However, the Saskatchewan government did pioneer certain programs to fight infant mortality which addressed some of the challenges specific to the rural nature of the province. Government documents were the major source of information for this chapter including annual reports from the Saskatchewan Bureau of Public Health.

Finally, this study evaluates how effective the programs implemented in Saskatchewan were in lowering the infant and maternal mortality rates. It also examines the various factors which might have influenced the government to adopt the programs they did. Critical to the discussion of infant mortality, and the strategies chosen to combat it, was the important effect of inter-professional rivalries. Doctors and nurses consistently blocked plans to train or import midwives to isolated rural areas in Canada even though they were aware of the
lack of services available to these residents. The midwife issue provoked heated debate among health professionals and reform groups dedicated to saving infant lives both in Canada and in the United States. By exploring these issues we gain insight into why the government of Saskatchewan chose the path it did.

I first became interested in this topic after reading Cynthia Comacchio’s book *Nations are Built of Babies* in which she discusses Ontario’s campaign to save mothers and babies in the early twentieth century. Since there had been no comparable study of efforts to reduce infant and maternal mortality in Saskatchewan I decided this would be an interesting subject for investigation, especially given the fact that the two provinces were so different. In the process of describing the various infant and maternal welfare campaigns initiated by the Ontario government, Comacchio argues that “patriarchal ideas and class dynamics shaped medical understanding of the child welfare problem.” She examines how child welfare and family life were increasingly seen as the responsibility of the state in the early twentieth century and how doctors played an integral role in delineating the targets of social reform.\(^5^8\)

Mimi Abramovitz expands on this idea of state involvement in women’s lives in *Regulating the Lives of Women: Social Welfare Policy from Colonial times to the Present*. She argues that as familial patriarchy gave way to social or public patriarchy, the state assumed regulatory functions previously confined to the family. She asserts that this intervention by the state into family life reveals the family’s importance to the survival of capitalism and patriarchy.\(^5^9\) Similarly in her path-breaking analysis of state intervention in social reproduction in Canada, Jane Ursel argues that with the transformation of familial patriarchy to social

\(^{58}\)Ibid., 4-8.

patriarchy came the legal and social reinforcement of women’s role as producer. She claims that the intervention of the state into family life was designed to "save the patriarchal family from the onslaught of industrialism."60

In their essay *Medical Power and Women’s Bodies*, Deborah Findlay and Leslie Miller analyze the rise in power and prestige of the medical perspective in society. They argue that the dominance of medical discourse is related to the professionalization of medical practice.61 Literature on the historical development of the medical profession in Canada includes: Bryan Turner’s *Medical Power and Social Knowledge*; C. David Naylor’s *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance 1911-1966*; and Sharon Baldwin’s M.A. thesis *Self-Interest and the Public Interest: Professional Regulation in Saskatchewan, 1905-1948*, which examines the struggle of the CCF to bring the professions under government control in 1946.62

The literature on the historical development of the nursing profession in Canada has also become quite extensive. Kathryn McPherson’s *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990*, looks at the dynamics of nursing work and organization during the early years of the profession’s existence. By focusing on the experience of nurses this study explores the connections between nursing, scientific medicine and the political economy. The contradictions of professionalism and gender are raised in Suzann Buckley’s essay “Ladies and Midwives?” and Dianne Dodd’s essay

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“Helen MacMurchy: Popular Midwifery and Maternity Services for Canadian Pioneer Women.” Buckley argues that nurses’ aspirations for professional status contributed to the demise of the midwife and threatened maternal and infant safety. Dodd asks the question: did female physicians, subservient to male physicians, desert and denigrate the midwife in order to secure a niche for themselves in the professional world of medicine?63

Much of the scholarly literature on early twentieth century feminism in Canada focuses on the equality-versus-difference dichotomy in which equal rights feminism is contrasted with maternal feminism. Joan Wallach Scott refers to this dichotomy as the “equality-versus-difference formulation in her ground-breaking book Gender and the Politics of History.”64 In her thesis, “Ground for Common Action”: Violet McNaughton’s Agrarian Feminism and the Origins of the Farm Women’s Movement in Canada, Georgina Taylor claims that McNaughton developed a “distinctly agrarian feminist ideology” which focused on farm women and their families.65 Taylor asserts that in addition to maternal feminism and equal rights feminism, McNaughton’s feminism included five additional elements that made it uniquely agrarian.

First, her agrarian feminism promoted the recognition of the partnership between women and men on the family farm rather than defining the production unit as a solitary male farmer. Second, it encouraged farm women to negotiate the conditions of their productive, reproductive and community work in order to improve these conditions. Third, her agrarian feminism aimed at improving conditions in which farm people as a class worked and lived, including the conditions in which farm women gave birth. Fourth,

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her agrarian feminism was based on the idea that the first National Policy had to be radically revamped before farm women, their families and other Canadians could live well. Fifth, her feminism was aimed at improving the poor conditions in which farm women and their families lived by using the principles of agrarian co-operation.

Therefore, according to Taylor, the equality-versus-difference dichotomy is not sufficient to describe McNaughton’s agrarian feminism and its impact on the farm women’s movement.

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66 Ibid, 11-12.
Chapter 2: Giving Birth on the Prairies during the Settlement Era

_The baby born in the West is buried in the West, and this may be the reason why a bit of my heart will always be there in the pioneers’ prairie land._

Mattie Wallace, 1904

Homestead women were essential not only to the success of the individual farm, but also to the expansionist dreams of Canada. Clifford Sifton, the federal Minister of the Interior from 1896 to 1905 and who had been very influential in settling the prairies, clearly articulated the need for women and children as a resource in the agricultural West. Sifton believed that the homesteaders needed sturdy, fertile women who were able to work hard and produce many children to help on the farm.¹ Yet in the federal government’s mad rush to settle the West, little thought had been given to the needs of women and children, and in particular accessibility to medical care to ensure for safe childbirth. If the birth or postpartum period involved any complications, homestead women faced the very real possibility that either they or their babies might not survive. While the possibility of death confronted every pregnant woman at this time, the prairie woman was at particular risk because of the long distances to be travelled on poor trails, and often in severe weather, to obtain whatever help might be available. The lack of trained medical practitioners and alternative birthing facilities such as hospitals or maternity homes also posed a significant problem for expectant mothers. The ways in which homestead women approached the challenge of childbirth, often several times over, demonstrated a remarkable degree of resourcefulness and courage. This chapter begins with some background information on the settlement period in order to provide the socio-

economic context homestead women were dealing with at the time.

When the North West Territories were acquired by the Canadian government under the Dominions Land Act in 1872, it was a wilderness populated by several thousand indigenous peoples and a handful of fur traders. Canada incorporated the vast territory into the rest of the nation by building the Canadian Pacific Railway and in 1872 passed the *Dominion Lands Act* to encourage agricultural settlement. For a ten dollar registration fee, an adult male could acquire 160 acres of farm land. Once on the land, the homesteader had to break the sod, erect a shelter and live on the property for at least six months of each year for three years. If he did this, then the land was his.²

Immigration was haphazard and sporadic for several years following the building of the railway. Huge land grants were given to the CPR and the Hudson’s Bay Company, and private syndicates held the land for speculation. Initially, Canada also had to compete with the United States for prospective immigrants, but once American land ran out, people began to look north to the Canadian prairies. The prospect of 160 acres of free land proved too good to resist and precipitated one of the largest human migrations in history. Tens of thousands of people from the United States, Great Britain, Europe and eastern Canada headed to the Canadian prairies to begin a new life.³

Canadian immigration literature portrayed the prairies as the land of opportunity. As homesteader Mary Row recalled, “At the time the papers were full of glowing accounts of the money to made in Canada.”⁴ Thus, most people who came to the prairies in the early twentieth century thought they had come to make their fortune. With little money and often no farming experience, settlers

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³Ibid. 10, 11.
were in for a rude awakening when they first arrived on the virgin prairie. Carolyn Toth tried to express the disappointment her great grandmother felt when she first saw their homestead:

The thought of one hundred and sixty acres of their own, was almost more than they could fathom, but what they saw when they arrived at their homestead was nothing compared to what they dreamed of. What they saw was a wild prairie covered by stubborn grass and deep-rooted clumps of trees. They soon realized that what little land they had in Hungary could produce many times what they had now. They were heartbroken and homesick. They yearned for their homeland and if they had had the money, they would have returned to Hungary.⁵

Many homesteaders had no time to inspect their land or made poor choices due to their inexperience and believing the government literature that portrayed any parcel of land as suitable for agriculture. Many were forced to apply for land in isolated areas far from a rail link or even a nearby town.⁶ Upon reaching their quarter section for the first time, one woman recounted, “I’ll never forget the desolate feeling that came over me, when, with the contents of the wagon out on the ground, we sat on a box and looked around, not a sign of a human habitation or a road leading to one to be seen, nothing but bluff, water and grass.”⁷

The settlers were also unaware that in many cases they were not the first occupants of the land. Many homesteads had already been abandoned by those who had failed to make a go of it. The basic requirements needed to secure title to their land (erect a shelter, cultivate at least 15 acres, and live on the land for at least six months each year) might not seem that difficult to meet, but many a settler was defeated by them. Hard work did not always guarantee success. Any kind of misfortune could prove disastrous in those early years, especially for

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⁷Robertson, Salt of the Earth, 28.
those with few resources to fall back on. The only assistance a homesteader could expect from Ottawa was help in locating his land and tents for temporary accommodation. As a result, many were broken, driven out by drought, bankruptcy or despair. Two out of every five homestead applications were cancelled on the prairies during the settlement era.\(^8\)

Timing, location, experience and sheer good luck were all factors in determining a homesteader’s success, but perhaps the most important factor of all was whether or not he had the help and companionship of a woman. Thousands of single men came to Saskatchewan in the early twentieth century with the plan of getting established on the homestead before seeking a partner. They soon discovered that it was virtually impossible to work the land, prepare the meals, wash clothes and maintain a household without the benefit of a spouse. Consequently, the bachelor homesteader was perceived as an unreliable settler as most gave up before securing title to the land.\(^9\)

Survival on the homestead usually required women to shoulder a variety of formidable tasks and responsibilities, many of which were not normally expected from women at the time. Traditionally, women had cared for cows and poultry, raised fruit and vegetables and processed foodstuffs. Homestead women did these things too, but also often engaged in heavier farm tasks such as working the fields and operating machinery. Basically they did whatever they had to do to survive. In addition, women were still expected to handle the chores associated with the home which meant they often had double the work load. Hard work followed women indoors as household technology was primitive, requiring ingenuity and a great deal of muscle power.\(^10\) It seemed like a

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\(^8\) Waiser, Saskatchewan: A New History, 105, 113.
\(^9\) Ibid., 105, 108.
woman’s work was never done and images of the overburdened farm woman reoccur in accounts of the early settlement period. Nellie McClung writes:

On the farms, before electricity and labour-saving devices lightened their loads, women’s work obsessed them. Their hours were endless, their duties imperative. Many broke under the strain and died, and their places were filled without undue delay. Some man’s sister or sister-in-law came from Ontario to take the dead woman’s place. Country cemeteries bear grim witness to the high mortality rate in young women.\textsuperscript{11}

Whether their husband acknowledged it or not, their wife’s hard work often spelled the difference between success and failure on the homestead.

Besides the never-ending agricultural and household duties required of Saskatchewan farm women at the time, they were also mothers. So not only did they have to take care of the children in addition to all of their other responsibilities, they were often pregnant while performing these arduous tasks. It was a very tough life indeed, and many were not cut out for this kind of demanding lifestyle, particularly those from Great Britain, who had not been accustomed to such hard physical labour. Some became workaholics unable to rest, others were completely overwhelmed and gave up, turning into slatterns, of little use to themselves or their families.\textsuperscript{12} Many simply went back home not prepared for the enormity of the undertaking. But for all those who left, thousands more stayed and persevered to create a new life on the Canadian Prairie.

In the crucial first years, homesteading was an impoverishing experience for most settlers. Many newcomers came ill prepared for life on the prairie. What they could not do when they arrived, they often had to learn the hard way, by trial and error. It often took several years before they could earn a decent

\textsuperscript{11}Nellie McClung cited in \textit{A Harvest Yet to Reap}, 82.
\textsuperscript{12}Ann Leger Anderson, “Saskatchewan Women: An Historical Inquiry,” SAB.
income from farming. Even those with the necessary experience and knowledge seldom had enough cash to stay afloat until their first profitable harvest. Those who persevered had to learn to live a simpler life, getting by with very little. They kept their purchases to a minimum by producing as much as they could at home. Doris Kewley talks about what it was like first starting out on the homestead:

The first few years we had in the bush, we didn’t have too much to eat. Many times we fed our family and Walter and I ate what was left. Sometimes he would go out and shoot a prairie chicken, partridge or duck, and I would boil it, put vegetables in and make a pot of soup.  

Joseph and Elizabeth Czinkota also endured many hardships when they arrived in the spring of 1895. In the beginning, “their meals often consisted of gopher, rabbit or prairie chicken. Their first home was like a teepee covered with sod strips. Inside, the ground was dug away to make a small hollow in which they slept.”

Homesteaders usually lived in tents until they built a more permanent structure. Often times, the husband would go on ahead and build the house before the rest of the family joined him. The initial home was likely to be wretchedly inadequate, usually a one-room sod shack with earthen floors. Mary Louisa Cummins describes her despair when she first set eyes on her new house:

When we arrived at the homestead, and at the sight of the “home” I had come to I burst into tears. “Am I to live in that?” I cried quite forgetting how hard Colin must have worked to build that little wooden box. It measured only sixteen by sixteen feet with a partition down the middle to separate the kitchen from the bedroom.

In later years she would come to have a sense of humour about that first home, “I

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13Letter to the author from Geraldine Procychyn about her mother Doris Kewley dated 6 November 2010.
15Memoir of Mary Louisa Cummins, “How About It?” Call No.mE2552, Accession No. R87-228, SAB, 31.
fancifully called our first homestead Pixholme after my uncle’s lovely home in England – a study in contrasts.”

The first winter spent on the Canadian prairies came as quite a shock to many of the early homesteaders. “The weather we endured all those fourteen years ranged from aching frost to unendurable heat,” Mary recalled, “I have seen sixty degrees below zero registered on our thermometer outside our door. It cuts one’s breath to take in air at that temperature.” One early settler described Saskatchewan winters as “bitterly cold with blizzards frequent and fierce.”

Angelina Hughan Campbell remembered the blizzards well:

True, there were no ferocious beasts to make the prairie formidable but there was that dreaded danger, the prairie blizzard that came with little warning and had no mercy on man or beast who were dazed and bewildered by its blinding, biting fury. The blizzards took considerable toll of life and ironically enough the victims were often found frozen not too far from the very place they had been seeking – home.

Homesteader Sue Harrigan Axhorn claimed, “Lots of men have been frozen to death just going to the barn from their house when a blizzard was on.”

In fact, the weather was one of the greatest hazards the homesteaders faced. Most of those early sod or log houses could be extremely cold during the winter months. “There were times when the wind roared and howled around the house when a blizzard was raging,” wrote one early settler, “You could feel the icy flakes of snow drifting over the bed.” Ellen Lively remembered, “Winter struck suddenly and fiercely….The house had been built with an air space and tarpaper, but with no insulating material. Consequently the rooms were very cold. Jack built fires in the kitchen and living room and we thawed out in time.”

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16Ibid., 61.
17Ibid., 55-56.
19Manuscript by Angelina Hughan Campbell, Microfilm R-E2469, SAB.
20Manuscript by Sue Harrigan Axhorn, Call No. R-626, Accession No. R-80-253, SAB.
21Mary Morrison cited in Salt of the Earth, 64.
22Ellen Lively cited in Salt of the Earth, 64.
And homesteader James Rugg recalled:

    The stove was all the heating we had in the winter. Very many of the
days and nights it froze in the house in spite of my getting up and putting
wood in the stove many times during the night, the temperature often
going to more than fifty below zero. There were no trees to protect us
from the wind and snow. Owing to the fact of having nothing for plaster
the wind often blew through the cracks of the sod walls.\(^{23}\)

Marion Underwood attributes the death of her aunt and new born baby to a cold
house:

    Dad’s oldest sister suffered an infection along with her last child’s birth.
They both died. It was wintertime and they lived in a log house. Rooms
were made by hanging sheets or blankets. Her mother and dad wouldn’t
let the girls and two small boys return to the home until there were better
conditions.\(^{24}\)

Delwyn Jansen from Leroy, Saskatchewan talks about the losses her
grandmother had to endure:

    My grandparents, upon marriage resided in my grandfather’s two room,
sod roof log house. The fourth child arrived in February, 1913 but died a
few weeks later. Winters for childbirth are more demanding on a
possible survival….It was devastating for Grandmother to lose three
children; most particularly the last two because both were born healthy.
A cold house or a flu epidemic caused their loss.\(^{25}\)

    The early settlers also found very few or none of the twentieth century
amenities and services available to them when they first arrived on the prairies.
Most acutely missed were medical facilities and personnel to assist with medical
emergencies and childbirth. Several factors would make childbirth, in particular,
a serious risk for homestead women. These included the living conditions and
work roles of expectant mothers; isolation; the high cost of doctors’ care; the poor
trails and slow means of transportation; the unpredictable weather; their lack of
knowledge about childbirth; and the absence of friends and relatives nearby to

\(^{23}\)James Rugg cited in Salt of the Earth, 32.
\(^{24}\)Letter to author from Marion Underwood dated 4 October 2010.
\(^{25}\)Letter to author from Delwyn Jansen dated 24 September 2010.
help. These conditions and circumstances converged to make childbirth a frightening and often very dangerous experience for homestead women.

**Childbirth on the Homestead**

The stories of childbirth on the Canadian prairies in the early twentieth century are diverse and reflect differences among women in terms of ethnic background, location, and socioeconomic status. Sometimes all went smoothly; other times they ended tragically. But however the ending, common to all was their resourcefulness in attempting to achieve as safe a birth situation as possible within the restrictions imposed by their individual circumstances. There were basically three strategies used by homestead women to ensure for safe childbirths: having the baby at home without any outside help; having the baby at home but sending for assistance, whatever was available and affordable; or going to a place where help could be obtained.²⁶

Whether alone or attended by husbands, neighbours, midwives, nurses, or doctors, most women gave birth at home during the settlement period. Assistance with childbirth depended on a variety of factors including: distance, availability, cost, weather, and the particular circumstances of the birth itself. In the early years of immigration, home births were most common if the homestead was far from a town or if the family was from a non-English speaking country. However, even when distances could be overcome and medical assistance obtained, the course childbirth might take was unpredictable. It was the combination of this unpredictability and the isolation of individual homesteads that increased the risks for expectant mothers.

The federal government’s *Dominion Lands Act* was designed to satisfy several purposes, however, the setting aside of railway reserves in every

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township served to disperse homesteads, thereby increasing the isolation of the early settlers. Isolation was probably the most devastating part of a homestead woman’s life. Although some immigrants came to Canada in cultural groups, most homesteads were established by individual families. Therefore each homestead was miles away from the nearest neighbour and often a day’s journey from the nearest town. As a result, many women found homestead life to be terribly lonely. The lack of female contact and companionship weighed heavily upon them. Typically, men were much more mobile. They often left the farm on business or to get supplies. They might even be gone for several months with seasonal employment, leaving the women to manage the farm alone. Angelina Hughan Campbell believes homestead women displayed exceptional emotional control and stability under the circumstances: “They had to endure loneliness and great deprivation at times. They were often alone for days, often with small children to care for and with some outside chores to do while their men folk made long hazardous trips with oxen for supplies.”

Some women found the isolation to be too much. In her book A Woman in Canada, Marion Cran relates one lonely woman’s experience:

One I can never forget, the story of a woman whose first two years on a lonely farm were childless and whose reason began to totter under the stress of loneliness until she found she was to have a baby. The prospect of such an interest changed her life, she was engrossed with hope; it was not possible to obtain a nurse and difficult to get a doctor to the distant homestead, so she and her husband made arrangements for her to go to the nearest hospital forty miles away. She drove over the rough road and the baby was born prematurely and died. I pictured her return to loneliness.

Because doctors initially went to areas with a significant population, medical care

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28 Angelina Hughan Campbell cited in Journey to Yesteryear – Reminiscences of Bateman District Pioneers 1907-1967, Microfilm R-2469, SAB.
29 Marion Cran, A Woman in Canada (J.B. Lippincott Company, 1910), 249-250.
was hard to come by. In the early settlement years doctors and hospitals were few and far between. There were only twenty hospitals and a few dozen nurses and physicians on the prairies in 1900.\textsuperscript{30} The idea of living beyond medical help was terrifying to many homestead women. As one expectant mother recalled, “Never until my dying day shall I forget the agony of knowing that if anything went wrong I hadn’t a chance.”\textsuperscript{31}

Most women were unaware of the conditions on the prairies until they arrived, their commitment to building a new life already decided. Marion Cran was hired by the federal government in 1908 to tour the Canadian west and promote it to prospective English women immigrants. She reported:

At last I found what I felt all along must exist; a hardship to be faced which make women justly shrink from the country. First from one prairie, and then from another, I heard a cry about the hardships of birth on the homesteads….I heard many stories of courage, stories of disaster….Within driving distance of a city a woman near her confinement may consider herself more or less safe. But the wives on ranches and farms at any distance, and there are hundreds of them, must spend hideous hours looking forward to the day of trial with every prospect of scrambling through alone, at the risk of the baby’s life as well as their own.\textsuperscript{32}

She felt the situation was serious enough to deter women from migrating to the prairies.

Monica Hopkins reveals her fears about childbirth as she describes the situation she and her neighbours found themselves in:

I had heard so many appalling stories of abnormal births since I came out here that I have made up my mind to spend the nine months in a hospital to be on the safe side! Mrs. B. has just had her second baby under the most unpleasant circumstances to my mind, though they may

\textsuperscript{32}Cran, A Woman in Canada, 249,251.
Others felt they had to measure up to the standards of courage and resourcefulness they saw in other prairie women. Kathleen Strange wrote in 1919:

When I observed with what serene confidence and lack of excitement the country mothers faced it, many of them giving birth to their babies without either doctor or nurse’s care, I realized that whatever my personal fears and qualms might be, I must try to face it in the same courageous and confident fashion if I was ever to hold my end up with them.34

Ignorance about pregnancy and childbirth was another significant problem for homestead women. Expectant mothers often had to make do without the support and advice of other women and first-time mothers were particularly vulnerable. On expecting her first child, homesteader Edith Lazonby writes:

Early in the next spring I was expecting a child. Often I would run and bury myself in the deep prairie grass and weep for my mother. How were babies born, anyway? The present-day girl with her comprehensive knowledge of life was a far cry from my girlhood, where we were literally sheltered from that type of knowledge.35

Some indicated a cultural taboo about discussing such things, even with one’s own mother. Elaine Schrader from Weyburn claimed: “It was a subject that elders didn’t talk about in front of children, which is bizarre because at sixteen those same girls were often married and pregnant.”36 Consequently, knowledge and experience was often not passed down to younger generations. Kathryn Strange reflected with regret on her lack of knowledge of childbirth:

Despite the fact that I had always regarded myself as a very modern young woman, and had known about most of the “facts of life” long before I was married, I actually knew little or nothing about the physical phenomena of human pregnancy and birth. I had no intimate friends at

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34Kathleen Strange, With the West in Her Eyes (New York: Dodge Publishing Company), 164.
35Edith Lazonby quoted in: Robertson, Salt of the Earth, 56.
that time from whom to seek advice or sympathy, so that, as the time passed and my, condition became physically apparent, I began to feel very bewildered, and sometimes terribly frightened, at the prospect of what was going to happen to me.\textsuperscript{37}

In addition, the inaccessibility to medical personnel and the lack of reading materials available on the subject made self-education very difficult. Marion Cran, who was also a trained maternity nurse, recalled a case in which a couple’s ignorance about childbirth put both mother and child at risk:

A lonely young couple found themselves suddenly ushered into parenthood, the nearest doctor was twenty miles away and they had not been able to get a nurse for love nor money. They were entirely ignorant of obstetric work, the baby was blue and they were frightened. There upon, with the placenta unborn, it was put in a hot bath; visions of inverted uterus rise, and appall the initiated. Countless unrecorded cases as terrible must occur.\textsuperscript{38}

Where, and with what kind of help one would give birth was determined more by the reality of the birth process than by advance planning. Aquina Anderson writes about the unpredictability of childbirth:

In 1927, in the spring was a continual rain. The tractors would bog down either on the prairies or main roads. These were the conditions when I went to the Red Cross hospital, where I expected Jimmy to be born. After staying two weeks I went home for a few days; and then it started a down-pour. This was the night Jimmy arrived without the aid of a nurse. However, a neighbour woman came and looked after me, and we got along just wonderfully.\textsuperscript{39}

Evelyn Springett had planned on her sister assisting her with the birth of her first child but found herself alone on the homestead when she went into labour prematurely:

My baby was not supposed to be born before the end of September, and I persuaded my sister to leave me for a ten day visit with the Cochranes about sixty miles south-west of us. All of these well-laid plans, however, were upset by the little one electing to arrive five weeks before she was expected. Neither doctor, nurse or sister was within reach, and having a

\textsuperscript{37} Strange, \textit{With the West in her Eyes}, 164.  
\textsuperscript{38} Cran, \textit{A Woman in Canada}, 250.  
\textsuperscript{39} Memoirs of Aquina Anderson, “Rock Creek Ramblings,” Collection No. R-E3249, SAB.
baby under these circumstances is by no means a pleasant experience. During one long horrible night I suffered in silence, thinking in my ignorance that it was a false alarm, but at about five in the morning I could bear it no longer, and one of the cowboys went galloping off to the station, sixteen miles away, to fetch the station agent’s wife, a good soul who had some experience in a slum district in England. Though she was vastly better than no one at all, I shall never forget those awful hours before the doctor arrived. The heat was terrific and I was devoured by flies. When at long last the child was born, I burst into tears at the site of her.

Until the population grew more concentrated, homestead women were primarily assisted in childbirth by family members and neighbour women. Even if the family could afford to pay a doctor, they often were unable to obtain professional help due to their geographic isolation. Out of necessity, husbands and prairie farm women were forced into the role of untrained midwife. Many times, only the husband was there to assist when the baby was ready to come. As one homesteader tells it:

I delivered the baby myself. We was out on the homestead far from everybody and my wife was pregnant. We was having our third child and we’d been to town and seen the doctor and he said it would be about so-and-so. Well, it wasn’t about so-and-so and it came along one night and my wife said, “We’re going to have the baby.” I delivered the baby myself. I didn’t know the first thing about what to do but she helped me.

Edith Lazonby describes the time her husband Duke delivered her baby:

The nearest doctor lived in Humboldt, fifty miles away...One night I awoke in an agony of pain. Arousing Duke, he lit the lamps and put on a huge tub of water to heat. I remember Duke, seen through the haze of the lamp light with sleeves rolled up and perspiration rolling down his face, walking between the book Advice to a Wife which was propped up on the table as he followed the processes of birth in the book, and actually delivered the child, a perfect boy. Duke wrapped up the child and layed it beside me. He knelt down beside the bed and put both hands around my face as gently as a woman, saying, “Christy, I don’t have to tell you to be brave, for there is no one like you in the world, but

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I'll have to leave you to get someone to go for the doctor, for the rest is a doctor's work, though I'll have to take the risk if I can't get him.” I heard later that when he reached the neighbour's threshold, he fell across in a dead faint. He came back to me and waited patiently for the doctor. As the hours passed Duke came to me and said, “Christy, I'm afraid I'll have to take a chance and remove…” Before he finished speaking we heard the faint tinkle of sleigh bells and soon the doctor entered. Duke showed the strain as he almost sobbed, “Thank God, Doctor, you arrived in time.” The doctor congratulated Duke on his skill. The memory of that night has never been erased from my mind. I know the meaning of the word 'man.'

Some women viewed childbirth as a natural process and were quite cavalier about the prospect of having their babies at home without medical assistance. As one farm woman described it, “I stay right here and when my time comes, I call Bill in from the field and he delivers them.” Others required no assistance at all. Beatrice Vincent never sought medical aid with childbirth:

I had all twelve of them without any doctor or woman...And the last baby that was born, I stood up and caught him in my arms laid him on the bed and reached over and got the scissors and separated the cord. Then I got a bowl of warm water and washed him and fixed up myself.

Some families had cultural, rather than practical reasons for not calling on doctors to assist during childbirth. Certain groups, such as Doukhobors, Mennonites, and Ukrainians, congregated in group settlements. They settled the land as a cooperative enterprise with assistance from their extended families, friends and the wider community and were often more successful than those who went at it alone. Being surrounded by familiar customs and language served to lessen any feelings of dislocation; however, it also intensified the immigrants' sense of separateness from the larger society.

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assimilating into the dominant Anglo-Saxon culture. For example, for women from some eastern European countries, the presence of a man, other than the husband, to attend a birth was strictly forbidden. In 1917 the federal government investigated rural Ukrainian communities on the prairies and discovered that only one woman in 85 had had either a doctor, or midwife, assist them in childbirth.\textsuperscript{46} Irene Parlby, President of the United Farm Women of Alberta, discussed the issue in a letter she wrote to Violet McNaugton in 1916: “One thing we are up against are the men and their wives who refuse to have any medical or nursing aid at childbirth. I know of many instances where the wife has never had anyone but her husband and they don’t seem to want anyone else.”\textsuperscript{47}

For most women, however, it was circumstances, not culture, which conspired to leave them alone during childbirth. When the time had come to have the baby, it was not uncommon for women to be alone, without anyone to assist or comfort them. This occurred because husbands were away, or had left to get help and did not return in time for the birth. Many times the weather was a factor. Wendy Mitchinson relates one tragic case which occurred in Saskatchewan in 1918. When a man’s wife went into labour, he set out to get a doctor. He travelled for hours on a blustery day, only to find the doctor busy elsewhere when he arrived. By the time the doctor was ready to leave the weather had worsened. When they finally arrived back at the house the next morning his wife had passed away.\textsuperscript{48} Sadly, this kind of thing happened all too often during the settlement period.

\textsuperscript{46}Frances Swyripa, \textit{Ukrainian-Canadian Women and Ethnic Identity, 1891-1991} (Toronto: University of Toronto Press, 1993), 30, 32.
\textsuperscript{47}Letter to Violet McNaughton from Irene Parlby dated 14 March 1916. McNaughton Papers, Accession No. A1, SAB.
A Time of Sisterhood

Most Saskatchewan women, however, could depend on the help and support of a neighbour lady or midwife when giving birth. Childbirth was a time of sisterhood during the settlement period, so when there was no other help to be had, homestead women responded to each other's needs, often with fear and apprehension, but they always responded. It was a tremendous responsibility to be burdened with, especially since many of them were young women with no previous experience or training in childbirth. Doris Kewley from Porcupine Plain recounts when her second daughter was born: “Jean was born before the doctor arrived. Walter had got a neighbour lady to stay with me, but when the baby was born, she just wouldn't touch her, but at least she kept the fire going until Walter arrived with the doctor.”

Co-operation was a critical feature of homestead life. Because it often took several hours to get to a doctor, many tragic losses occurred on the prairies during the settlement period. Neighbours had to stick together and help each other out if they were going to survive. In most communities there were women who became midwives out of necessity. Harriet Neville was forced into this uneasy role because there was simply nobody else to call upon. It was a responsibility she felt she could not ignore:

I tried recently to count the number of births at which I was the only assistant. I was never thought very strong but for years I never went to bed without leaving my clothes ready to slip on at a moment's notice and a candle ready for my husband to light and go to when a call came.

She recalled one tragic family she helped repeatedly attending six births and five deaths at which they had no other person to help. One morning, bright and early,

50Letter to the author from Geraldine Procychyn about her mother Doris Kewley, dated 6 November 2010.
the father came by:

He was highly indignant because I had not sent one of the girls over to
tell him her father was sick and said he owed us for many turns of help. I
do not think I ever stood a scolding so well as when he told me what he
thought of me for not letting him know our situation.\textsuperscript{52}

His own death was the last time she attended to the family. Sadly, he left three
small children without a mother who died after the birth of the youngest.\textsuperscript{53}

The term midwife had different meanings for different people. According
to Wendy Mitchinson, there exists no accepted definition of what a midwife was
during this period. A woman like Harriet Neville, with no previous experience,
who helped out neighbour women in their time of need, would acquire the title of
midwife. A woman who apprenticed with a midwife and went on to deliver babies
on a regular basis was a midwife. Retired nurses who served their community
were considered midwives and, of course, women with formal training in
midwifery were midwives.\textsuperscript{54} On the prairies, during the settlement period, most of
the midwives were like Harriet, women in the community who just sort of fell into
the role. Jane Blake from the Duval area was one such midwife:

I was the only woman here for a short time, however I soon had
neighbours. In 1906 a Scotch lady, Mrs. Weatherspoon, was expecting
a baby. As there was no one to attend to her, I took on the job. It was
my first experience, which I shall never forget. At the first sign of pain
the lady’s husband went into the barn with a book and her sister rushed
into a bluff. I never prayed so hard to the good Lord that I was doing the
right things. Both mother and son survived. I attended most of the
women around on such occasions, becoming a midwife. I attended 81 in
all, none of them died.\textsuperscript{55}

Typically, midwives would comfort the women in labour, help with the
delivery of the baby, cut the umbilical cord, dispose of the afterbirth, and wash

\textsuperscript{52}Ibid.
\textsuperscript{53}Ibid.
\textsuperscript{54}Mitchinson, Giving Birth in Canada, 71.
\textsuperscript{55}Jane Blake cited in Between Long Lake and Last Mountain: Bulyea, Duval and Strasbourg
Vol. 1, 1982, 141.
both mother and child before putting clean clothes on them. The postnatal period was the time when midwives were particularly helpful, giving the mother time to rest before getting back to work. They often stayed for several days after the birth cooking, cleaning, washing clothes and caring for the other children. If the baby was premature she might stay longer until she could be sure that both mother and child could manage. They would usually provide these services free of charge, however, most people felt obligated to give them something for their help, if not money then livestock or fresh produce.56 In the Foam Lake area Mrs. Lena Shychoski performed the midwife duties:

She went out, rain or shine, frost or warm weather; if she was needed, she was there. She holds a record of not losing a baby or a mother in all of the 200 cases that she attended to. She never charged the people for her work but did receive some money as it was a custom to throw silver into the water in which the baby was bathed.57

At the time, experience and reputation were usually the main criteria to be a midwife. Kay Martin recalled how her mother became midwife for their community even though she had no formal training:

After mother became known and because, I suppose, she had a fair sized family, because she had no training in nursing, she certainly did a great deal of nursing in the community. In fact, it was a bit of a joke on us. As youngsters we would wake up in the morning and find mother had gone on an errand of mercy. I don't know how many babies in that area really were ushered into the world with mother helping....I don't think she ever turned anybody down. She would say, "Well the poor things, they had no one to help them"....In those days some childbirths were grim but I know there would have been many more disastrous endings without someone like my mother."58

Although many of these women lacked the formal training in midwifery,

57 They Came From Many Lands: A History of Foam Lake and Area (The Foam Lake Historical Society, 1985), 54.
they became quite skilled at delivering babies, often working in primitive conditions. Over time, they would establish an aura of expertise in their community, almost like that of a physician, and would often be consulted on a wide variety of health issues. According to Walter Jacobson Lindal, all the Icelandic midwives deserve special mention but one of them, Gudrun Goodman, stands out as the “finest example of courage and initiative in an emergency.” He tells the story of one expectant mother:

A young woman was with child, expecting in about a week. She was pumping water for a team of oxen who were drinking out of a low trough. Both the oxen had long sharp horns. One of them suddenly raised its head and one of the horns caught the woman in the side and ripped it open. Gudrun Goodman was immediately summoned. She saw that she could not save the woman but was determined to save the child. She administered an anesthetic, chloroform, operated and got the child while still alive. She brought it up, Guobjorg Eyjolkfson, who later became Mrs. Thomas Halldorson of Leslie, Saskatchewan.

During the settlement period, transportation was difficult at best on the prairies, and in winter could be almost impossible. The local midwives would travel by horse and buggy, wagon or sleigh in all kinds of weather and roads, day or night, to get to the women in need. Jane Irwin served as midwife to most of the children in the Lansdowne district. Her granddaughter Mary Carson relates one harrowing experience often told about her grandmother:

One of the neighbours, Bill Toppings came to get her as his wife was expecting another child. He had two oxen hitched to a stone-boat for conveyance. A stone-boat is a flat surface railed to two wooden runners. Its main use was for piling manure when the barn was being cleaned. As there are no sides to hold on to for support, Billy decided that in order not to lose Jane in a snow bank he would tie her on with some ropes. On the way to the Toppings they stopped at a neighbour’s. Billy ran in to leave a message leaving Jane tied to the stone-boat. The family dog came out barking and scared the oxen who then threw up their tails and took off in full flight. I never heard how Grandmother was rescued but I

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59 Mitchinson, Giving Birth in Canada, 168.
60 Walter Jacobson Lindal quoted in A Harvest Yet to Reap, 76.
believe she made it in time to help bring another little Toppings into the world.\textsuperscript{61}

Many of the local midwives on the prairies were also trained nurses. They often felt an obligation to provide essential medical services where none had been organized. Mina Bergh immigrated to the Northern Light district of Saskatchewan as a young girl with her family. As new immigrants, the experience her family had with the health care system was less than ideal. She became a nurse to ensure that her family, friends and neighbours would always have assistance in emergency situations. In 1931 she married and moved to Chelan. Despite a very busy household, she felt she had a responsibility to serve her community in whatever way she could by utilizing her nursing skills. Mina continued her nursing career working out of her home. Her most common type of nursing was maternity. For several years she operated a small hospital, of sorts, on their farm to which she admitted local women about to give birth. She would deliver the babies and then care for the mother and child for approximately ten days after the birth. Sometimes expectant mothers would come and stay at Mrs. Bergh’s for days, or even weeks before the expected date, because of the weather or health concerns of the patient. She accepted gifts of meat, grain and fresh produce for her services.\textsuperscript{62}

Lena Kernan Bacon, also a trained nurse, always responded to a request for help. She wrote in her memoirs:

In my three and one half years on the prairie I cared for thirty-four obstetrical cases without the aid of a doctor, as we were thirty miles from Davidson and that was too far to go by horse and buggy. One baby born near Girvin, died in spite of a doctor in attendance. Here I was, nurse and undertaker, and even lined a homemade casket with white silk and

\textsuperscript{61}Mary Carson, “Memories of my Grandmother,” sent to author 4 December 2010.

\textsuperscript{62}Celeste D. Rider ed., \textit{Women Pioneers of Saskatchewan} (Regina: Saskatchewan Genealogical Society, 2009), 48-49.
artificial flowers. The mother asked me to hold a bedside service.\textsuperscript{63}

When people heard about Lena’s experiences they often encouraged her to move back to the United States where nursing was so much easier, but she believed that Saskatchewan was “just the place a real nurse was needed.”\textsuperscript{64} In addition to her maternity care she held informal nursing classes in her home for women in the community. She provided education on pregnancy, childbirth and how to care for the baby. Initially, she refused to take any pay for her maternity services. She claimed: “The pioneers could not afford to pay, and help could not be procured.”\textsuperscript{65} However, after her husband died, and because she had a young daughter to support, Lena started charging three dollars for maternity cases. Those who could not afford to pay in cash usually paid in kind with chickens, butter, eggs or fresh produce. She actually could have been prosecuted, for at that time, according to an 1885 ordinance of the North West Territories still in effect after Saskatchewan became a province, only doctors were legally entitled to charge for maternity cases.\textsuperscript{66}

As doctors became more plentiful in the province, they would often call upon the local midwives and nurses to assist them. Physicians in other parts of the country, particularly large cities, usually objected to anyone other than a doctor delivering babies.\textsuperscript{67} Prairie doctors, however, recognized the shortage of medical help available to women and some even provided on-the-job training to those who continued to practice as midwives. They understood that someone with a little training and experience was better than a neighbour woman with

\textsuperscript{63}Memoirs of Lena Kernan Bacon, “Four Years in Saskatchewan from June 1904 to July 1908,” 7. Call No. R-E30, Accession No. R77-54, SAB.
\textsuperscript{64}Ibid., 8.
\textsuperscript{65}Ibid., 9.
Lola Boyd was a nurse in Saskatchewan during the homestead period. She writes:

During my nursing career, I brought a number of children into the world unassisted by a doctor, not because I wanted to, but because I was caught. Dr. Belcourt had told me that would happen, and he instructed me what to do and gave me medical books to read, etc., and I’m proud to say I never in my nursing career, had a case of infection in childbirth or operation.69

There might be several midwives in a doctor’s territory, and each would help in her own district. The people in the Strasbourg area were fortunate to have the services of Mary Pirie and her nursing home for forty years. “After helping to deliver a baby in an emergency in 1911, she was started on her career. She was chief helper to a succession of doctors in the district and helped at many kitchen table operations.”70

Kay Martin was a nurse before she married and moved to Ogema with her husband. Even though she was officially retired from nursing, she claimed she never worked harder in her life. The first six years she was there, the town was without a doctor, and she recalls “I got calls for everything and never turned anyone down…I felt it was my duty.”71 She recalled one day:

I was terrified going to a maternity case at Aylesbury. A Dr. Gibson called and asked me if I would go with him because this particular woman had had trouble delivering babies. She didn’t have a living child. I got into this little country house, there wasn’t a thing to work with, not anything. And I stayed and the baby was delivered and lived. Then Dr. Gibson didn’t want me to go, he wanted me to stay with her. I stayed there thinking if they could just see me now at Vancouver General…even the idea of using anything other than pure white sheets.72

According to homesteader Aquina Anderson those early nurses could not be

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68 Ibid., 288.
70 Between Long Lake and Last Mountain: Bulyea, Duval and Strasbourg, Volume 1, 141.
71 Oral History of Kay Martin, Call No. R-A395, R-A396, SAB.
72 Ibid.
over-praised: “Having families of their own, yet they often took hazardous chances on call to go and care for the sick.” Aquina remembered nurse Disney being there when she needed her:

About 11 pm one night I knew I had to have a nurse (Mrs. Disney), but then the snow was three to four feet on the level, no trail broken and it was an extremely cold night. There was the danger of a person getting lost on the prairie. There were no settlers between our place and Disney’s – a distance of seven miles. After spending most of the night in anxiety wondering what to do, I went down to the bunk house and asked Gene (a ranch hand) to hitch up a team and go for Mrs. Disney. By 4:30 am he was on his way, and by 9 am they were home. Margie was born at 10 am. This is an example of pioneer nurses in action!”

Margaret Douglas came west from Ontario in 1914 with her children to join her husband on their homestead, ten miles south of Lafleche. One night she went to assist a neighbour lady with the birth of a baby boy. Word soon spread, “there’s a nurse in the Wood River Community, and booking commenced. In 1916, a baby procession started and Mrs. Douglas was in constant demand until 1924.” She often said she was so proud and thankful to be there for her community in those early homestead years. That kind of neighborliness seemed to be what living on the prairies was all about.

Many homestead women preferred local midwives to doctors, even if one was available in the area. Because she was a woman, and most likely shared her class and ethnic background, there was often a bond between them that perhaps would not have existed with a physician. Also, doctors tended to arrive long after labour had started and left soon after the baby was born. Midwives, on the other hand, were usually there to support the mother throughout the labour and would stay several days afterward to help out around the house.

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73 Aquina Anderson, “Rock Creek Ramblings,” 27., SAB.
74 Golden Memories of the Wood River Pioneers, 31.
75 Ibid.
76 Mitchinson, Giving Birth in Canada, 168.
pioneer women would trust the experience and wisdom of a midwife over the education of a doctor any day. Elizabeth Akitt was one such lady:

I had a doctor, and I had a nurse. She was a nurse who had come from the old country where she’d been trained in nursing and midwifery. If I hadn’t had her when my youngest son was born I would have been dead. We had a doctor who wouldn’t take any notice of what she said, even though she’d had good training in the old country….She saved my life, because the doctor told my husband he couldn’t save me. I was really sick but she did the trick, she knew what to do. She said she told him two hours before my baby was born that she could do it if he let her. And he did let her. He said, “You take the consequences.”

The midwives and nurses who volunteered their services during the settlement period provided invaluable medical advice and assistance when there was no other health care to be had. They gave freely of their time, helping anyone who asked, regardless of their economic circumstances or ethnic background. They tirelessly served as nurses, midwives and housekeepers and then had to work twice as hard when they returned home to catch up on their own neglected housework. In addition, they sometimes had to perform the necessary, but heartbreaking task of laying out corpses, very often their dear friends. Angelina Hughan Campbell had nothing but praise for those early midwives in the homestead period, “Many of them had the hands of a nurse, the heart of a saint, and some of the practical knowledge of a doctor. They were truly amazing ladies!”

**Prairie Doctors**

There were very few doctors in Saskatchewan during the settlement years, particularly in the rural areas. It was hard to make a living as a physician on the prairies because homesteaders had very little money to pay for medical services. Many of the local doctors actually had to farm to supplement their

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77 Elizabeth Akitt quoted in *A Harvest Yet to Reap*, 78.

78 Angelina Hughan Campbell cited in “Journey to Yesteryear,” SAB.
income. Consequently there was a high turnover of doctors and recent graduates were not standing in line to move to the harsh Saskatchewan climate to start their careers.  Of course, there were other drawbacks to being a doctor on the prairies. Because there were very few hospitals in the province, they were usually required to make house calls. This meant spending a great deal of time travelling on poor trails, often in severe weather, to get to the patient. At this time, many doctors who had recently graduated from medical school had little or no practical experience with childbirth, and certainly not in home births, with no facilities available to them. They had been trained in the sterile environment of a hospital but were forced to work in the unsanitary conditions of the pioneer home. The general lack of electricity, running water, and even adequate space made their job that much more challenging. This was not exactly what they were expecting a doctor’s life to be and, as a result, many did not stay long in Saskatchewan.

However, there were some wonderful prairie doctors who persevered in the difficult conditions of the early settlement period and served rural Saskatchewan communities for their entire career. Lucy Johnson remembered one doctor who responded in her time of need:

I would like, here, to pay a tribute to this fine pioneer medical man, for braving the bitterly cold blizzard of that February of 1906, when he and the hired man risked their lives through getting lost to obey the summons. They had to keep getting out of the sleigh with lighted lanterns to find out if they were on the trail or not. Many times they wondered off and got lost. They encountered a terrific storm and the weather was well below zero. Many time during this trip they had to give the horses free rein. Sometimes horses can sense the trail better than human beings when it is covered with drifted snow. It took the hired man two or three days to return with the doctor.

80 Mitchinson, Giving Birth in Canada, 173.
81 Memoir of Lucy L. Johnson, “Against the Wind: A Story of Forty Years Pioneering in Western Canada,” R-E2878, SAB.
The long distance from medical care was a serious problem for most rural families, particularly in the very early years of settlement. Because there were no telephones, someone had to go to the doctor’s home to let him know he was needed. Alice Self went into labour with her first child on Christmas Eve, 1912. Her husband and the hired man took turns driving to town to get the doctor, four trips of twenty-eight miles each, there and back.82 Due to the distances to be travelled, quite often the doctor did not arrive in time. Mary Cummins recalls giving birth to two children on the prairies in the 1890’s:

When Tom was to be born Colin sent a man off to Boadview for the doctor but he fell foul of the drink. He and the doctor slept on the prairie arriving at the house when Tom was already twelve hours old….When Marjorie was born in March 1889, I broke down completely and nearly died before the doctor could get to me.”83

Women also resented when a physician arrived after the birth but still charged for his time. Beatrice Vincent had twelve children but only called on a doctor to assist with the first one:

I’d never had a doctor ever since I’d come from England to Canada and then it wasn’t because I wanted to, but because they told me I should….So we sent for one and they was three hours late and I had everything done, had the baby dressed and myself washed and the afterbirth taken out and put into the heater. And then he came and felt my pulse and said, “Well you’re just as nature led you. That’s forty- five dollars please.” So after that when I was in a family way I never sought for any doctor.84

Sometimes the doctor did not arrive at all due to poor weather or road conditions. One early settler describes the situation many pioneer women found themselves in:

There was no telephone to get in touch with the doctor. The only thing you could do was to send somebody on horseback to get the doctor.

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82Alice Self, Oral History, 1973, Saskatchewan Archives Board.
83Memoir of Mary Cummins, “How About It? The Story of a Woman’s Life,” Accession No. R-E2552, 17, SAB.
841975 interview with Beatrice Vincent, cited in A Harvest Yet to Reap, 68.
But, of course the roads were bad, he probably never got there. He’d start but he wouldn’t get there, so she’d have to gather up her courage and do what she never did before.\textsuperscript{85}

Most pioneer doctors, however, did whatever was necessary to reach their patients. They often had to travel for hours in extremely cold weather or blizzards to get to expectant mothers. “In the wintertime, fur coats and caps were worn by the men and a big buffalo robe covered their legs”, recalled Ruth Jeeves, “Foot warmers with heated bricks in them kept their feet warm.”\textsuperscript{86} Another homesteader remembered, “They used to have relay stations set up all down the line. There would be fresh horses ready to go, waiting at each station. When Yorkton was reached, the doctor went back along the same route, changing horses at each station until he reached his destination.”\textsuperscript{87}

Later on, cars became more prevalent on the prairies, and many doctors chose this mode of transportation. However, due to poor road conditions or geography, they often did not make it to their final destination. Geraldine Procychyn tells of how the doctor tried to get to her mother but could not make it over the stumps in the road. Her mother ended up walking two miles, in labour, to the doctor’s car. He then took her to the Red Cross outpost where she had a healthy baby boy. Marion Underwood recalled how their local doctor sometimes had calls from people on the other side of the Saskatchewan River, “In favorable seasons it could be crossed on ice or by ferry. Other times it could be crossed in a basket suspended by cables pulled along by the occupant. His vehicle was left on one shore and he was picked up on the other side and driven to needed home.”\textsuperscript{88}

Saskatchewan certainly was not the easiest place to practice medicine in

\textsuperscript{85}1974 interview with Mrs. Rogers, cited in \textit{A Harvest Yet to Reap}, 68.
\textsuperscript{86}Letter sent to author from Ruth Jeeves, dated 23 September 2010.
\textsuperscript{87}Mrs. Donald quoted in \textit{They Came From Many Lands: A History of Foam Lake and Area}, 53.
\textsuperscript{88}Letter to author from Marion Underwood, dated 4 October 2010.
the early twentieth century, however, there was probably no place in Canada where medical care was more urgently needed. The country doctor was usually located in a small town at the centre of a widely scattered farming community. They frequently had to travel in conditions that would test their courage and powers of endurance. They were also forced to work in the primitive and unsanitary conditions of the pioneer homes. It took a special kind of doctor to practice on the prairies during the homestead period.

**Leaving the Homestead to Give Birth**

In the late 1920s and 1930s, many women travelled to hospitals or private maternity homes in towns or cities to have their babies. The journey was rough and uncomfortable at best, with women often exposed to the elements for several hours. Kathleen Strange will never forget the time she was trying to get to the hospital in a torrential rainstorm, while in the advanced stages of labour:

Oh, the memory of that awful drive…It haunts me yet. The roads fulfilled my worst expectations. The car slithered from side to side in the mud and three times went clear over the bank into the ditch. Fortunately we did not turn over and each time, by dint, of hard exertion in which I was forced to join, we were able to get back on the road again. The rain came down in sheets and completely obscured the trail. The windshield wiper refused to work and my husband had to stand on the running board, most of the time, and wipe it with his pocket handkerchief. Then the headlights went out, so we had to drive the last five miles in pitch darkness. Meanwhile in the back seat, I was doing my best to be brave. The rain poured in on me through the tattered side curtains of the shabby old car….Finally we pulled up to the hospital. I staggered up the steps and into the hall but my baby refused to wait any longer. As I mounted the stairs assisted by two kindly women, it made its final and complete appearance. By this time, however, I was lost to all consideration of what was happening. That drive of twenty miles had taken us four hours and twenty minutes.89

Obviously this type of last minute travel was dangerous to both mother and child, and quite often the expectant mother did not make it to the hospital in time for the

89Strange, *With the West in Her Eyes*, 259-261.
birth. Sometimes the baby was born in the wagon, sleigh or car on the way to the hospital. Other times the husband would stop at a nearby farm house and his wife would have the baby there.

As an alternative to last minute travel, some women moved to the home of a friend or family member weeks ahead of time to await the birth. Some of those who had come from the United States, Great Britain, or eastern Canada might even travel back to their home country to have their baby. Of course, many homesteaders could not afford this option. Conversely, a woman’s mother or sister might come to her to assist with the delivery. In 1913, Otilia Delainey from the Meadow Lake area decided to go to her mother’s home in Cavel, Saskatchewan to prepare for the birth of her child. She and her husband set out in horse and buggy, but on the way she began to hemorrhage. They were in the middle of nowhere but eventually her husband found a deserted cabin where he left Otilia to go get some help. Unfortunately, she had died by the time he returned.90

In later homestead years, the private maternity home became an increasingly prevalent option for Saskatchewan women. Maternity homes had existed in eastern Canada for several decades before they were established in Saskatchewan. According to Leslie Halladay, two conditions allowed for the appearance of private maternity homes in the prairie region. First, a number of women who came to Saskatchewan from central Canada were familiar with the operation of maternity homes in Ontario and Quebec. While homes in the West were modified somewhat, they were based on the example of those in central Canada. Secondly, the lack of action by the provincial government created a gap in maternity services that western private entrepreneurs were quick to fill. As a

90Telephone interview with Connie Leask (granddaughter of Otilia Delainey), 30 November 2010.
result, private maternity homes, specific to the needs of prairie women, began to appear around the 1930s.91

So Many Babies!

During the homestead period childbirth was regarded as just part of the day’s work, and for many, no exceptional event. The birth and death of babies was simply an unavoidable fact of life. Because of the need for extra labour on the homestead, families tended to be large in those days. As one homesteader put it:

Yes, big families. They just kept coming and coming. They certainly didn’t have the pill or any other doodads they have now….Once my mother got going, she had one every year. She had eleven children. The people down the road had twelve. I have known women to have fifteen children and when the oldest was twenty, maybe ten or twelve of those children were still alive.92

At the time, using birth control was considered to be immoral, not to mention illegal. Even if the isolated farm woman was willing to consider it, she had little access to or knowledge about it. Consequently, many women spent the better part of their reproductive years either pregnant or nursing infants. In 1927 a reader wrote to the Western Produce begging for information on contraception. She declared, “I am a mother of five children, the oldest being seven. I am 25 years old. We live on a farm, but owing to sickness we haven’t got on very well. I trust we will do better soon, as debts are a constant worry….Please send information on birth control.”93

Although illegal at the time, it was quite common for doctors to get requests to perform abortions. One doctor claimed, “If you only knew the number

91Laurel Halladay, “‘We’ll See You Next Year’: Maternity Homes in Southern Saskatchewan in the First Half of the Twentieth Century” (unpublished M.A. thesis, Carleton University, 1996), 33.
92Broadfoot, The Pioneer Years 1895-1914, 190.
93Rasmussen, A Harvest Yet to Reap, 72.
of women who come here with tears in their eyes asking for relief." If desperate enough, women would attempt to abort the baby by themselves. Elaine Schrader from Weyburn commented, “Once Pa figured he had enough some mothers had to resort to the crochet hook, because of course he didn’t limit himself.” Sadly, this would often end badly and botched up self-induced abortions contributed to the high maternal mortality rate on the prairies.

The enormous workloads homestead women were responsible for, together with the strain of multiple pregnancies, took their toll on prairie farm women. One lady observed, “Most men had two wives as one woman usually wore out before the man did.” For many women their former state of health never returned. Peggy Holmes wrote about a homestead woman who had born many children and worked very hard for many years, “It was difficult to imagine how she looked when she was young, as she was in such poor condition physically and mentally…how she must have suffered. Here was a happy bride, full of hope, now a human wreck.”

In 1924, Dr. Helen MacMurchy from the federal Department of Health researched maternal mortality in Canada. She reported:

> Very often the health of the pregnant woman is neglected or not properly looked after, consequently she becomes run down and weakened mentally and physically, so that when the time comes she is in no condition to go through labour successfully. Again, as I have found it very often….a mother has not time to properly recuperate from one labour to another, because it is a frequent occurrence for a mother to bear a child every year, which soon saps her strength and endurance.

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94Ibid., 74
95Letter to author from Elaine Schrader, dated 12 December 2010.
97The Corrective Collective, Never Done, Three Centuries of Women’s Work in Canada (Toronto: Canadian Women’s Educational Press, 1974), 52.
98Holmes, It Could Have Been Worse, 119.
There was also little opportunity for post-partum rest and healing. At the time, most midwives and physicians recommended that women stay in bed for ten to twelve days after childbirth. “Why twelve days I don’t know,” recalled Imelda Possberg, “they were told the breast milk had to have a chance to flow freely without her working to weaken her. Also the uterus had to be relaxed to go gently into place.” However, for many women this was simply not possible when “men must eat.” Because farms and ranches were dependent on women’s work, many women delayed their recoveries by returning to their daily routines too quickly. Mary Cummins had great difficulty recuperating after the birth of her fifth child. With all her pregnancies close together, coupled with a heavy workload, she withered away to a weight of fifty-eight pounds, from her usual ninety pounds. She was eventually sent back home to England to rest and recover.

Sometimes young women from the community were hired to help out around the house for a few weeks after the baby arrived. Doris Kewley wrote, “We had a girl who came in to cook, wash, and look after the family until I was able to be up and take over again.” However, this was a luxury many farm families could not afford. The young women might accept gifts or fresh produce in exchange for the work they did around the house. “Dad had to hire a lady to care for the other children and mom after she had several,” recalled Imelda Possberg, “Mom and dad had little money, the entire town was in the same position, so any lady that came had so little furniture that they were happy to have a piece of furniture made by dad.”

100 Letter to author from Imelda Possberg, dated 30 October 2010.
101 Cummins, “How About It? The Story of a Woman’s Life,” SAB.
102 Ibid.
103 Letter to author from Doris Kewley’s daughter Geraldine Procychyn, dated 6 November 2010.
104 Letter to author from Imelda Possberg, dated 30 October 2010.
The hard life homestead women led, as well as the conditions in which they lived and worked, could often lead to the death of the mother and/or child. Many farm women faced heavy physical and emotional demands throughout their pregnancies. Mary Cummins described an incident where she found herself at nine months pregnant, “sprawled across the top of an eighty foot well, assisting the hired man to hoist himself out after rescuing a foal who had fallen down it.”105 There were many miscarriages during the settlement period because of the demands placed upon farm women. Doris Kewley remembers the night she lost a child:

Late one fall when my husband was away, someone had drove through our farm and must have left the gate open, so after it was dark that night, I heard cattle bawling so realized the neighbours cattle were at our place and would be in my garden. So I went out trying to chase them out so I could shut the gate. Fell over this and that, bumped into stumps. I ended up having a miscarriage the next day. Another neighbour went for a midwife. When she arrived I had lost so much blood, and was so weak, she sat with her fingers on my pulse, and I kept fainting away. Somehow they got word to Walter.106

Amy Arn recalls how her mother had three miscarriages in as many years due to overwork. She then lost another son in a self attempt to give birth to twins. Her husband was gone, and she refused to enlist the aid of her elder daughters because of the squeamishness of the times.107

Many mothers might have been spared during the homestead period, had there been experienced help on hand to assist with childbirth. Bonnie Werdal from Aylesbury, describes the breaking up of the family after her grandmother died in childbirth in 1921. Her grandfather abandoned the children, and the Salvation Army ended up raising them. In fact, several incidents reported in the

105 Cummins, “How About It? The Story of a Woman’s Life,” SAB.
106 Letter to author from Geraldine Procychyn (daughter of Doris Kewley), dated 6 November 2010.
maternal mortality research conducted by the federal government pointed to the collapse of families and of farm operations when the mother died. Men simply could not take care of the children and the farm without the help of a woman. They would often quickly remarry, purely out of convenience, just to keep the farm going and the family together.

Harriett Neville, who assisted at many births during the early settlement period, wrote in her memoirs, “Out of one family who were neighbours, two of the women died in childbirth.” Peggy Holmes recalled, “There were so many bereavements in the district. Two widowers were left with seven children each. That made 14 more motherless children to be cared for.” She believed the deaths were caused by neglect at childbirth. Sarah Roberts was married to a doctor in Saskatchewan during the homestead period. She remembered one woman her husband tried to help: “She had not had the services of a physician during confinement. He found her in a raving delirium.” She was taken to the hospital but died a few days later. The lack of medical assistance available to the early settlers during childbirth surely contributed to the high infant and maternal mortality rates in Saskatchewan at the time. If the birth or postpartum period involved any complications, the chances of either mother or child surviving were slim.

The death of a child was a very common occurrence during the homestead period. There were very few families who had not lost at least one child. Sadly, many precious lives might have been saved had there been experienced help on hand. One of the early settlers revealed that “Many a coffin hid the face of both mother and infant.” In addition, there was often no official

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108 Harriett Neville, “Pioneering in the Northwest Territories 1882-1905,” SAB.
110 Ibid.
111 Rasmussen, A Harvest Yet to Reap, 78.
record of the death of child, just a tiny grave or tombstone located on the homestead. Sarah Hardy Gamble lost two babies; one child lived for five hours, the other was stillborn, “They were buried in a tiny open spot among the bushes on the hillside not far from the house. Wooden boxes were framed and the tiny remains placed therein.”

Ruth Jeeves was the executor of her aunt and uncle’s estate. They had homesteaded west of Govan, Saskatchewan. She writes:

One day, the man that purchased Uncle Jim’s farm told me there was a small headstone leaning against a shed, down by a dry slough. He said he remembered being told that my Uncle and Aunt had buried their stillborn baby down there about 1915. After several legal inquiries, we mounted the baby’s headstone between my Uncle and Aunt’s headstones in the Govan cemetery.

No doubt, there are probably thousands of tiny gravesites such as this scattered across the Saskatchewan landscape as the only evidence that a child had once existed.

Homesteading was a very different experience for women than it was for men. Women literally risked their lives to establish their families and build a future on the Canadian prairies. Limited recognition by governments of the conditions in which homestead families lived resulted in few services being available to women to ensure for safe childbirth. The major barriers for prairie women to overcome in their preparations for giving birth included: the lack of trained medical practitioners; the lack of facilities at home in terms of heat, water, and space for birthing a baby safely and comfortably; the isolation of the individual homesteads; the slow means of transportation on poor trails and the severe weather conditions on the prairies. In addition, most women faced the limitations of their own ignorance with regard to childbirth. These circumstances,

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112 Campbell, “Man! Man! Just Look at that Land,” SAB.
113 Letter to author from Ruth Jeeves, dated 23 September 2010.
together with their own weakened condition from overwork and multiple pregnancies put homestead women at risk each time they had a baby. Prairie women provided each other with the practical and emotional support that childbirth demanded and served as midwives for each other when there was no other medical care to be had.
Chapter 3 – The Public Response

In every work the beginning is the most important part, especially in dealing with anything young and under.

Socrates

The federal government put much time and money into settling the prairies but was little prepared for the immigrants once they arrived. Few resources or services were provided and no provisions were made for medical care for the new immigrants to Canada. Underlying the slow development of essential services was an indifference shown by Canadian governments to the needs of the early settlers and a frontier ethic that valued profit over people. However, women did not sit passively by and accept the lack of services and medical care available to them at this critical time in their lives. Farm women and female organizations initiated campaigns that directly attacked this frontier ethic and revealed its high human cost.

Lady Aberdeen and the Victorian Order of Nurses

One of the first women to take up the cause on behalf of prairie women was Countess Ishbel Aberdeen, the wife of Canada’s Governor General Lord Aberdeen who represented Queen Victoria from 1894 to 1898. Lady Aberdeen was also the President of the National Council of Women of Canada (NCWC) during this period.¹ With common beliefs in the efficacy of maternal influence, the distinctiveness of the female character and societal injustice, women began to form national partnerships.² Established in 1893, the NCWC pledged itself to the preservation of two of the three major institutions in society: the family and

the state. The belief that “the health of the family is the health of the nation,” provided the justification for many of its health-related reforms. This credo formed the cornerstone of the NCWC programs.³

In her essay “Helpers or Heroines? The National Council of Women, Nursing, and “Woman’s Work” in Late Victorian Canada,” Beverly Boutilier claims that members of the National Council “strongly identified with the new generation of largely Anglo-Saxon women who were building farms and communities in the Canadian Northwest before 1900.” Council members repeatedly asserted that women played a crucial role in the nation-building process, which they perceived as a gendered enterprise. As Boutilier describes it:

While men made a new region productive by tilling the soil and generating economic wealth, only women’s reproductivity could truly establish a new community and provide it with the moral and spiritual sustenance it needed to survive.⁴

As a result, the maternal welfare of isolated prairie women became one of the most urgent responsibilities taken on by this newly-formed organization.

In her autobiography Lady Aberdeen writes of the Annual Meeting of the NCWC in 1896:

An interesting discussion took place during which many of the members told pathetic stories of cases where young mothers and children had died, whilst husbands and fathers were travelling many weary miles for the medical and nursing aid which might have saved them.⁵

At the meeting, a resolution was passed which addressed the need for medical aid in the North-West and other outlying areas of Canada. It called on the local councils to study the matter and suggest some practical solutions to this very

³Ibid., 101.
serious problem.

The NCWC designed a scheme it called the “Victorian Order of Home Helpers,” in which local midwives were given additional training in the medical method of childbirth. The Home Helpers would not only aid local women in childbirth, they would also help with the household chores while the mother recovered for two weeks or more, depending on the individual circumstances. Lady Aberdeen believed that local women would make the best Home Helpers as they lived in the rural areas the Order intended to reach, and would already have the confidence and respect of their neighbours. The Victorian Order of Home Helpers was similar in concept to the system of village nursing pioneered in rural England during the 1880s to provide isolated communities with “semi-skilled” nursing and maternity aid.\(^6\)

The plan was to train the Home Helpers in a hospital for one year, instead of the two or three year hospital apprenticeships required of graduate nurses, during which time they would learn the basic skills required to gain admission to the Order, including first aid, simple nursing, and cooking. They would then also take a three-month course of training in midwifery.\(^7\) In England, the profession of midwifery had a much more accepted recognition than it did in Canada or the United States. It was never suggested that the Home Helpers would be equivalent to the physician in their ability to handle births, but it was felt that they would be an ideal interim aid to serve rural districts until the population of the community was sufficient to support a doctor.\(^8\)

The NCWC members were surprised and dismayed to discover how

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\(^6\) Beverly Boutilier, “Helpers or Heroines?” 35.

\(^7\) Ibid., 33-34.

strongly the medical community opposed their plan. Trained nurses were the first to publicly object to the Home Helpers scheme. As a newly organized group they were trying to establish nursing as a profession. For much of the nineteenth century, nursing was considered to be a type of domestic service undertaken in well-to-do homes and in urban charity hospitals by working-class women. It was not until the 1890s that nursing moved out of the domestic into the public sphere and was widely accepted as an occupation suitable for Canadian women of the middle classes. Although the medical ideology in the late 19th and early 20th centuries emphasized a gendered division of labour in which well paid prestigious and autonomous male physicians “cured” while poorly paid and subordinate female nurses “cared” for patients, women successfully established a professional niche for themselves in health care. The education, social status, and financial independence of the “modern” nurse distinguished her as a new kind of woman worker.9

Although nursing eventually evolved into a profession in the early 20th century, the perception of nurses as domestic workers persisted. The medical profession’s representation of trained nurses as subordinate helpmates did not help, as it merely reinforced the image of nursing as a specialized area of female domestic labour. In the interest of raising their professional status, nurses had been struggling for years to distance themselves from the domestic labour associated with nursing. They feared that the Home Helpers scheme would reverse any progress they had made in this regard because, as the name implied, Home Helpers would also be domestic workers. The nurses felt their efforts to gain economic security would be undermined by a new type of worker

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with less training and lower wages. They viewed the Home Helpers as glorified midwives, and midwives, of whatever caliber, simply did not fit with the ‘Nightingale mystique’ of the professional nurse.\textsuperscript{10}

There was considerable objection to the scheme from doctors as well. At this time, physicians were also trying to professionalize the practice of medicine by strengthening their pecuniary positions and their control of medical care. Childbirth, in particular, was one aspect of medicine they were determined to bring under their control. Attending at the birth of a child often initiated a doctor’s association with a family and its illnesses and was therefore the key to a physician’s future income. This was a prime opportunity for doctors to monopolize a new area of medical treatment and such rivals as midwives or ‘home helpers’ had to be eliminated as competitors. Therefore, in the late 19\textsuperscript{th} century, “midwifery” was essentially appropriated as a branch of masculine medical science and physicians began to protest against the unregulated competition of midwives. The midwife was henceforth commonly associated with images of dirt, ignorance and danger.\textsuperscript{11} Dr. W.B. Hendry, head of the Canadian Medical Association’s Maternal Welfare Committee from 1914 to 1922, described midwives as “those untrained, unkempt, gin-soaked harridans, unfit for the work they were supposed to do and a menace to the health of any woman they might attend.”\textsuperscript{12}

In contrast to the perception of the midwife, the modern nurse was associated with cleanliness, hospital training, and medical subordination. Many

\textsuperscript{10}Mason, “Midwifery in Canada,” 108.
in the medical community feared that “half-trained” helpers would undermine the professional standing of fully trained nurses and claimed the scheme would create two classes of nurses. The editors of the *Montreal Medical Journal* commented:

Much time and labour have been expended in bringing trained nursing to its present state of efficiency and this proposed scheme seems like a retrograde step and we very greatly fear will prove to be such. To a large portion of the laity a nurse is a nurse no matter how long or short a time she has spent acquiring her training, and the public mind would utterly fail in many instances to grasp the difference between the two classes of nurses….if a nurse with one year’s training is good enough to nurse some people she may be considered good enough for all people.\(^{13}\)

Medical commentators took particular exception to the suggestion that partially-trained female birthing attendants were an adequate substitute for male medical expertise. They claimed that the Home Helpers’ limited training would put the public at risk. The Ontario Medical Association captured those sentiments in the following resolution passed at its annual meeting in June 1897:

The Ontario Medical Association feels that it would be neglecting a serious public duty if it failed to express its most unqualified disapproval of the scheme, on account of the dangers which must necessarily follow to the public should such an order be established.\(^{14}\)

The medical establishment’s opposition to the Home Helpers scheme was too strong to ignore. Lady Aberdeen accepted the fact that they would have to devise a new plan. One of the few doctors who supported Lady Aberdeen’s scheme, Dr. Thomas Gibson, tried to overcome some of the primary objections. In early 1897 he drafted a proposal stipulating that the Victorian Order would supply only thoroughly trained nurses, thereby eliminating the midwives connotation. This was a radical departure from the original concept for the

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\(^{14}\) Reported in the *Canadian Journal of Medicine and Surgery*, Vol. 1, No. 6 (June 1897), 269-271.
Order; however, the opposition to the Home Helpers was so strong the NCWC felt it had no choice but to acquiesce.  

Lady Aberdeen then turned her attention toward a district nursing scheme. She had been involved in establishing a cottage hospital and system of district nurses at her husband’s estate in Great Britain. In England a great stimulus was given to district nursing by Florence Nightingale, who helped establish the Metropolitan and National Nursing Association in 1875. Then, on the occasion of her first Jubilee in 1887, Queen Victoria donated seventy thousand pounds towards the founding of Queen Victoria’s Jubilee Institute for Nurses, later to be known as the Queen’s Institute of District Nursing. Florence Nightingale was instrumental in establishing the rules and constitution for the new order. She advised on the training the nurses would receive and the service they would provide in the home. 

Lady Aberdeen thought a similar system of district nursing might help to alleviate the lack of medical services on the Canadian prairies. In 1897 the NCWC drew up a provisional scheme of district nurses to be called the Victorian Order of Nurses (VON) in commemoration of Queen Victoria’s Jubilee. The scheme did not follow the exact pattern of the Queen’s Institute of District Nursing, which served a much smaller and more densely populated area. It was modified to fit the particular circumstances of such a widespread country as Canada. Initially, the plan drew tremendous support from several influential people. At a public meeting held in Ottawa of February 10th, 1897, a resolution approving the plan was moved by Prime Minister Wilfrid Laurier and seconded by

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15Ibid., 137.  
16Gibbon, *The Victorian Order of Nurses for Canada*, 1  
17Ibid., 80.
Clifford Sifton, Minister of the Interior.\(^{18}\) The purpose of the order was thus defined by Lady Aberdeen: “To supply nurses, thoroughly trained in hospital and district nursing, and subject to one central authority, for the nursing of the sick who are otherwise unable to obtain trained nursing in their own homes, both in town and country districts.”\(^{19}\)

However, far from reducing medical opposition to the order, the decision to hire only fully trained nurses only intensified it. Doctors perceived the district nurses as an infringement on their professional territory. In their eyes, midwifery was about to become legitimized by being turned into a job. At medical meetings the problem of the British midwife was raised. It was said that in Britain medical men were forced to make visits at a shilling each to counter the competition from the midwives. They feared the same thing would happen in Canada. VON nurses, who were to earn their livelihood through midwifery, would be in direct competition with the country doctors in a way that neighbour birth helpers never were. Reassurances that VON nurses would work mainly in areas where there were no doctors made little impression.\(^{20}\)

Of course the medical profession did not publicly claim fear of competition as the reason for their disapproval of the VON. On 28 May 1897, the *Toronto Globe* printed a dispatch from a mass meeting in Winnipeg dealing with Lady Aberdeen’s proposed Order where the following resolution was passed:

> This meeting, representing the Medical Society of the city is unanimously of the opinion that though the object that Lady Aberdeen has in view in establishing the VON is highly commendable, with our more perfect knowledge of the country in attending the sick, we feel that the scheme, at any rate so far as Manitoba and the North West is concerned, will

\(^{18}\)Gibbon, *Three Centuries of Canadian Nursing*, 251.

\(^{19}\)Countess Ishbel Aberdeen, *What is the Use of the Victorian Order of Nurses for Canada?* (Ottawa: The Mortimer Co., 1900), 3.

\(^{20}\)Mason, “Midwifery in Canada,” 108.
English literary pundit Goldwin Smith even weighed in on the issue. In a statement regarding the VON he claimed:

Numbers of the medical profession are opposed to it on the grounds of its impracticability. While the scheme might work admirably in towns and cities, it will be impossible to find in Canada a body of young women who will be disposed to devote themselves to a life of incredible hardship in the remote parts of the country where the nurse might be the only woman in the house. The sacrifice asked of our young girls is too great.

Another article written in the Ottawa Citizen on 1 June 1897 was sympathetic to the idea but referred to the indifference with which the scheme had been received. Lady Aberdeen was quick to respond:

Our devoted Hon. Secretary, Professor James Robertson, who from his acquaintance with the conditions under which agricultural work was carried on in every part of the Dominion, had ample knowledge of the hardships undergone by settlers, their wives and families, because of the sparse amount of medical and nursing aid available, met and discussed the scheme with farmers and their wives, and found it hailed with gratitude and delight.

There is also no evidence of opposition to the VON by doctors in Saskatchewan, or those who had once practiced there. Dr. O.C. Edwards of Ottawa responded to Goldwin Smith’s article on 29 June 1897 in the Ottawa Citizen:

I lived in the Qu’Appelle District of the North West Territories for eight years, and know well what I am talking about. During my medical practice there time and again I would have welcomed gladly such a valuable helper as the VON propose to supply….The Women’s Council who first took up this question of nursing in the outlying districts, never intended that ‘the young girls’ Dr. Goldwin Smith speaks of should be employed. The idea was that the kind of nurse set to do this work should be a matured and experienced woman….I, for one, heartily wish the scheme God Speed! I venture to say that the medical men who are

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21Ibid., 11.
22Ibid., 12.
23Ibid., 13.
actually in practice in the territories will in every instance welcome and warmly welcome the Nurses of the Victorian Order.\textsuperscript{24}

However, the opposition from the medical establishment, primarily in central Canada, was unrelenting. The VON was severely criticized by some of the leading medical journals in the country. The articles became so virulent that Lady Aberdeen was advised by members of her committee to stop campaigning for the Order. They felt the wife of the Governor General should not be exposed to such opposition. But Lady Aberdeen was undeterred in her quest to provide health care to the newly settled regions of the country. Her next move was to issue an appeal directly to the “Children of Canada”, which she sent to teachers all over the country with the request that it be read to their students. The following are extracts:

If the Queen herself could appear in your school rooms and ask you to do something for her, what a rush and competition there would be to do it! Well, Her Majesty has asked us all to do something. She has said: “Make this a Year of Jubilee to the Sick and Suffering of My Dominions.” And now His Excellency the Governor General and I come to each of you in her name and ask you to help us to found a VON, who will go in the Queen’s name to all parts of Canada, caring for the sick and suffering in their own homes. In the towns they will go to those who cannot now afford the care of trained nurses and often die for the lack of it; on the prairies, in the forests, in mining districts, everywhere throughout the country they will go hither and thither amongst our brave pioneers and bring help to those heroic people who are building up the future of this beautiful country amidst many hardships and privations. Will you give a hand, Children of Canada?\textsuperscript{25}

Lady Aberdeen also realized that much of the objection to the VON from the medical community was based on false information. Many still believed that the nurses were to be only partially trained, and that they were to act independently of medical men in rural areas, and were thus likely to be employed in the place of doctors because of their lower fees. Lady Aberdeen set out to

\textsuperscript{24}Ibid.
\textsuperscript{25}Ibid., 15.
clear up these misunderstandings with the help of an American physician, Dr. Alfred Worcester, who had made the subject of district nursing a life-long study in both America and England. He advised the NCWC to remove all talk of midwifery and to present the Order as one of district nursing, with the nurse in strict obedience to the doctor. Dr. Worcester then lectured to medical societies across eastern Canada on his experience with district nursing in the United States. He assured them that the VON would simply be assistants in the home, making the doctor’s work lighter and seeing to it that his orders were carried out.  

Thanks to Dr. Worcester’s lectures, many in the medical community changed their attitudes toward the VON and began to support the idea. This was evidenced at a public meeting held in Toronto, when several of the most prominent doctors said they now understood the real objects of the Order, and that they “most heartily and emphatically endorsed it.”

Finally, after sixteen months of uphill work, and a vastly different organization from that originally conceived, Lady Aberdeen succeeded in winning the support of most doctors and in securing a charter for the Victorian Order of Nurses of Canada.

By late November 1897 the VON had begun its work under the direction of Chief Lady Superintendent Charlotte MacLeod. In early 1898 a training school was established in Ottawa to provide specialized training in district nursing to VON nurses. The qualifications for these nurses were high. Only those holding diplomas from a recognized hospital training school and who came highly recommended were eligible for the six month course in district nursing. In addition to district nursing, they were trained in maternity work, cooking and

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27 Lady Aberdeen, What is the Use of the Victorian Order of Nurses for Canada, 10.
dietetics, and the principles of home sanitation. Because the work was hard and the conditions often uninviting, on acceptance to the VON, each nurse took a pledge of two years’ service anywhere in the Dominion. This could mean district nursing in an urban centre, or serving in one of the Cottage Hospitals which the Order planned to establish in remote districts across the West.29

Lady Aberdeen’s plan included building small homelike cottage hospitals, similar to those in England, to service outlying districts. They would accommodate up to ten patients with quarters for two nurses and a maid. They were to be staffed by VON nurses and given the legitimacy of a national organization, but local funding would still be required. The first VON cottage hospital was established in Regina in 1898. Dr. David Low of Regina had always been an outspoken proponent of the VON, even when the majority of physicians in the country were adamantly against the idea. He told the VON headquarters that if a cottage hospital was to open in Regina, he would guarantee it received sufficient patients. Unlike doctors in eastern Canada, he was well aware of the need for more medical care on the prairies and would have probably welcomed the prospect of a hospital staffed with trained nurses.30

The Regina Council of Women (RCW) had been working toward establishing a hospital in Regina for several years by the time the VON began its work. Lady Aberdeen had previously supported their hospital project and thought Regina might be the perfect location for the first VON cottage hospital. At a public meeting in July 1898, Lady Aberdeen answered questions regarding financing a VON hospital in the town. She assured those in attendance that should Regina decide to establish a local branch, three quarters of Regina’s

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29 Gibbon, Three Centuries of Canadian Nursing, 253.
30 Ibid., 252, 268-269.
contribution to the hospital would be returned for local purposes. It was moved by the Premier of the North-West Territories, Frederick Haultain, and unanimously agreed upon, that the hospital fund raised by the RCW be allocated to establishing a VON cottage hospital in Regina.\(^31\) The VON cottage hospital was opened in Regina on November 29, 1898 under the supervision of Nurse McCullough.\(^32\)

The Regina cottage hospital was initially located in a small tenement house and could only accommodate six patients. One nurse ran the hospital single-handedly for the first five months; then in May 1899 a second nurse and housekeeper were sent by the VON to help out. Following a visit to the Regina cottage hospital at the end of the first year, Superintendent Charlotte MacLeod reported that: “Fifty-six patients have been nursed there since last November, mostly men and boys, who have not homes, and the doctors there told me had they not had this little house with the two Victorian Nurses, two-thirds of that number surely would have died.”\(^33\) The six-bed hospital quickly became inadequate to meet the town’s needs and in 1901 was transferred to a new site. A training school for nurses was also established at this time. Six years later it was taken over and absorbed by the Regina General Hospital.\(^34\)

Over forty cottage hospitals were eventually opened by the VON in the early twentieth century, including seven in Saskatchewan. However, from the outset, the cottage hospital scheme was plagued with problems. The hospitals needed more in the way of financing than Lady Aberdeen was ever able to secure. Not long after the VON’s inauguration, her husband’s term as Governor

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\(^{31}\) Regina Leader, 14 July 1898.

\(^{32}\) Regina Leader, 1 December 1898.


\(^{34}\) Gibbon, *The Victorian Order of Nurses for Canada 50th Anniversary,* 60.
General ended and Lady Aberdeen was set to return to England. She was happy to have finally succeeded in establishing the Victorian Order of Nurses of Canada, but lamented the fact that the great majority of rural districts, where the Order was needed most, were unable to raise the required funds to cover the expenses of a VON nurse. Before resigning as president in 1899, she addressed some of the financial problems they had been experiencing and issued a final plea:

If we are to spread the Order in these districts where it is most needed, we must have a Central Fund, from which generous grants can be made at the outset, grants which can by degrees be reduced until the district becomes self-supporting….My parting words as President must therefore be an earnest entreaty to the friends of the order who believe in its power for good. Will not they make an effort to secure such support for the Central Fund as will place it on a sure basis for the carrying out of its objects.

There was also the challenge of obtaining an adequate supply of good nurses. Superintendent Charlotte MacLeod commented on the staffing shortages and tried to appeal to the nurse’s professional sense of honour:

This is pioneer work, and it does not appeal to those who like a city life, with its brightness and comfort, though it should be said that, even in remote districts the Victorian Order Nurse is not, by any means, forgotten or neglected. No nurse practicing her calling, even in most luxurious homes, can receive such honour and hearty gratitude as is accorded to our nurses amid their rude surroundings.

Finding nurses willing to work in rural prairie communities would remain an acute problem until the 1920s.

Following Lady Aberdeen’s departure from Canada, a succession of ladies of Rideau Hall took a special interest in some aspect of the VON’s activities so that it was never allowed to lie idle. Lady Aberdeen’s successor, Countess

35 Lady Aberdeen, What is the Use of the Victorian Order of Nurses for Canada, 67.
36 Ibid., 67-68.
37 Miss Charlotte MacLeod cited in Gibbon, Three Centuries of Canadian Nursing, 269.
Minto, took the cottage hospital idea under her wing. At the third annual meeting of the Board of Governors of the VON on 14 March 1901, Lady Minto outlined the need and value of the cottage hospitals:

Wherever a cottage hospital has been placed it has proved of the greatest value. Hospitals are already in existence in nearly all the large centres of population….as is well known they are doing good work; and in the more distant and sparsely settled localities, from which in many cases patients cannot be conveyed long distances to these centres, cottage hospitals would be of real benefit.

Lady Minto also stressed the educational value of the hospitals:

Each is in itself an example of the skilled care of the sick, and where necessary the assistance of untrained women can be used in the hospital, under supervision of the physician and nurse, so that in their measure such hospitals can become little training schools in their districts. In the Regina Hospital, help of this kind has been used with the happiest results.

It was therefore resolved that a special fund be created for the establishment and maintenance of cottage hospitals in the North-West Territories to be called the Lady Minto Cottage Hospital Fund. Money was raised by appealing to the public and by applying for government grants. The additional funding helped to establish several cottages across the prairies which came to be called Lady Minto Hospitals.

The Victorian Order of Nurses was initially conceived as a way to provide maternity care for women in isolated western settlements. However, because of the difficulty in getting to the cottage hospitals from remote areas, and the costs involved, few women were able to take advantage of the services provided by the VON. In addition, the particular circumstances of the homestead woman, whose work was essential to the maintenance of the farm, made it very difficult for her to

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38 Gibbon, The Victorian Order of Nurses for Canada 50th Anniversary, 2.
39 Lady Minto cited in document entitled The Lady Minto Cottage Hospital Fund in connection with the Victorian Order of Nurses of Canada, 5.
40 Ibid.
41 Ibid., 3.
be away, even for a few days. Women were also reluctant to go to hospitals in the early twentieth century. Historically, this was just the beginning of the period in which childbirth was taking place in an institutional setting. The vast majority of women still gave birth at home, preferably with a doctor in attendance. As a result, maternity cases occupied less than ten percent of the cottage hospital beds.\textsuperscript{42}

So while the VON was doing good work in the towns and cities, the Order was failing to live up to Lady Aberdeen’s original vision of providing maternity care to rural women. According to Marion Cran, the Victorian Nurses were in no way able to meet the urgent need of maternity care for the sparsely settled regions of the country. In her opinion, saving the future citizens of the Empire had to be more important than the accidents and illnesses of adults. She argued:

\begin{quote}
It is the race that is involved with maternity work, not the individual. A pregnant woman is a national asset, a national glory, a national responsibility. It is the next generation to which we owe our allegiance, should show mercy and consideration, to which we should bend our energies and skill….The blood chills to think of the lonely mother-women, of the effect on their babes of the unnecessary harshness of the birth hours and the nervous expenditure in the anticipation of it.\textsuperscript{43}
\end{quote}

Cran believed what prairie women really needed was trained midwives, not nurses working in cottage hospitals hundreds of miles away. Farm women needed someone to come to their home and assist with the birth of the child and then stay on to help with the housework, something nurses were no longer willing to do. She writes:

\begin{quote}
The fully trained nurse has been through her purgatory of drudgery in the hospitals, she has washed and cooked and scrubbed and polished, and is now a nurse, not a superior ward-maid. Therefore she would be useless practically in the little prairie shacks where she would have to do
\end{quote}

\textsuperscript{42}Langford, \textit{Childbirth on the Canadian Prairies 1880-1930}, 291.

\textsuperscript{43}Cran, \textit{A Woman in Canada}, 260.
all the domestic work as well as the nursing.\textsuperscript{44}

In her many interviews with homestead women at the beginning of the twentieth century, the lack of maternity care on the prairies came up again and again. As one woman described it:

The women suffer much out here in these wilds for lack of proper nurses. They want qualified midwives who will do housework for them. It is a dreadful thing to know how many prairie women go through their confinements alone. I was lucky, I was able to get to a hospital, but lots of them can’t.\textsuperscript{45}

Cran, who was a maternity nurse in England, felt like she had to do something and came up with the idea of importing British midwives to work in the prairie provinces:

The care of the lonely mothers, then, as far as I can see, devolves on the individual courage and skill of their British sisters. In the old country many more women are trained for maternity work than there is work for, and that it should be possible to select from among those women who can bake bread, sew, cook and run a house, women who knowing the conditions in the West would be willing to come for the sake of guaranteed employment, and who after settling the patient would turn to and mind the house….If there were a guarantee of steady employment it would be a small matter to get all the picked women needed, for steady work is a great attraction to an English nurse.\textsuperscript{46}

Her plan was to have a maternity nurse in every small town and hamlet across the prairies, under government auspices, from whence they could radiate out to the surrounding districts. In such cases where the homesteader was unable to pay, the nurse would be guaranteed a minimum fee by the government. The homesteader would then be obliged to pay the government back as soon as he was able. In return for such protection the nurses would pledge to take each case that applied. The settler’s wives would only need to write a letter to the nearest branch asking for a trained midwife at such a date. Cran suggested that

\textsuperscript{44}Ibid., 254.

\textsuperscript{45}Ibid., 119-120.

\textsuperscript{46}Ibid, 262.
the nurse should stay on at the homestead, or return daily for no less than twelve days, in the interest of safeguarding the health of both mother and child. She further explained how government aid would not be needed indefinitely: “After a while some of the nurses would make money and start maternity homes here and there; which in their turn would make good training centres for the next generation of nurses, and so the situation would gradually work itself out.”  

Cran presented her proposal to the Minister of the Interior, Frank Oliver. She made it clear at the outset that the midwives would not be substitutes for doctors, only allies, and only in situations where a doctor was unavailable because of distance or cost. Cran tried to impress upon him that a trained midwife would be infinitely better for all concerned than nobody at all. She writes how Mr. Oliver listened with ‘perfect courtesy,’ and agreed that such a scheme was needed, however, declared that it was a provincial, rather than a Dominion, matter. He explained how, “It was the business of the Dominion Government to bring settlers into the country, but the business of the Provincial Governments to look after them when they had settled.”

At this point, Saskatchewan and Alberta had only been provinces for a few years. Nevertheless, Mrs. Cran sent her proposal to the premiers of the four Western provinces. The premiers of British Columbia, Alberta and Manitoba all responded the same way by saying it was the responsibility of the federal government. “This was a game of battledore and shuttlecock,” she bemoaned, “the need of women being the shuttlecock between the greater and lesser governments.” Cran hoped that Saskatchewan would be more receptive to the idea and decided she might have more success if she presented her proposal in

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47 Ibid., 264.
48 Ibid.
49 Ibid., 258.
person. When she arrived in Saskatchewan, the Premier was away so she met with the Provincial Health Officer Dr. Maurice Seymour. Cran writes of the meeting:

The public health official, who makes tuberculosis his hobby, assured me in the airiest way that the women were amply provided for, yet he lives in the province where maternity nurses are scarcest and where one doctor, has a circuit of sixty miles whereon to lavish his attentions.  

Cran was astonished by the indifference shown by both the provincial and federal governments to this issue:

Canada, so fatherly in its government, so sane and sensible, so wise and patient in most of its measures, is here in this particular matter extraordinarily callous and short-sighted. All over the country one finds schools, well built, well managed, the scholastic system is Canada is really a remarkable one. Yet it neglects its children at the fountain head of being and hopes for a contented healthy people….A government which works sanely on commercial lines for the good of the greatest number, and for all its sense neglects its women and babes, at the hour of birth, leaving them untended on the outlying homesteads.

Having no luck with either level of government, Mrs. Cran approached the VON. She detailed her scheme to the executive committee, asking if it were not possible that such a body of maternity specialists could be attached to the existing Order, acting as an endowed government body, but incorporated with the present Order. Cran believed that the only way to get to these isolated farms was through “some subsidized band of itinerant midwives, a sort of mobile corps unattached to any given town, but working coherently under the direction of a single government.”  

After speaking to the Matron, Cran writes that she knew immediately that she had met with prejudice:

The pity of the whole position is this, that while the fully trained nurse in no more that a trifle scornful of maternity work, she is violently

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50 Ibid.  
51 Ibid., 264, 282.  
52 Ibid., 253.
antipathetic to the “half-baked” sister, the midwife who has taken only the short maternity training and is not qualified for all branches of nursing. I have noticed that prejudice over and over again, and always with resentment. They might scorn the maternity nurses to the crack of doom and welcome it if they were willing to do the work themselves, but they are not. They oppose the idea of giving maternity nurses a definite status, and themselves leave the work undone. Meanwhile the mothers suffer. Any scheme for alleviating the distress, which none denied, was unwelcome to the VON.\footnote{Ibid., 259.}

One person who did take an interest in what Mrs. Cran had to say was her Excellency Lady Grey, who succeeded Lady Minto. Lady Grey realized that while the cottage hospitals were helping many people across the country, they were failing to help those whom the hospitals had initially been set up to serve: homestead women. Aware of the great opposition Lady Aberdeen had experienced with the Home Helpers scheme, she knew that the medical community would not support the idea of importing British midwives. But she liked Cran’s idea of a mobile corps to serve isolated communities and in 1909 Lady Grey initiated a Country District Nursing scheme specifically for the prairie provinces. The plan was to supply VON nurses to the people living on farms and ranches. A Nurse’s Home would be established at the centre of a rural district, which could accommodate one or two patients, and always have one nurse in attendance. A VON nurse would then attend cases within a twenty mile radius by horseback. As part of this expansion into isolated areas, nurses were encouraged to select “desirable women and girls” to assist them on their calls. For a small fee, these ‘Mother’s Helpers’ would work in the patient’s home under the nurse’s supervision, looking after the house, cooking, cleaning, etc. They would then be left in charge of the patient and home while the nurse went on to other more urgent cases.\footnote{Chief Superintendent Mary Ard Mackenzie, cited in Gibbon, The Victorian Nurses of Canada 50th Anniversary, 64.}
Initially, there seemed to be a lack of interest in the Country District Nursing scheme by the districts it was set up to serve. Chief Superintendent Mary Ard Mackenzie believed the women of the prairie provinces simply needed to be educated as to what it was all about. By attending and addressing conventions of Home Makers Clubs and Home Economic Societies she was able to reach hundreds of women, representing many localities. The Homemakers’ Clubs brought local women together to share practical information on a wide range of topics from health care to gardening. Prairie women were well aware of the high rates of infant and maternal mortality in the rural areas, and once informed about the scheme and the services it would provide, wholeheartedly supported the idea.\footnote{Ibid.}

By 1916, the VON had organized eleven Country Districts, mostly in Saskatchewan. Many prairie doctors supported the Country District Nursing scheme. Dr. A.D. Campbell of North Battleford wrote a letter to Superintendent Mackenzie praising the good work of the District Nurse installed at Hyde Park, Saskatchewan:

> The people living in the above district are many miles from the nearest doctor, and as it is a comparatively new district many of the homes are, to put it mildly, very modest. In some cases, in fact, the nurse is fortunate in having one tin basin for solutions, when conducting maternity cases….Last summer I was called out there to see a baby that was ill, and on arriving I found Miss Skuse (the VON nurse) there before me, doing all she could for the infant at 4 a.m. After I had finished attending the baby, I happened to notice that the nurse had a number of contusions on one side of her face and a very black eye. The homesteader informed me that two or three days before she had been pitched out of a buggy in a runaway escapade, while going to see another patient. Most people would have taken a few days rest to recuperate, but she had gone on with her work as usual, because she couldn’t be spared for two or three days. That is the type of nurse they need out in the country and I consider them unusually fortunate in getting
Obviously, this was not the typical type of nursing position, with the nurse spending a great deal of her time on horseback. As a result, the VON had great difficulty finding nurses willing to work in the country districts. Considering the fact that VON nurses had taken a supplementary course in district nursing in addition to the regular nursing training, and the strenuous circumstances involved with Country District Nursing, the salaries offered were certainly moderate. Superintendent Mackenzie overcame the staffing problems, to a degree, by increasing their salaries and by providing additional training for this specialized kind of work. In 1916 a VON district nurse in the cities and towns made $35 per month including board and head nurses. Country District Nurses started at $45 a month with board, lodging and laundry. This salary was to be increased by $5 a month until the maximum of $60 a month was reached.\(^{57}\)

While the Country District Nursing scheme seemed like the perfect solution to aid prairie women in their time of need, the difficulties in sustaining the program were great. The initial idea of the VON district nursing program was to give about an hour of skilled nursing care to five or six patients during the course of a day. But because the country district nurse spent much of her time on horseback, she was unable to reach as many patients. Financing the scheme was also a continuous headache for the VON executive, especially after the departure of Lady Grey in 1911. To help finance the program, the Duchess of Connaught started a campaign to raise funds in March 1912, raising $223, 250 in about a year. This helped for a while; however, when the war broke out, the lack of funding became an acute problem. This, coupled with the severe shortage of

\(^{56}\)Ibid., 65.
\(^{57}\)Ibid., 65-66.
nurses during the war, caused the scheme to virtually collapse in 1916.\textsuperscript{58}

The Victorian Order of Nurses did provide an important healthcare need during the settlement period. They coped with epidemics of typhoid and influenza, treated emergencies, cared for the chronically ill, and sometimes assisted physicians with childbirth. However, the limited number of VON nurses and cottage hospitals could only assist a small percentage of the population. In addition, financing and staffing the cottage hospitals continued to be a major challenge, particularly during the war. Most of the smaller communities were unable to sustain the hospitals once the start-up grants from the VON were expended and by 1920 all of the cottage hospitals in Saskatchewan had either closed down, or been taken over by larger municipal hospitals.\textsuperscript{59} Likewise, Lady Grey’s Country District Nursing scheme was plagued with problems from the outset and was unable to survive the war as nurses and funding were appropriated for the war effort. So in the end, Lady Aberdeen’s noble dream to provide maternity care to the women in the newly settled regions of Canada only scratched the surface of the infant and maternal mortality problem in the West.

\textit{Violet McNaughton: “The Mighty Mite”}

Farm women also came to play a more active role in public affairs in the early twentieth century. Violet McNaughton, nicknamed the “Mighty Mite” because of her short stature, was one of the most influential farm women and activists in Canada during this period. When she first arrived in Saskatchewan she was shocked to discover the lack of services available to homestead families, in particular, the inaccessibility of health care. Her upbringing in southeast England predisposed her to both recognize rural problems and to

\textsuperscript{58}Ibid., 64.
\textsuperscript{59}Gibbon, \textit{Three Centuries of Canadian Nursing}, 269.
believe reform could be achieved. She was therefore resolved to take action in order to improve the conditions in which homestead families lived. In 1913 McNaughton initiated the formation of the Women's Section of the Saskatchewan Grain Growers' Association, the first of its kind in Canada. This signaled a collective effort by Saskatchewan farm women to begin to address some of the larger problems of rural society.

Violet McNaughton nearly died in the spring of 1911 following a serious operation. This traumatic event had a significant impact on her life because it left her unable to have children. McNaughton’s life would have probably been very different if she had had a typical agrarian marriage with children of her own to raise and nurture. She would never have had the time to become the dedicated activist and leader in the farm women’s movement that she would eventually become. The operation and subsequent stay in the hospital also helped push her into activism as she became aware of the contrast between the prosperity of the city and the poverty and hardships experienced by rural people. While still in hospital, McNaughton decided she was going to do something about the conditions in which homestead families lived.⁶⁰

In 1913 McNaughton threw herself into the organization of the Women Grain Growers (WGG). She was president from 1914 to 1917 and Honourary Secretary during 1917 and 1918. McNaughton’s primary goal during these years was to bring medical aid to the people of rural Saskatchewan, particularly to farm women. She believed that with so many young pregnant women in the province, their health was most at risk, and were therefore in the greatest need of medical services. At its founding provincial convention in 1914, the executive of the WGGA was asked to work on this issue by launching a passionate six year

⁶⁰Ibid., 164-165, 177.
campaign for more medical services in rural Saskatchewan. It was an all encompassing campaign for more midwives, doctor, nurses and hospitals that would be accessible to all farm women and their families.\(^{61}\)

Following the convention McNaughton began to research the medical aid question, and as she travelled around the province speaking and hearing about the conditions in various districts she became more outraged. “In my prairie trips I am constantly crossing the tracks of dead babies and dead mothers, who never ought to have died. It is nothing more or less than National Murder. The State guards and protects our hogs and our forests and allows our children to die.”\(^{62}\)

McNaughton was more determined than ever to do something about the situation. In a letter to Zoa Haight, her ally in the campaign and a founding member of the WGGA, she claimed:

I am going right after this medical aid question. I am going to make it my subject. I have found out some most awful things. Race suicide and I don’t know what on the prairie. Birth and death registration just shameful. I found in one place in five minutes five children one to five not registered and one or two babies deaths. And this in one little spot. I am going right after it.\(^{63}\)

Due to the incompleteness and unreliability of surviving vital records, we will probably never know the precise statistics on infant mortality in the early twentieth century. The laws in regard to registration of births and deaths were very lax in Canada at this time, and with the indifference of the general public and physicians at large, only a crude estimate can be reached. Dr. Alan Brown, Director of the Division of Child Hygiene in Toronto in 1913-14, estimated that the margin of error amounted to probably well over twenty percent on account of the

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\(^{61}\)Ibid., 376-378.

\(^{62}\)Saskatchewan Archives Board, Papers of Violet McNaughton [hereafter cited as McNaughton Papers], A1 E72, “The Need of Nursing Care for Women on the Prairies,” a brief presented to the Canadian Graduate Nurses Association.

\(^{63}\)Saskatchewan Archives Board, Papers of Zoa Haight [hereafter cited as Haight Papers], A5 2, McNaughton to Zoa Haight, 13 March 1916.
incompleteness of registration. Saskatchewan was actually one of the first provinces in the country to gather statistics regarding infant mortality. In 1914, the Commissioner of Public Health for Regina, Dr. J.A. Rose, issued a report entitled *Infant Mortality in Saskatchewan*. He reported that in the province of Saskatchewan during 1914, 1293 infants under twelve months of age were known to have died, making the infant mortality rate 74.81 per 1000. This is an extraordinarily conservative estimate given that most homesteaders had neither the time nor the inclination to register deaths, particularly stillborns. To put this number into context, the current infant mortality rate in Canada is 5.2 per 1000. Of the 1,293 babies that died in 1914, nearly half were lost in the first week of life. Dr. Rose attributed these deaths to problems of the pregnancy or the delivery of the baby. He writes in his report:

> It might be said that under improved conditions for maternity at least fifty percent of lost babies would be saved. Skilful aid at birth is a crying necessity, to ensure which maternity must be subsided and the wards of the State – the newborn protected by protecting mothers.  

Statistics for maternal mortality were not officially studied on a national level until 1925, when a report was commissioned by the federal government. It showed, that for adult women in Canada, childbirth was the second leading cause of death after tuberculosis. Postpartum complications were responsible for most of the childbirth deaths. While this was true for all Canadian women during this period, it was perhaps more the case for prairie women because of the challenges they faced in obtaining medical assistance. Statistics for maternal mortality were not collected in most Canadian provinces until 1921; Saskatchewan, however, began to gather maternal mortality statistics in 1914.

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which might be an indication of the seriousness of the problem. During that year 112 Saskatchewan women were reported to have died from maternity-related causes, but once again, due to the unreliability of the statistics, the number was probably much higher. The maternal mortality rate would continue to rise for several years in Saskatchewan and not significantly decline until well into the 1930s.67

The stories of mothers and babies dying, as well as the many children who were left motherless, had a profound impact on Violet McNaughton. She saw first-hand the terrible toll multiple births and endless physical labour took on too many farm women. McNaughton described them as “faded, physically overtaxed, mentally fatigued, and working almost automatically.”68 She writes: “The West is developing a type of woman that is not in keeping with her offer of progress. At first sight you place her age as 50, a second glance you think 45, and finally when you examine her closely you realize that she is not more than 35.”69 Because these women did not have the option to take it easy during their pregnancies, the hard work they had to endure often led to miscarriages.

McNaughton believed that governments had a responsibility to safeguard the health of the people and was determined to convince those in power of the real value of human life. In her opinion, governments put an inordinate emphasize on the economy and agricultural production, rather than on genuine human issues. McNaughton’s first step in the campaign was to inform the public of the seriousness of the problem and ask them to consider whether women and children should be considered less valuable than livestock and grain production.

68 Haight Papers A5 2, McNaughton to Zoa Haight, 13 March 1916.
69 Ibid.
She argued that it was the responsibility of the government to provide medical services for everyone, not just those in the cities. She stressed the urgent need for more hospitals, doctors and nurses in rural districts and that this should be paid for by the federal and provincial governments and by property taxes at the local level. She also believed that these much needed services should be controlled by the municipalities, not by politicians and bureaucrats hundreds of miles away.\textsuperscript{70}

McNaughton employed an effective strategy by forging alliances with some of the most influential organizations in Saskatchewan. In 1916 she spoke before the full convention of the Saskatchewan Grain Growers’ Association (SGGA) about the need for medical aid. By this point, McNaughton had already gained the support of many of the grassroots men at the district conventions that preceded the provincial SGGA convention. She was well received at the district conventions as the homesteaders, particularly in newly settled regions, were well aware of the need for medical aid. Sixteen district conventions passed motions endorsing McNaughton’s plan. By the time she gave her speech at the provincial convention she already had established a large base of support for her ideas and it was resolved that

\begin{quote}
Whereas through the scattered nature of settlements in new districts and the poverty of many new settlers, many lives are lost annually through the lack of proper medical and nursing attention, therefore, be it resolved, that this convention deems it advisable that the Provincial Government should take up the matter of providing adequate nursing and compulsory medical facilities for rural districts at public expense.\textsuperscript{71}
\end{quote}

With the passing of the motion the SGGA had committed itself to supporting McNaughton’s demands for compulsory medical aid in the rural districts.

\textsuperscript{70}Taylor, 389.
\textsuperscript{71}Minutes of the SGGA Annual Convention, February 1916 cited in Taylor, 395.
McNaughton’s next move was to form an alliance with the Saskatchewan Association of Rural Municipalities (SARM). At the 1916 SARM convention, she gave a speech addressing the medical aid problem on the prairies. She stressed the particular need for maternity care and quoted statistics from Dr. Rose’s 1914 report on Infant Mortality. She pointed out how

Under improved conditions for maternity at least fifty percent of lost babies could be saved and the province would be richer by 616 lives per annum. We can grow our own population were the means provided to take care of what we have….This matter will cost money. The Dominion Government spends huge sums on the conservation of natural resources. They issue a vast amount of literature on the subject, but no word concerning the greatest natural resource, our children.  

Following McNaughton’s speech, SARM passed a resolution calling for municipal hospitals throughout the province, in which several municipalities would cooperate by building a ‘union’ hospital.

With motions on the books by both the SGGA and SARM, McNaughton had successfully forged alliances with the two most powerful organizations in the province. She had their full support on the medical aid issue thereby putting a great deal of pressure on the Liberal government of the day. When these two organizations spoke, the government listened if they wanted to stay in power. After much effort, McNaughton and the WGG had finally succeeded in getting the government to act in regard to medical care. Later that year the Rural Municipalities Act was amended so that the services of a municipal doctor could be secured and his salary guaranteed by the Municipality for up to $1500 per annum. Another change to the Act stated that “the municipalities now have additional powers in providing for the appointment of a nurse for the municipality.

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72 “Prairie Farm and Home Edition” of the Regina Leader, 26 April 1916.
73 McNaughton Papers A1 E38, Resolutions of the SARM Convention in Regina, March 1916.
or granting aid to an organized society for securing services of such a nurse."74

Subsequently, the government also passed the Saskatchewan Municipal Hospital Act which provided that

Two or more rural municipalities may cooperate with one or more urban centres in the establishment of a municipal hospital. Each municipality concerned has the power to levy a rate not exceeding two mills on the dollar, on all assessable property within its borders, for hospital purposes.75

McNaughton had succeeded in arousing widespread interest on the issue of medical aid, and by cementing alliances with the SGGA and SARM was able to persuade the government to pass the aforementioned legislation. Now, she and the other members of the WGGA had to learn the skills necessary to mount campaigns to convince the people to contribute to their own health care. The first order of business was to educate farm people on the new legislation and how it worked. McNaughton believed that if farm people truly understood the new legislation they would be more inclined to approve the additional taxes to establish hospitals and procure medical staff.76

She began by writing several columns in the Saturday Press and Prairie Farm dedicated to the medical aid issue. In June 1916, just after the government passed the new laws, she asked her readers for a favour; "Will you make time to read, mark, learn and inwardly digest the following recent rural municipal enactments? Those referring to medical aid and district nurses should be noted by every club in the province."77 McNaughton would continue to keep her readers posted on any new developments regarding medical aid. The WGGA

74 Statutes of Saskatchewan 1916 (Regina, King’s Printer: 1916), 357-358.
75 David Grieve Tuckwell, “Helping to Solve a Prairie Problem”: How the People of the Western Provinces are Endeavouring to Provide Hospital Accommodation for their Rural Sick,” Canadian Medical Association Journal, Vol. 7, No. 9 (Sept. 1917), 800.
76 Taylor, 406.
had received so many letters and requests for information that in August, 1916 they decided to print a circular containing the required information to establish a union hospital. The pamphlet gave the arguments for building a hospital, the arguments for taxation for a hospital, and a plea for “justice for women and children.”\(^7\) At the provincial convention of the WGGA in 1917, McNaughton summarized the work that had been done in the last year on medical aid. She reported that:

Several men and women are engaged in promoting the scheme, but a great deal of educational work remains to be done before it is popular. The country is new; the idea of extra taxes, and local jealousy over the hospital site, too often mitigate against the success of the scheme.\(^7\)

Realizing that establishing union hospitals and acquiring medical personnel could take several years to accomplish, McNaughton began to consider more immediate solutions to the medical aid problem. She believed that a midwives act would save the lives of many Canadian mothers and babies and thereafter focused her attention on getting one passed. As she put it, “it appeared to provide for similar needs in England.”\(^8\) Great Britain had passed the State Midwives Act in 1902, in which an instructional program for midwives was established. Once certified, midwives could practice; however they were required to advise patients to call a doctor in for difficult cases.\(^9\) In Canada, no system of formal midwifery training existed as it did in England, where many district nurses were qualified both as nurses and as midwives. Canada did provide training in obstetrical nursing; however, maternity nurses were taught only how to assist a doctor, the training did not prepare or authorize them to

\(^7\)Taylor, 404.
\(^7\)SAB, pamphlet G35.1, Women’s Section, SGGA Yearbook 1917.
\(^8\)McNaughton Papers A1 E38, McNaughton to Mrs. R.J. McDonald, 20 May 1920.
\(^9\)Buckley, “Ladies or Midwives?” 133.
deliver babies on their own.\textsuperscript{82}

In 1916, McNaughton laid out her platform in a document entitled “A Plan to Secure Midwives for Sparsely Settled Districts.” The seven points of the plan were:

(1) The Need – The need is as great as it was twenty years ago.
(2) What Will Fill the Need – Strong women who are trained midwives and can also take charge of the household.
(3) Sources for Financing the Plan:
   (a) Federal aid for provinces who have not control of their natural resources.
   (b) Provincial aid for those that do control their resources.
   (c) Municipal aid.
   (d) Membership fees.
   (e) Nurses charges.
(4) Remuneration for Nurse – A minimum of $__ a month, board, uniform and laundry.
(5) Accommodation for Nurse – Probably the same as teachers of rural schools.
(6) Immediate Supply – Until we have the means of training our Canadian women the supply can be secured from Great Britain.
(7) Proposal for Training Canadian Women – Hospitals in the city where cases shall be treated free. These should be supported by the Government, as training schools for the care of child and mother just as agricultural colleges are supported to train those who care for stock.\textsuperscript{83}

McNaughton hoped to receive the support of Dr. Maurice Seymour, the Commissioner of Public Health for Saskatchewan. She had J.B. Musselman, the SGGA secretary, send Dr. Seymour a recently passed resolution from the WGGA asking the government to pass legislation “whereby women can qualify in midwifery, without undergoing hospital training.”\textsuperscript{84} Seymour replied to McNaughton’s request in an evasive way, claiming that the question of “providing assistance in maternity cases is at present time receiving attention, and it is

\textsuperscript{82}Beverly Boutilier, “Helpers or Heroines?” 34.
\textsuperscript{83}McNaughton Papers A1 E31, “Plan to Secure Midwives for Sparsely Settled Districts.”
\textsuperscript{84}McNaughton Papers A1 E31, M.M. Seymour to J.B. Musselman, 12 June 1915; Musselman to McNaughton, 19 June 1915.
hoped that a plan will be worked out in the near future.”85 In further correspondence to McNaughton that same year, Seymour advised that her letter regarding recognition of midwives had been passed on to the Medical Council of Saskatchewan, which had “the control of the practice of medicine which includes midwifery.”86 He chose to exclude the fact that he had established the Council himself. In the end, nothing came of it as Seymour and the medical profession was clearly more concerned with maintaining its position on top of the health care workers’ hierarchy than ensuring the safety of mothers and babies.

Despite Seymour’s apparent indifference to the matter, McNaughton continued to repeat her argument for midwives in her speaking engagements in an attempt to gain public support. To drive her point home, she would often quote statistics from Dr. Rose’s 1914 Report on infant and maternal mortality in Saskatchewan. Unlike Dr. Seymour and most of his contemporaries, Dr. Rose believed midwives would be of great value in the sparsely settled regions where health care was not yet available. He had previously written an article espousing the delivery of babies by handywomen, a term used to describe local untrained midwives in rural Saskatchewan.87

In 1917, acting in the professional self-interest of his department, Dr. Seymour, or a staff member, wrote to J.B. Musselman accusing McNaughton of “making statements which gave a false impression as to the infant mortality and the deaths of mothers in rural sections at the time of childbirth in the province.”88 The letter included statistics on infant mortality in the province during 1914, 1915 and 1916 and claimed the Department to be a higher authority than Dr. Rose in

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85 Ibid.
88 McNaughton Papers A1 E37, an undated letter from an unknown bureaucrat, very likely M.M. Seymour, to J.B. Musselman.
regard to provincial statistics. This was despite the fact that Dr. Rose had been the acting Assistant Commissioner of Public Health for the Province in 1913 while Seymour had been away. By sending the letter to Musselman, Seymour was attempting to go over McNaughton’s head in the hopes the SGGA would “rein her in.” However, McNaughton was not deterred and continued to fight for midwives in the province.89

The provincial government also rejected an offer to place trained British midwives temporarily in the province. In 1916, the Regina Council of Women received a letter from Lady Piggott, founder of the Colonial Nurses Association (CNA) of Great Britain, claiming she had heard distressing accounts of the mortality and grave difficulties experienced by young Canadian mothers during and after childbirth. She asked “if it was true as has been frequently stated that a large number of young mothers live so far from doctors or nurses or hospital help that there is not only a great deal of suffering experienced, but also the danger to life both for mother and child.” The Association, Piggott said, believed that because the Empire was experiencing so much loss of life during the War, “great importance should be placed on infant life.” She then inquired whether it was possible (or desirable) for the women of Great Britain to offer their help to the women of Canada. She proposed a scheme whereby “suitable women whose homes have been broken up by the war,” might be trained as midwives, who in return for such training would serve a two year tour in any part of the Empire their services were needed. She concluded by saying “it would be against the spirit of our race, if this difficulty once realized was not adequately met.”90

When the RCW passed the letter on to McNaughton she was very pleased

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89 Taylor, 428.  
90 McNaughton Papers A1 E37, Letter from Colonial Nursing Association to RCW, 24 July 1916.
with the offer and included it in her column in *The Saturday Press and Prairie Farm*.\(^{91}\) However, this practical solution proposed by Lady Piggott came to naught because there was no legislation permitting midwives to practice in the province and because George Langley, who was the Minister of Municipal Affairs (the department that oversaw the Bureau of Public Health,) opposed it. Langley responded to McNaughton’s letters with condescension by repeatedly pointing out her “misapprehension of the law” with regard to medical aid.\(^{92}\) As Dr. Seymour had done, Langley went over McNaughton’s head by using the central office of the SGGA to control McNaughton and the WGG. In a letter to SGGA Secretary J.B. Musselman, Langley explained why he did not want the Colonial Nursing Association sending women to Saskatchewan:

> Till now we have not encouraged the VON in this province, for the reason that in one or two cases where they were engaged they refused to submit to any authority, claiming that their headquarters were in Eastern Canada and the head of the Order located there was the only party from whom they would take instructions. Our experience in that instance makes me rather dubious in connection with an Order of nurses whose headquarters are in London, England….I am decidedly of the opinion that anything we do in these somewhat ticklish matters should be done by ourselves as a Provincial undertaking, so that in dealing with nurses working in our Province we should be able to speak with authority against which there could be no appeal.”\(^{93}\)

In other words, Langley would rather see the women of the province put at risk, than have nurses or midwives who would not submit to the authority of the provincial government.

Despite Langley’s attitude and the general antipathy towards midwives shown by the medical community, McNaughton believed the larger stumbling block faced by the WGGA was the Nurses’ Associations, which she saw as

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\(^{92}\) McNaughton Papers A1 E38, George Langley to McNaughton, 5 September 1916.

\(^{93}\) McNaughton Papers A1 E37, Letter to J.B. Musselman from George Langley 13 September 1916.
standing for “full class protection.” In 1916 McNaughton presented a brief on behalf of prairie farm women to a sub-committee of the Canadian National Association of Trained Nurses (CNATN) outlining the needs of prairie farm women with respect to maternity care. She proposed a scheme which incorporated the partnership of “strong women who are trained midwives and can also take charge of the household and district nurses, paid for by provincial and federal governments.” McNaughton told them of the offer she had received from the Colonial Nursing Association to send trained midwives to Saskatchewan. The executive of the CNATN acknowledged McNaughton’s insights and the deep impression she made on those at the meeting, however, they aligned with the medical community on the midwife issue. They believed in the doctor’s right to the delivery fee, and the right of nurses to assist during childbirth, neither of whom would do housework.

The executive of the CNATN were, however, not completely indifferent to the matter and resolved that a committee be appointed to work with the NCWC to find a solution to the lack of maternity care on the prairies. The subsequent meetings revealed a different emphasis from the nurses to that of the NCWC. While the NCWC focused on the lack of any kind of care for rural women, the nurses continued to emphasize the issue of unskilled care. One committee member suggested that it never occurred to Mrs. McNaughton that “the midwife would be perfectly helpless with nine-tenths of the cases that came her way.” Another member claimed that a graduate nurse “will not assume the responsibility of child-birth alone. That is what the midwife will do, and she is

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94 Ibid., McNaughton to Dowager Countess Grey, 6 January 1919.
95 McNaughton Papers A1 E72, McNaughton, “The Need of Nursing Care for Women on the Prairies.”
96 Langford, Childbirth on the Canadian Prairies 1880-1930, 290.
willing enough to assume the responsibility because she does not know the difference: it is ignorance on her part.”\(^{97}\) The nurses argued that if something was not done about the situation “more lives would continue to be lost by the inexperience and unskilled attention of midwives.”\(^{98}\) Midwives often became the scapegoat for the high infant and maternal mortality rates of the early twentieth century, despite the fact that there was no evidence to back that statement up.

In the end, the CNATN decided that its strategy would be to lobby provincial governments to provide small hospitals throughout the prairies where trained nurses would work in conjunction with doctors. Unlike the VON nurses who were willing to travel great distances in harsh conditions, many regular nurses refused. The CNATN could not see nurses making home visits into remote areas but agreed to supply nurses if suitable facilities were provided.\(^{99}\) They agreed to recommend to provincial associations to appoint a committee to lobby the government and to state through them that they would be willing to supply nurses if “they will supply the funds and get the hospitals ready.”\(^{100}\) Most nurses were not willing to threaten their economic well-being and professional status to help mitigate the high rates of infant and maternal mortality on the prairies.\(^{101}\)

Not all nursing organizations agreed with the position of the CNATN. Charlotte Hanington, who became Chief Superintendent of the VON in 1917, supported the introduction of midwives as a temporary measure and felt that the

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\(^{98}\) Buckley, “Ladies or Midwives?” 142.


\(^{100}\) Buckley, “Ladies or Midwives?” 144.

\(^{101}\) Ibid., 149.
scheme presented by the CNATN was not an adequate solution. Unlike most of the executive of the CNATN, she was well aware of how desperate the situation had become in Saskatchewan. During the last year of the war there were only three VON nurses working in the entire province, despite having requests for more from 12 districts. Hanington sympathized with the situation and explained to McNaughton how the war had created “a time of great national stress,” and that the VON was “utterly unable to cope with the calls for nurses.”

Hanington believed that prairie women deserved some help, even if it was not highly trained help, and in her opinion trained midwives were the only practical way of dealing with the problem.

Dr. Thomas Gibson, who had been instrumental in founding the VON and was now honourary secretary, agreed with Hanington. In a report to the board he included a reminder that the original reason for the existence of the VON was to serve the nursing needs of the sparsely settled districts of Canada. He explained how it was “quite probable that the obstetric needs of the West cannot be satisfied by small hospitals and regular district nurses, at least for many years to come.”

He cited the scarcity of trained nurses, the heavy demands put upon a nurse to serve all citizens in a district, and the difficulties mothers would experience in accessing a hospital because of her responsibilities on the farm.

In a speech given at an executive meeting of the NCWC, Hanington made a plea for trained midwives on the prairies.

What our mothers need is a woman with sufficient training to attend a normal case at birth, who understands the care of babies, and above all who will assume the mother’s household cares, allowing her to rest, and this must be at a fee the household can afford. The best visiting nurse

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102 McNaughton Papers A1 E37, Hanington to McNaughton, 24 June 1918.
103 Buckley, “Ladies or Midwives?” 146.
104 Ibid.
105 Ibid.
cannot meet this need, she never will, she cannot live in these settlers’ homes and she will not assume household chores...for the present, giving midwives proper education and state control, is the only practical way of dealing with this problem, having for its object the temporary safeguarding of helpless women and children.  

She was able to convince many members of the NCWC of the reasonableness of her argument for midwives; however, she, like McNaughton, came up against a brick wall when dealing with the nurses’ associations. But Hanington was not easily deterred and would become a great ally to McNaughton and the WGG in their campaign for better medical aid on the prairies.

Realizing that they were not getting anywhere with the midwife idea, Hanington and McNaughton began to shift their focus away from midwives toward nurses, or the lack thereof in Saskatchewan. During the war there was a scarcity of nurses to begin with, and finding ones who were willing to work in the harsh prairie conditions was almost impossible. Indeed, working conditions for nurses were so bad in remote areas that McNaughton had to resort to using evangelical and imperialist rhetoric in her attempts to attract them to the province. In an appeal to the Canadian Graduate Nurses Association she asked the nurses to be self-sacrificing and serve “the pioneer women of the Western Prairies, these lonely Daughters of the Empire.” What they needed, she said, were “practical women filled with missionary zeal, women of vision.” What they needed were nurses willing to travel long distances and work in very difficult conditions.

McNaughton knew what she was asking for was a tall order and sympathized with the difficult conditions prairie nurses were forced to work in.

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107 McNaughton Papers A1 E72, McNaughton, “The Need of Nursing Care for Women on the Prairies,” a brief presented to the Canadian Graduate Nurses Association.
108 Ibid.
This was evident in a letter she wrote to Lady Piggot of the Colonial Nursing Association who, unlike many others, was not prepared to give up on prairie women. When her midwife proposal was rejected she offered to send fully trained nurses to the province instead. McNaughton told Piggott she did not want to mislead nurses from Great Britain who were considering coming to the prairies and outlined some of the challenges maternity nurses would be facing:

Too often the house consists of one room; if the weather is severe the new baby must be born practically in the presence of the rest of the family. Too often there is no soft water. Sometimes both mother and child have to wait whilst efforts are made to procure soft water. Too often, if the nurse cannot do the maternity washing, it must change again until the washing is done. Too often it is impossible to get anyone to look after the rest of the family. The cooking etc. must all be done in one room with the patient. Too often the nurse has to contend with peculiar and unsanitary prejudices on the part of the patient and friends, particularly amongst the non-English speaking. Too often no doctor can be obtained. Too often there are no suitable utensils for nurses to use.109

Realizing such honesty was probably not helping her cause, McNaughton felt obliged to continue.

Added to these and other difficulties are journeys by ox wagon, stoneboat and every description of vehicle, in every kind of weather. In one case that I know personally, the husband drove forty miles, and in returning with the nurse found the river had risen. They were obliged to camp under the wagon, on the river bank for twenty four hours and when they reached their destination they found the mother very sick, with a dead infant beside her. When I first came, I heard a man extolling the virtues of a nurse they always had, because if necessary she would “muck the barn out,” i.e. clean the stable. That of course is an uncommon quality, but many strange conditions must be faced by a prairie nurse.110

In March 1919 McNaughton received a telegram informing her that the


110 Ibid.
lack of maternity care among settlers had led the Colonial Nursing Association, now the Overseas Nursing Association (ONA), to form a Dominions Committee, with the Dowager Countess Grey in the chair. This was the same Lady Grey who had initiated the Country District Nursing Scheme when she had been president of the VON. According to the telegram, the ONA was prepared to place three maternity nurses in Saskatchewan and would even pay the additional expenses not covered by their earnings. Once McNaughton had gotten approval to proceed from the WGG executive, she eagerly wrote to Countess Grey with the news. However, the nurses were never sent because, as McNaughton put it, “the proposition was not agreeable to the powers that be.” The “powers that be” probably included the Canadian Nurses’ Association and her old foe George Langley, who wanted absolute authority over any nurses working in Saskatchewan.

In 1919 at the annual meeting of the Canadian Nurses Association, Charlotte Hanington did her part by trying to convince the members that they need not be afraid of the prospect of British nurses coming to Canada. She assured them that they would be comparatively few in number, and equally important, they would not practice obstetrics unless it was “a case of absolute necessity and a matter of relieving their sisters in their hours of distress.” But once again, the Canadian nurses were unreceptive and objected to the idea. Despite their professed concern for the women on the prairies, they were more concerned about the risk of possible competition from British nurses.

The attitude of the nurses’ associations angered Hanington for she knew

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111 McNaughton Papers A1 E 37, Telegram from a representative of the Overseas Colonial Nursing Association to McNaughton, 6 March 1919.
112 McNaughton Papers A1 E38, McNaughton to Mrs. R.J. McDonald, 20 May 1920.
113 Charlotte Hanington cited in Buckley, “Ladies or Midwives?” 145.
114 Ibid.
that most Canadian nurses were antipathetic to both obstetrical cases and
working on the prairies. However, she did not give up, and having failed to win
the nurses’ support on importing maternity nurses from Britain, she thought she
would try another, more radical strategy. In an address to the NCWC, Hanington
appealed to nurses to challenge the monopoly that doctors had on obstetrics.

I have no hesitation in saying and I am sure every thinking nurse in
Canada will agree with me, that nurses are given a very inadequate
maternity training so far as the technique of delivery is concerned. We
are warned on no account to take a case without a doctor, and with our
training we are not likely to do so. The medical profession is responsible
for this condition. They do not fear the competition of the nurse in any
other department of the practice of medicine. Childbirth is a natural
process and with non-interference and cleanliness most mothers are
safely delivered. After that, rest and lack of worry for the mother and
simple care of the babe is all that is required.115

She continued: “It is to our shame that we give the safe keeping of half of our
child-bearing mothers into the hands of women who are ignorant and careless,
because they have had neither the training nor the necessary supervision.”116
She then tried one last-ditch effort time at revisiting the debate on legalizing
midwifery.

This time Hanington might have gone too far. Soon thereafter, Elizabeth
Smith Shortt, one of the few female doctors on the Executive of the NCWC,
stepped in and marshaled an all-out effort to end the midwife debate once and
for all. She dismissed midwives on economic grounds.

The trained midwife would only be available in sufficient numbers if she
were allowed to charge sufficiently large fees to ensure a good income.
If this were so, the majority of those now without trained service at time
of delivery would be still so because of the fact of the increased
charge.117

Kate Matheson, the first vice-president of the Canadian Nurses Association then

116 Ibid.
put forward the position of the Canadian Nurses Association:

The Canadian Nurses Association, which has a membership of 10 000 Registered Nurses in Canada and which is affiliated with the National Council of Women, is opposed to any scheme for the training and licensing of midwives in Canada....While people have been talking for years and years of the perils to mothers on the prairies, the Canadian Red Cross Society had been quietly working out a solution. During the last few years, in Alberta, Saskatchewan, Manitoba and Northern Ontario, Red Cross outposts have been established in outlying and sparsely settled districts far from doctors and nurses and even railroads.¹¹⁸

The NCWC accepted the findings of the Canadian Nurses Association that the solution to the maternity care problem on the prairies lay mainly in the Red Cross outpost hospitals and dissolved the committee on nursing. Hanington told McNaughton that the Canadian Nurses Association represented a central Canadian, urban, middle-class perspective which could not relate to prairie circumstances. She believed they put a higher priority on professionalization rather than Hanington’s idea of service. In 1924, when Hanington made a final plea to the NCWC for trained mid-wives on the prairies she was forced to resign. With her removal, Violet McNaughton and the WGGA lost a staunch ally in their campaign to bring medical aid to Saskatchewan farm women.¹¹⁹

The opposition from the nursing associations, the provincial government, and the medical profession effectively put an end to the midwife question in Saskatchewan and left many farm women without medical aid for several years to come. McNaughton summed up the question of midwives in a speech when she noted that “the law will not allow midwives to be acknowledged, but allows any woman, with or without experience, to practice with or without charging.”¹²⁰

As a result of the opposition from the nurses’ association and the medical associations, the opposition from the nursing associations, the provincial government, and the medical profession effectively put an end to the midwife question in Saskatchewan and left many farm women without medical aid for several years to come. McNaughton summed up the question of midwives in a speech when she noted that “the law will not allow midwives to be acknowledged, but allows any woman, with or without experience, to practice with or without charging.”¹²⁰

¹¹⁸ Ibid.
¹¹⁹ Taylor, 446.
¹²⁰ McNaughton Papers A1 E 72, McNaughton, “Municipal Nurses,” a speech, ca. 1916.
community, midwifery was not legalized in Saskatchewan until 1997.

Realizing that importing British midwives or nurses was not going to be an option, McNaughton and the WGG continued the fight to bring more Canadian nurses to Saskatchewan. McNaughton came to the conclusion that the only way they were going to get more nurses was by increasing the number of small hospitals. As a result, McNaughton and the WGGA concentrated their efforts on helping farm people attempt to organize municipal hospitals throughout the province. They pressured the government into make amendments to hospital legislation which made it easier for local people to establish union hospitals. By 1920 there were 10 union hospitals in operation, two more were almost complete, and twenty others were in the works. With more hospitals came more nurses and more doctors willing to set up practices in rural areas.121

Despite the many challenges along the way, Violet McNaughton never gave up on her mission to bring medical aid to prairie women. Although she was unable to get midwifery legalized in the province, due to the endless hours of hard work by McNaughton and the women of the WGGA, legislation was passed allowing for municipalities to hire nurses, doctors and establish union hospitals. They then made sure the public was aware of the newly passed legislation and worked hard to convince them to take advantage of it. The union hospitals were probably the most gratifying and tangible result of their campaign, and left the most enduring legacy.

121 Taylor, 456-457.
Chapter Four – The Government Response

The state refuses to accept its full responsibility in this matter. The full protection of all bodies engaged in Public Health work and all their resources should be thrown about the women of this country who are bringing to the nation the gift of life.

Charlotte Hanington, 1919

The infant mortality movement of the early twentieth century in Saskatchewan must be viewed within the context of international developments in medicine and the evolution of public health as one of the essential services of the modern industrial state. New scientific discoveries in Europe, particularly in bacteriology and the preventive concept in medicine, ushered in a new era in health services aimed primarily at controlling the spread of communicable diseases. These developments led to a public health movement which spread from Great Britain to Eastern Canada and eventually to the prairie region.

The government of Saskatchewan essentially followed Ontario’s lead in the area of public health. Much of Ontario’s experimentation with public health occurred during the settlement period in Saskatchewan, therefore it, more than any other province in Canada, had accumulated the experience necessary in health care methods and enacting legislation. In 1884, a new Public Health Act, modeled largely after the British Act of 1875, was passed by the Ontario provincial government. It compelled all municipalities to appoint health boards, whose power and responsibility in regard to the prevention of disease were clearly defined. According to Cynthia Comacchio, this was the most important piece of public health legislation passed in Canada because it motivated the enactment of similar legislation in the other provinces and gave Ontario a pre-eminent role in the establishment of public health in the country.¹

Under the British North America Act, the provinces and municipalities

¹Cynthia Comacchio, Nations Are Built of Babies, 27.
were assigned exclusive jurisdiction over health and welfare. The fact that the fathers of Confederation failed to recognize the health of the population as a national responsibility is not surprising considering the public health movement was in its infancy in 1867. As a result, the Act made little specific provision for public health matters apart from giving the provinces exclusive rights to legislate in regard to hospitals, asylums, and similar institutions. This put Saskatchewan and Alberta at a distinct disadvantage as they only became provinces in 1905. In addition, when the Autonomy Bills became law, the legislation gave the federal government continued control over western lands and resources, severely limiting the provinces’ ability to provide necessary services such as health care. This resulted in a slower development of health services in Saskatchewan, as compared to other services. The establishment and continued maintenance of a hospital, for example, was much more costly than that of a church or school. At the turn of the twentieth century there were only two hospitals in what would become Saskatchewan, each with seven beds to serve approximately 90,000 people. When Saskatchewan became a province in 1905 there were six hospitals in operation to serve over 250,000 people. The great majority of doctors at the time were private practitioners, most of whom were attracted to the larger towns and cities. In 1894, only 36 doctors gave their address as being in the area now Saskatchewan. In other words, medical care in the early settlement period was virtually nonexistent. As one homesteader described it; “If

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you got sick you either had to get well or die.”

Saskatchewan’s first provincial election was won by Liberal leader Walter Scott. The Scott government was tasked with the responsibility of bringing order and structure to a largely rural community scattered over thousands of square miles. In 1906 over 80 percent of Saskatchewan’s population was rural. In 1907 the Municipal Commission was established to examine the best way of delivering a system of local self-government to the province’s disparate settlements. The Commission recommended that nine-township rural municipalities be created with broad local powers and a uniform rate of land taxation. This system was incorporated into the Rural Municipality Act of 1908-1909, under which a Department of Municipal Affairs was established to oversee it. By 1912 nearly three hundred rural municipalities had been organized throughout the province. This structure of local government exists in Saskatchewan to this day.

Initially, public health in Saskatchewan had a low profile as a mere branch within the large and powerful Department of Agriculture, and then within Municipal Affairs. The lack of administrative machinery and the existence of only rudimentary health legislation complicated and delayed the ability of the government to provide public health to the province. In order to extend health services, health legislation first had to be devised and then enacted by the provincial legislature, a process which takes time. Ontario served as the model in regard to both administrative organization and health legislation.

In 1906, Dr. Maurice M. Seymour was appointed as the first Provincial Health Officer of Saskatchewan. He had obtained his medical degree from

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5Foam Lake Historical Society, They Came From Many Lands: A History of Foam Lake and Area (Foam Lake: 1985), 53.
7C. Stuart Houston, Steps on the Road to Medicare, 21-22.
McGill University in 1879 and was one of the first physicians in Canada to receive a diploma in public health from the University of Toronto. Seymour was determined to start public health in the province on a sound and scientific basis, and as such, he spent his first year as Provincial Health Officer travelling to cities across North America for the purpose of studying issues relating to public health, hospital construction and hospital management. By visiting boards of health in Toronto, Detroit, Chicago, New York, and Philadelphia, Dr. Seymour was able to acquire the necessary scientific and practical information that would have taken a very long time to acquire in any other way. He claimed that as a result of his travels, he felt “very much better prepared to deal with the many difficult questions relating to public health and sanitation in Saskatchewan.”

Dr. Seymour would spend the rest of his professional life in charge of public health in the new province.

The Public Health Act was passed in 1909, establishing the Bureau of Public Health under the Honourable George Langley, Minister of Municipal Affairs. Dr. Seymour became the Commissioner of Public Health for the province of Saskatchewan. As a preparatory step it was imperative to organize the rural municipalities into health districts, with its council constituting a health board, with a medical practitioner as medical officer of health with full responsibility for the enforcement of health regulations. The activities of the local health units were directed and coordinated by the Bureau, which also acted in advisory and supervisory capacities as well as providing a clearing-house for all health-related issues. In addition, Seymour organized a Council of Public Health for the purpose of considering and reviewing rules and regulations pertaining to public health.

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health. By 1910 regulations were in force for the control and notification of communicable disease and for the improvement of sanitation throughout the province.\textsuperscript{10}

In his initial years as Public Health Officer, Dr. Seymour laid a solid foundation for the development of public health in Saskatchewan. Once that was accomplished, much of his time and energy was devoted to the amelioration of tuberculosis, one of the biggest public health problems of the early twentieth century. Because his own son had contracted tuberculosis, Seymour had a personal stake in learning as much as he could about treating the disease and controlling its spread. In 1908, he attended the International Congress on Tuberculosis in Washington D.C. On his return he noted that his attendance at the congress "evoked an enthusiasm in the anti-tuberculosis movement as nothing else could."\textsuperscript{11} For the next several years, Seymour was consumed with educating the public on the nature of the disease, building a sanatorium for people with advanced cases, and organizing anti-tuberculosis leagues from one end of the province to the other. He claimed in his annual report for 1908 that "the mortality from tuberculosis is a problem compared with which all other social problems of a medical character sink into insignificance."\textsuperscript{12}

Seymour’s preoccupation with fighting tuberculosis did not leave a lot of time to concentrate on other public health concerns such as infant and maternal mortality, despite the fact that they too presented significant problems. According to a report on maternal mortality prepared by the federal government in 1925, maternity followed only tuberculosis as the leading cause of death for

\textsuperscript{11}Dr. Maurice M. Seymour, \textit{Annual Report for the Division of Public Health for the Province of Saskatchewan 1908}, 224.
\textsuperscript{12}Ibid., 226.
adult women in Canada in the first three decades of the twentieth century.\textsuperscript{13} However, due to the unreliability of statistics during this period, it is possible that maternal mortality due to pregnancy was higher than mortality from tuberculosis in some areas, particularly among prairie women who had no access to medical care. Today, most births take place in hospitals, making registration a routine matter. During the settlement period, however, most births took place in homes and were often not officially registered. It is estimated that figures on infant and maternal mortality were underreported by as much as 25 per cent in the early twentieth century.\textsuperscript{14}

Medical interest in childbirth developed as part of a larger transformation of childbirth from a social event managed by women in the home, to a medical event managed by doctors in a hospital. This process was accompanied by a transfer of control from untrained women to male professionals. The stimulus for this move came from the medical profession who began to view childbirth as a potentially life threatening event and concluded that women should deliver in hospitals to ensure the best possible treatment to protect both mother and child.\textsuperscript{15} This transition from homebirths to hospital births had only just begun in the early twentieth century. It is therefore not surprising for Dr. Seymour to have discovered that some hospitals in the province had not taken in a single maternity case in 1908. He notes in the annual report for that year that:

The matron of one hospital informed me that such cases were not admitted, it being against their rules. If there is one class of patients that government aided hospitals should make room and care for, it is maternity cases. These women should be made to know that one of the principal reasons why the government aids hospitals so liberally is that a


\textsuperscript{14}Wendy Mitchinson, \textit{Giving Birth in Canada}, 261.

place may be provided where they can come to, and receive such medical care and nursing as they and their children require at that important time.\textsuperscript{16}

Marion Cran made a similar comment in regard to the reluctance of hospitals to take maternity cases in the early part of the century; “the general hospitals are in nearly every instance averse to maternity wards. They say, and quite justly, that maternity work should have a separate building and staff.”\textsuperscript{17} At this time hospitals were not required to make special provision for the care and treatment of maternity cases. That would change over the next few years when the Bureau of Public Health enacted hospital regulations requiring one-tenth of the total bed capacity of hospitals to be set aside for maternity cases.\textsuperscript{18} But women had been giving birth at home since the beginning of time; therefore the hospitalization of childbirth was not something that was going to happen overnight. According to statistics, in 1912 only one in twenty births in the province occurred in a hospital. This number would increase to one in six hospital births by 1924.\textsuperscript{19} It would not be until after World War Two, however, that hospital births would really start to dominate in Saskatchewan.

Therefore, the first mention made by Dr. Seymour in regard to childbirth in the province was in his annual report for 1908, in which he urged women to give birth in a hospital and for hospitals to make provision for the care of maternity patients. He then went on to say; “Think of the number of women in this province living where it is impossible for them to secure the services of a doctor and

\textsuperscript{16}\textsuperscript{16}Seymour, \textit{Annual Report of the Division of Public Health for the Province of Saskatchewan 1908}, 218.
\textsuperscript{17}Cran, A Woman in Canada, 252.
\textsuperscript{18}Seymour, \textit{Annual Report for the Bureau of Public Health for the Province of Saskatchewan, 1911}.
\textsuperscript{19}Seymour, \textit{Annual Report of the Department of Public Health for the Province of Saskatchewan, 1924}. 
nurse!" So in the same breath that Seymour declared women should be giving birth in a hospital, he acknowledged the fact that it was impossible for most of them to do so. His contradictory comments reveal that he was aware there was a problem in relation to childbirth early on, but made no attempt at offering a real solution at this time.

**Ontario Leads the Way**

The rise of medical professionalization and specialization in the early twentieth century was a trend that greatly contributed to medical dominance in the child welfare movement. By 1912 Canadian doctors had obtained enough assistance from the state to allow for considerable professional power. That year, a spokesman for the Canadian Medical Association asserted that:

> Organized medicine should use every legitimate means in its power to enable it to speak with truth and with authority on all matters pertaining to the physical well being of the people. More importantly, physicians should assume the full responsibility of leadership in public health.  

At the same time, pediatrics was establishing itself as a legitimate specialty within the profession. Despite their small numbers, (in 1914 there were only two pediatric specialists in Toronto), the pediatricians’ express interest in the conservation and improvement of child life made them natural leaders in the child welfare campaign. Dr. Alan Brown was the pre-eminent Canadian pediatrician in the early twentieth century and one of the leaders in the infant welfare movement in Canada. Ontario was the first province to establish a child welfare division as part of its Board of Health and Dr. Brown was the Director of that division for the city of Toronto. He claimed that pediatricians must “maintain leadership in all matters pertaining to problems of child life and should rightfully represent the

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highest authority in this area.” Brown also believed that the most important function of the pediatric specialist was “his sphere of influence on child care as a whole throughout the country.”

Public health departments across Canada increasingly relied upon the expertise of specialists, particularly those such as Brown who were affiliated with major children’s hospitals and health departments. Their research findings, which were published in medical journals and presented at conferences, formed the basis of child welfare initiatives during this period and much of the advice literature on infant mortality.

At the beginning of the twentieth century it was becoming increasingly apparent to health care specialists that the foremost threat to children occurred during the first year of life and was due primarily to common intestinal disorders, the most prevalent being cholera infantum, later redefined as gastroenteritis. Also known as the filth disease or ‘summer’ diarrhoea, cholera infantum killed thousands of babies every year, and occurred predominantly in the summer months. The disease was likely bacterial or viral in origin and was transmitted by unclean hands, linen or bottles, or through contaminated milk, water or food.

Canadian physicians kept abreast of international studies on infant mortality and contributed their own findings. The best known and most cited Canadian research was Dr. Helen MacMurchy’s series of infant mortality reports in which she closely examined the reasons why nearly seven thousand infants died in Ontario in 1909. In her report, she pinpointed the three leading causes of infant mortality as prematurity and congenital debility, intestinal disorders and respiratory diseases but placed particular emphasis on intestinal disorders.

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24. Meckel, Save the Babies, 42.
Most of the leaders in the child welfare movement in Canada favoured a combined approach that incorporated both environmentalism and hereditarianism. Until the beginning of the twentieth century, the popular belief was that premature or stillborn babies were not ‘proper’ babies, or were ‘unfit.’ As Dr. C.A. Hodgetts explained, these babies “have survived the intra-uterine period of life, but find the extra-uterine conditions too severe for their separate existence.”

Dr. Hodgetts was the medical advisor to the Commission of Conservation which was established by Laurier’s government in 1909. Included in the Commission’s roster was the National Council of Health, which would act in an advisory capacity to federal and provincial governments. Hodgetts believed there was a strong environmental component to infant mortality and claimed that “it is quite probable that more of such infants are to be found among people of the poorer classes than among those of the well-to-do; those where the environment of the mother and child is such as, under ordinary conditions would tend to favour life rather than cause a premature death.” Dr. Brown probably best expressed the combined hereditarian/environmentalist approach by declaring that “infant mortality should not be a question of the survival of the fittest, for it is our task to see that every baby is made fit.”

Hodgetts presented an analysis of infant mortality in Canada in the *Canadian Medical Association Journal* in 1911, its first year in publication. Drawing extensively from British studies into the leading causes of infant death, he reported that intestinal disorders, primarily cholera infantum, accounted for the largest number of deaths deemed preventable. Citing Dr. Arthur Newsholme, the

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27 Ibid.
28 Ibid.
medical officer of public health in Great Britain, he noted the predisposing factors of poor housing conditions, contaminated soil, seasonal heat, and feeding practices, especially the use of cow’s milk. Hodgetts concluded that Newsholme’s findings “would in the main be substantiated for Canada.” He asserted “the leading British authority had laid down the following dicta, which cannot be impressed too strongly upon the medical profession of Canada: epidemic diarrhoea is chiefly a disease of urban life, as a fatal disease it is a disease of the artisan and still more of the lower laboring classes.”

Yet, while Hodgetts agreed with the class basis of infant mortality, he denied that poverty was as important a factor in Canada as it was in Great Britain. He suggested that the high infant mortality rate here was largely a question of social status rather than poverty. In other words, it was not so much the environment that had to be changed as the behaviours of the parents. Alcoholism, poor feeding, unclean living environments, women working outside the home, and parental ignorance were all listed as causes of infant death. Hodgetts claimed “ignorance of parental duties is a great and growing evil, one which must be met by a better and broader education in all that relates to the child and child life.”

Dr. MacMurchy also viewed infant mortality as a “class-mortality,” and like Hodgetts, emphasized the limits of environmental reform in a way that led her to blame the victims. By suggesting that class was the primary cause of infant mortality, while at the same time downplaying poverty, MacMurchy implied a sort of willful neglect on the part of the parents that seemingly had nothing to do with money. In her mind, knowledge and cleanliness were within the reach of even the poorest households and the victims needed to be aware of their share of the

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29 Ibid.
30 Ibid., 725.
She believed that it was up to society and the state to make people understand that they were personally responsible for improving their own health and that of their children.\textsuperscript{32}

Several subsequent studies on infant mortality would repeat this same confused logic that recognized the link between infant mortality and the lower classes but steadfastly refused to see poverty itself as a primary cause. As a result, doctors overwhelmingly adopted and maintained the position that maternal ignorance was the fundamental cause of infant mortality, the alleviation of which could only be effected through mass education. First they had to educate the public in order to inform and motivate action; secondly, and more importantly, they had to educate mothers in the care and feeding of their children. And this education was to be designed and conducted exclusively by medical professionals.

Ontario physicians took the lead in the infant mortality movement in Canada because there was no federal department of health for the first two decades of the twentieth century. The Canadian Medical Association had been calling for a dominion health department since its inception in 1867 but these pleas went unheeded until 1919. The federal Department of Health established that year was intended to cooperate with the provincial health authorities and provide leadership. In 1920, a separate Child Welfare Division was created under the direction of Dr. Helen MacMurchy. Its purpose was “to assist in cooperative activities, coordination and education, and to study problems pertinent to the field.”\textsuperscript{33} This prompted a massive government campaign to educate women in the complex art of motherhood. Mothers were inundated with

\textsuperscript{31}Comacchio, \textit{Nations are Built of Babies}, 42.
\textsuperscript{32}Ibid., 19, 41.
\textsuperscript{33}Ibid., 26.
advice manuals documenting appropriate maternal behavior, covering every aspect of motherhood in meticulous detail. Through films, lectures, and especially through the production of pamphlets and booklets, the federal government’s Division of Child Welfare sought to teach women the skills of being a mother. The first publication produced by the division was *The Canadian Mother’s Book*. This publication went into six editions, and approximately 800,000 copies had been distributed to mothers across the country by 1933. In addition to the Canadian Mother’s Book, the Division of Child Welfare produced a series of booklets which came to be known as the ‘Little Blue Books.’ This infant and child care literature was distributed at summer exhibitions and by public health nurses during the course of their work in well-baby clinics and home nursing classes.

A significant component of the maternal education program involved convincing women of the importance of breastfeeding. Dr. MacMurchy insisted that “it must be made known and thoroughly taught and impressed upon everyone, that the great and most effectual and important means of lessening infant mortality, is that the baby should be nursed by the mother. If the baby is fed in any other way the chances are great that it will die.” Dr. Alan Brown, director of the Division of Child Hygiene for the Department of Public Health in Toronto also claimed that that the “method of feeding is the most potent single factor influencing the fate of the newborn child.” He said that there was no good substitute for mother’s milk and that the onus was on the physician to

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35 Ibid., 40, 52.
inform mothers of this fact, and not just working-class mothers. Women of every class were considered to be ignorant in varying degrees and all would benefit from medically supervised instruction. Thus, educating women became the basis of much of the work in maternal and child welfare in the 1920s.

**Dr. Seymour’s Plan to Fight Infant and Maternal Mortality**

The first time Saskatchewan’s public health commissioner mentioned infant mortality was in the annual reports for 1909 and 1910 in which he declared that “hundreds of thousands of babies die annually from diseases that are the direct result of improper feeding, and most of these deaths are absolutely preventable, which fact places the responsibility upon the parents.” Seymour made specific reference to cholera infantum and how the highest rate occurred in children under 12 months from being fed impure milk. He also noted that “women’s milk is unquestionably the best food for the baby for almost the first year.”

So it appears that Seymour simply followed Ontario’s lead in fighting infant mortality despite the fact that cholera infantum was clearly defined as an urban disease most prevalent in the working class districts of large cities. Intestinal epidemics such as these were virtually non-existent in rural areas and, at the time, over eighty percent of Saskatchewan’s population was rural. That is not to say that babies did not die of intestinal disease in Saskatchewan, they did; however, it did not constitute a high percentage of infant deaths in the province. According to Dr. Rose’s report on infant mortality, in the year 1914 infant mortality was in the annual reports for 1909 and 1910 in which he declared that “hundreds of thousands of babies die annually from diseases that are the direct result of improper feeding, and most of these deaths are absolutely preventable, which fact places the responsibility upon the parents.”

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mortality due to digestive disorders ranked 7th among possible causes.41

The first mention of maternal mortality appeared in the annual report for 1913 which stated:

Female diseases and disorders - 469 cases that may be put down as being largely due to improper surroundings, want of adequate care and attention or careless treatment during childbirth. These constitute a strong plea for the necessity of the adoption of some measures that would eliminate needless suffering amongst the women of the province, and endless expenditure in families afflicted with sick mothers.42

This implies an awareness by public health officials that the real problem in relation to maternal mortality in Saskatchewan was inaccessibility to medical care. When these comments were made in 1913, Dr. John A. Rose was acting Assistant Commissioner for the Bureau of Public Health. His subsequent report on infant mortality in Saskatchewan which also refers to the high maternal mortality rates in the province, suggests that he was more concerned about the high infant and maternal mortality rates in the province than perhaps his contemporaries were. In addition, Dr. Seymour had by this time gained quite a reputation in the field of public health, not only in Canada, but internationally. He was elected as President of the Canadian Public Health Association for the year 1913-1914 and in 1915 he served as vice-president of the American Public Health Association.43 During these years, infant and maternal mortality may not have been at the top of his list of concerns considering his responsibilities to these other organizations. He was also still very involved with the prevention and treatment of tuberculosis at this time.

In the 1914 annual report of the Bureau of Public Health, a great deal more focus was placed on infant mortality than at any time previously. It was

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43Houston, Steps on the Road to Medicare, 25.
also the first year that there was a separate section specifically dealing with infant mortality. It began by reporting that the greatest loss of infants occurred during the first month of life and that:

The education of the mother will be the principal factor in the reduction of this human waste. She should be taught the importance and value of breastfeeding, if this be impossible she should than be given definite reliable information as to the best methods of artificial feeding, including the nature of food and its preparation, and the amount and the time when it should be given. The danger from flies and heat should also be made clear.”

It further stated that “the belief has been rather general that women by instinct know how to manage babies. That this is not the case, the large mortality among infants is proof.” So, like the leaders in the child welfare campaign in Ontario, public health officials in Saskatchewan blamed the mother for the high infant mortality rate and recommended maternal education as the primary solution. This strategy, however, was directed at diminishing deaths due to intestinal diseases, which had already been determined was the cause of only a small proportion of infant deaths in the province.

The annual report also noted, however, that a large proportion of infant deaths in the province occurred in rural areas and pointed to the lack of skilled physicians in attendance during birth as the reason why. Doctors continued to argue that having the baby in a hospital was the most practical and efficient solution to the problem. However, there were still very few hospitals in Saskatchewan during this period, especially in the rural areas. So, in the meantime, the Bureau of Public Health introduced a maternity grant system for mothers in remote areas or in financial need. The basic idea was to make it

44 Annual Report of the Bureau of Public Health for the Province of Saskatchewan 1914, 44.
45 Ibid., 46.
46 Ibid., 107.
possible for the mother to secure medical attention during childbirth. The grant of $25 was to assist in the preparation for confinement, a portion to go to the mother and a larger portion to the doctor who would attend her. The portion allowed for the doctor was not intended as his full fee but rather his out-of-pocket expenditures if he made a long trip. The part allotted to the mother was to be used to buy necessities for the baby. To qualify for the grant the mother had to be remote from a doctor and/or for financial reasons unable to secure the necessary medical attendance during confinement. Applications were to be made to the Commissioner of Public Health through the registrar of births, marriages and deaths of the district, who must recommend the application before it being acted upon. The Order-in-Council which provided for the grant was signed in 1921 but reports indicate that its provisions had been in effect since at least 1914, and possibly even as early as 1910. The grant was, essentially, medical relief for maternity cases and, as such, was groundbreaking legislation in Canada. How many women actually took advantage of the grant, or even knew of its existence, is hard to say. The earliest statistics are from 1921 and indicate that 206 grants were given that year. By 1925, 496 mothers received the maternity grant. However, considering the thousands of births which occurred in any given year, it is hard to imagine the grant had any effect on the high infant and maternal mortality rates in the province at the time.

The 1914 report also referred to the fact that the greatest number of infant deaths in Saskatchewan, occurred within the first week of life. Congenital debility alone was the cause of thirty six percent of infant deaths in that year. Congenital

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debility is an old term, referring to premature birth and full-term birth of underdeveloped babies. These babies were born with a definite condition of weakness which is why so many died within the first twenty-four hours after birth. At the turn of the century, the medical profession focused its campaign on intestinal and respiratory diseases because prematurity and congenital debility were still believed to result from hereditary causes outside medical control, although they accounted for the majority of infant deaths. As the child welfare campaign progressed, some doctors began to question this axiom. Dr. Rose was one of those doctors. In his 1914 report on infant mortality he stated:

While in England one fifth of the deaths during the first year of life occur during the first week. In Saskatchewan, instead of being considerably less, the figure is very much higher. Taking the children which actually lived it reaches one third (and were stillborns included in nearly half) of those which were lost in the first year were so in the first week of life. Rose listed the top ten causes of infant mortality in Saskatchewan as:

1) Stillborn
2) Diseases of early infancy, e.g. premature birth, congenital debility, etc.
3) Ill-defined Causes
4) Malformation
5) Diseases of the nervous system
6) General diseases including Genito-urinary diseases
7) Diseases of the digestive system
8) Diseases of respiration
9) Diseases of circulation
10) Affections induced by external causes

He went on to state that the infant mortality rate in Saskatchewan was 74.81 per thousand, although he added that the reporting of infant deaths were far short of what it should be and that the actual rate was probably much higher. He then compared Saskatchewan’s rate to England’s infant mortality rate in 1910 of 106

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49 Marie Stringer Buchler, “The Premature Baby,” The British Journal of Nursing (July 1938), 188.
per thousand and London’s of 103 per thousand. He claimed that “Saskatchewan’s rate was not very far behind that of London, a city containing the worst slums in the world. We, on the other hand are in a new and clean country. The main causes do not operate here in the West.”\textsuperscript{51} He cited the main contributory causes of infant mortality as: urban conditions, industrial employment of women, poverty, domestic insanitation and maternal ignorance and mismanagement. The only cause applicable to Saskatchewan was maternal ignorance and mismanagement. “That we do have on both sides of the water,” Rose conceded, “but it is probably no greater, if as great, as in England and it is therefore insufficient in itself to account for the high infant mortality rate.”\textsuperscript{52}

The statistics did not add up in Rose’s mind, prompting him to question why. He stated:

We have none of the urban conditions and industrial employment of women and although there may be individual cases of poverty and domestic insanitation neither do we have these in the concentrated and widespread degree of the mother country. We have therefore to look for exceptional causes for the abnormally high death rate among Saskatchewan infants when compared with peoples and countries such as these. The facts alone point to the health of the mothers and inefficient maternity being vital causes of infant death.\textsuperscript{53}

Rose went on to list what he believed to be the best means of preserving infant life:

1) Skillful aid at birth
2) Good health of the mother
3) Education of elder girls and mothers
4) Maternal care
5) Breast-feeding
6) Cleanliness in all respects

He also voiced his concerns about the high maternal mortality rate in the

\textsuperscript{51}\textit{Ibid.}
\textsuperscript{52}\textit{Ibid.}, 3-4.
\textsuperscript{53}\textit{Ibid.}, 1.
province and how that translated into infant deaths.

104 women die in one year from childbirth, and were the truth known nearly double that number; that one woman in every three delivered of a child, is materially injured in her chief function in a new country rendered liable to bear immature, unhealthy and diseased children. It might well be said that under improved conditions for maternity at least fifty percent of lost babies would be saved. Skilful aid at birth, is a crying necessity, to ensure which, maternity must be subsidized and the wards of the state, the newborn, protected by protecting the mothers. The government may or may not be prepared to aid by measures of this description.\textsuperscript{54}

This is the first time that the health of the mother was suggested as a primary cause of infant mortality and that prenatal care was offered as the solution. In this regard, Rose was ahead of most of his Canadian colleagues, who had been for years preoccupied with the prevention of infant death to digestive disorders such as cholera infantum. There were signs of growing medical interest in maternal welfare and prenatal supervision during World War One but it did not become part of the official policy in the infant welfare campaign in Canada until after the war. It was then that the child welfare campaign became synonymous with the health and well-being of both mother and child. Once the medical profession accepted that the spheres of child and maternal mortality were inseparable, education became even more important.\textsuperscript{55}

The 1914 annual report of the Bureau of Public Health does mention prenatal care for the first time as a means of reducing infant mortality. It stated that the number of deaths occurring in the first week of life indicated that proper care was not being given to mothers during pregnancy. It therefore recommended that a woman see a doctor as soon as she suspected that she may be pregnant and that the expectant mother be instructed as to personal

\textsuperscript{54}\textit{Ibid.}, 4-5.
\textsuperscript{55}\textit{Comacchio, Nations are Built of Babies}, 65, 67, 91.
hygiene in diets, baths, clothing, fresh air, sleep and exercise. It went on to say that if the high infant mortality rate was going to be reduced, reform must begin now. The fact that this information on prenatal care was provided in the report makes one wonder if Dr. Rose was still Acting Commissioner at this point. It is unclear whether he was or not; however, we do know that Dr. Seymour was still serving as president of the Canadian Public Health Association during this year.

For the years 1915 and 1916 more emphasis was placed on prenatal care as a way to lower the infant mortality rate. The cause of the greatest number of deaths under one year of age was once again congenital debility which, according to the report, was an indication that mothers were not in good physical condition during pregnancy. It stated:

An overworked, ill-nourished mother cannot possibly give birth to a strong child with the power to resist the dangers of early life. It is very essential that a pregnant woman secure the necessary amount of rest and avoid heavy work, especially during the late months.56

This was simply not an option for most homestead women who were often pregnant for much of their reproductive lives. A woman’s day-to-day hard work was essential to the success of the farm.

Maternal education was still the main focus of the infant welfare program in Saskatchewan. Great stress was placed on the importance of breastfeeding as a way to ward off diseases of the digestive system. It was made clear that mothers were to blame for infant deaths from these diseases pointing to improper feeding and neglect on the part of mothers to nurse their children.57 Most farm women during the settlement period could not take the time to breastfeed their babies because there was too much work to be done. Homesteader Doris Kewley talks about the difficulties involved with breastfeeding at the time, “As

57 Ibid.
soon as I was up I went back to work and had to put my baby on the bottle. This happened with all my children. On the farm in those days, there was no time to loaf or take it easy.”58

Farm women could, however, benefit from education on hygienic methods in artificial feeding and being informed of the dangers of childhood diseases. As early as 1916, the Bureau of Public Health organized child welfare conferences and baby clinics to be held in conjunction with local exhibitions. The first of these conferences was held at the Regina Exhibition in the summer of 1916 and was advertised in the Regina Leader as follows:

A baby show and babies’ welfare conference will be held during the Exhibition under the direction of Dr. M.M. Seymour, Commissioner of Public Health...Parents from all over the province are invited to bring their children to this conference and enter them in the various competitions. Dr. Seymour has arranged for ten classes in which a total of $220 is offered in prize money. Outstanding physicians and nurses from all over the province will be present to deliver lectures and demonstrations on how to care for the baby.59

Dr. Seymour is quoted as saying that “The infant mortality of the province could be greatly reduced through a systematic educational campaign.”60

At the conference babies and their progress were evaluated by score card approved by the American Medical Association. The tests were: (a) Mental development, (b) Measurements, (c) Physical examination (d) Eye, ear, nose and throat examination. Eminent doctors from across the province gave lectures on topics such as infant feeding, weaning and teething, and diseases of infancy. These lectures were later printed in full in the Evening Province. Public health nurses gave instructions and demonstrations on the care and feeding of infants and children and literature relating to child welfare was distributed free of

58 Letter to author from Geraldine Procychyn dated 6 November 2010.
59 The Leader, 22 July 1916, 25.
60 Ibid.
The Regina Leader reported the baby conference to be a great success with many in attendance. Dr. Seymour was quoted in headline type proclaiming the conference to be “The Finest Baby Show ever held in Canada.”62 A second conference was held that summer in Weyburn, also in connection with its Exhibition. Posters were displayed at the Exhibition Grounds and several doctors including Dr. Seymour gave lectures. The following year the conference was repeated in Regina and one was held in Midale. At these conferences, children up to five years of age were given a thorough physical examination and any defects requiring attention were brought to the notice of parents. In 1918 exhibits were displayed and conferences conducted by members of the Bureau staff at North Battleford, Creelman and Midale; at other points, exhibits were lent and instruction and assistance given to local societies organizing the work.63 By 1925 Dr. Seymour reported that the work in connection with child health had grown enormously in the province. He stated:

Within the last few years all parts of Saskatchewan have been covered by baby clinics, special attention being given to outlying districts far from qualified medical assistance. This work has been very much appreciated, with the result that a number of districts have now child welfare clinics held regularly under the supervision of the local physician.64

In 1919 the Bureau of Public Health appointed three public health nurses to organize and conduct home nursing classes primarily for the benefit of those living in rural areas. The classes were organized through the cooperation of various women’s organizations such as the Homemakers’ Clubs, the Saskatchewan Grain Growers’ Association and the Canadian Red Cross Society.

62The Leader, 26 July 1916.
The course was conducted free of charge and included educational addresses on prenatal care, care of the baby, and the general care of the sick. A booklet giving mothers instruction on prenatal care and general care of babies was also distributed at the classes. Child welfare clinics were frequently held in conjunction with the home nursing classes. In 1921, classes were conducted at eighty locations across the province with an average attendance of approximately sixty women, thereby reaching almost 5,000 women. The annual report for 1921 claimed that “Public interest in child welfare and home nursing has been greatly awakened in Saskatchewan during the past year.”

The classes did not, however, offer any instruction on how to assist with childbirth in situations where professional help could not be procured. Central to the educational campaign was to make it clear to women that if they would only consult a physician, follow a prescribed prenatal regimen, and give birth in a hospital the infant and maternal mortality rates would be greatly reduced. But again, this really was not a realistic option for most homestead women. Most of them could not even obtain a doctor at the moment of birth, let alone engage their services for prenatal care. And even when doctors were available, many homestead families could not afford them. This came to light in a meeting of the Infant and Child Welfare Section of the Canadian Public Health Association in 1918 when it was brought up that many letters had been received from prospective mothers claiming that it was impossible for them to follow the instructions in advice literature and booklets, “living as they did away from civilization, nurses and physicians.”

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66 Annual Report for the Bureau of Public Health for the Province of Saskatchewan 1921  
winter months is taking her life in her hands unless she can go to a city or town in
the fall and stay there until the spring as otherwise it is impossible to get help to
her." The home nursing courses offered a lot of practical information on child
rearing and general first aid, thereby helping women to better care for
themselves and their families. However, this type of adult education was of little
value to a woman giving birth all alone, or with only the assistance of a female
neighbour.

However, in the deluge of advice literature distributed throughout the
period, there was one document that was somewhat of an exception to the
prevailing norm. In her study “Helen MacMurchy: Popular Midwifery and
Maternity Services for Canadian Pioneer Women,” Dianne Dodd refers to a
supplement to the widely read Canadian Mother’s Book which she argues clearly
illustrates the contradiction between the public health message, which stressed
the importance of obtaining a doctor for maternity care, and the reality of
restricted medical services in rural areas. In 1923, Dr. Helen MacMurchy, who
was Chief of the Child Welfare Division of the federal Department of Health at
this time, wrote a supplement which Dodd claims was essentially a popular
midwifery guide. It was written exclusively for women in isolated areas and their
“untrained” neighbours who often assisted at births when no one else was
available. The Supplement was divided into two parts, the first entitled “A Word
to the Mother,” which was intended to reassure her that everything would be fine
until the doctor arrived. The second part, entitled “The Neighbour’s Part,” offered
detailed instructions on labour and childbirth. As an advice manual, this was
clearly an anomaly given the strong emphasis on medical professionalization at

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68 Ibid.
69 Dianne Dodd, “Helen MacMurchy: Popular Midwifery and Maternity Services for Canadian
Pioneer Women,” in Caring and Curing, 137.
the time.\textsuperscript{70}

The \textit{Supplement} was highly contradictory in tone and revealed a strong sense of reluctance by the author in providing laywomen with medical information, and particularly toward recognizing midwifery. It began with MacMurchy asserting the need for medical attendance at childbirth.

The best nurse we can get and the best doctor we can get are needed when the Baby arrives. We should think of this when we build our Canadian home. The baby is coming. Try to settle within reach of medical and nursing aid. You need a Doctor and a Nurse. You should have them if it is possible.\textsuperscript{71}

This was an absurd statement considering the remoteness of most homesteads and the extreme lack of medical services available on the prairies at the time. In addition, “the neighbour,” to whom the bulk of the comments were addressed, was never referred to as a midwife. MacMurchy portrayed “the neighbour” as a frightened, inexperienced helper. In fact, the term midwife was never used.\textsuperscript{72}

However, despite its shortcomings, the Supplement “conveyed far more information about the process of labour and childbirth than was typical of advice literature of the time. It basically translated medical knowledge into plain English for a lay public. Dodd argues that the contradictory nature of the document reveals that MacMurchy’s loyalties were divided between the medical profession and women. On the one hand she was concerned about the high infant and maternal mortality rates in rural areas and recognized that many women had no choice but to turn to a neighbour for help during childbirth. At the same time, she felt the need to placate the male-dominated medical profession, who insisted on an obstetrical monopoly.\textsuperscript{73}

\textsuperscript{70}Ibid., 136.  
\textsuperscript{71}Ibid., 139.  
\textsuperscript{72}Ibid.  
\textsuperscript{73}Ibid., 139-142.
The quality of professional care, when available, also proved in some instances to put women at risk. Many doctors, especially those who were recent graduates had little or no practical experience, particularly with childbirth, and certainly not in home births with no facilities available to them. Robert Ferguson, professor of obstetrics and gynaecology at Western University in the 1920s, when referring to obstetrical training, claimed that “experience gained in the early years of practice is often acquired at the risk of the patient.”

Lois Carson talks of her mother’s child birth experiences:

It happened that Mary White Irwin’s first three confinements were attended by Jane Herdman Irwin and there were no complications. However, on the occasion of her fourth confinement she was attended by a medical doctor, who has just come from attending another woman. Mary White Irwin, unfortunately contracted child bed fever and was very ill for some time following this birth because the doctor never did wash his hands. Consequently Mary Irwin had to be sent to Winnipeg for treatment and lengthy convalescence.

Giving birth in a hospital was not necessarily the answer for homestead women either. According to the 1922 annual report of the Bureau of Public Health, more women died in childbirth who were attended by a doctor than those attended by a midwife or nobody at all. The report states:

Many mothers die at childbirth from blood poisoning, as the result of meddlesome interference on the part of those in attendance at the time, and it was decided that action should be taken to limit and control as far as possible, this cause of death. It is the opinion of this council of public health that the maternal mortality in this province is unnecessarily large and that this large death rate could be materially reduced by a stop being put to so called ‘meddlesome midwifery.”

In connection with this, the council stressed the need for improvement of the medical work being done in hospitals.

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This situation was not unique to Saskatchewan. It was well known through studies of infant and maternal mortality across North America at the time, that maternal mortality rates were generally higher when the patients were attended by physicians than when they were attended by midwives.\textsuperscript{77} The cause of death was usually attributed to ‘meddlesome midwifery.’ The term ‘meddlesome midwifery’ was commonly used to refer to the reckless interference in the childbirth process by doctors. The transition from home to hospital births relied heavily on the medicalization of childbirth and the application of science to the process of delivery. Therefore, most would agree that the basic tenet of science in childbirth was and is power over nature. In this way of thinking, the medical practitioner is likely to conduct some sort of interference in a natural process in order to prove one’s skill as a doctor. During the medicalization of childbirth, the temptation by doctors to interfere during delivery was perfectly acceptable and altogether too prevalent. Midwives, on the other hand, were typically much more inclined to let nature take its course and not interfere in the delivery process.\textsuperscript{78} Dr. R.C. McIlraith called attention to the main causes of puerperal death during this period. He claimed:

There is too great a tendency to injudicious, and particularly too premature, use of forceps. Furthermore, many men doing obstetric work in hospitals fail, I am afraid, to realize the value of precautions by which their work is surrounded. The aseptic delivery room, sterilized water, solutions, dressings, instruments and ligatures; the preparation of the patient for delivery, the gloves, gowns, caps and masks, with which they are supplied, are taken for granted, laughed at or even refused.\textsuperscript{79}

Thus, many doctors did not consider operative obstetrics to be surgery and

\textsuperscript{77}Herbert M. Little, M.D., “Obstetrics During the Past Twenty-Five Years,” \textit{The Canadian Medical Association Journal}, Vol. 14, No. 10 (October 1924), 904.
\textsuperscript{78}Halladay, 20.
would therefore fail to take the necessary aseptic precautions. In addition, the busy practitioner was often impatient to terminate labour in order to save time and attend to his other patients.\textsuperscript{80} The medicalization of childbirth was a process which took approximately fifty years to complete. It was not necessarily a smooth process, and in the early years, many women died as a result of incompetent medical attendance. Obstetrics was arguably the least esteemed specialty in medicine at the time and was in the process of reforming and legitimizing itself by improving the quality of obstetric training.\textsuperscript{81}

Dr. Seymour served as the public health commissioner for Saskatchewan for almost twenty five years. In that time, he gained an international reputation for his expertise in public health and laid a solid foundation for Saskatchewan’s future leadership in healthcare. According to Stuart Houston, his greatest strength was “his ability to react rapidly to provincial needs by drafting, forward-looking legislation and to harness Saskatchewan’s highly developed co-operative spirit.”\textsuperscript{82} Agitation on the part of organizations like the Saskatchewan Grain Growers’ Association led by Violet McNaughton, brought about the passing in 1916 of the \textit{Union Hospital Act} and the Municipal Doctor Plan. Saskatchewan was the first province in Canada to pass legislation for hospitalization on a cooperative basis. Likewise, the municipal doctor legislation was the first of its kind in North America. It provided for a resident physician in areas which otherwise might be without medical aid. However, even though the doctors’ basic salaries were paid from public funds, a fee for maternity cases was still allowed. In addition, the municipal doctor program in Saskatchewan did not

\textsuperscript{80}Ferguson, “A Plea for Better Obstetrics,” 902.
\textsuperscript{81}Meckel, \textit{Save the Babies}, 120.
\textsuperscript{82}Houston, \textit{Steps on the Road to Medicare}, 22.
really take off until the Depression years.\textsuperscript{83} The Saskatchewan Union Hospital plan did not prove to be the answer to women’s maternity needs either. The Minister of Health reported that only one in six births took place in a hospital in 1924, which, considering the low standard of obstetric training at the time might have been a good thing.\textsuperscript{84}

Seymour’s strategy to fight infant and maternal mortality in the province was much less ‘forward thinking’ than some of his other initiatives. With the exception of the maternity grant program, he essentially followed Ontario’s lead by blaming the victims. Maternal ignorance was determined to be the fundamental cause of infant mortality, and the solution was to be found through mass education. The information was disseminated to Saskatchewan women primarily through baby welfare conferences and home nursing classes. A significant component of the maternal education program involved convincing women of the importance of breastfeeding and prenatal care. However, Ontario’s circumstances differed significantly from those of Saskatchewan, the most important of course being the rural nature of the province. Maternal education was geared primarily toward fighting infant mortality due to digestive diseases which were prevalent in the working-class districts of large cities and virtually non-existent in rural areas. Farm women might have gained some valuable knowledge on child-rearing and prenatal care through the conferences and home-nursing classes, but whether they were able to apply that knowledge is another matter. Much of the advice given was simply not practical for homestead women to follow. As a result, the government’s educational program had little to no impact on the high infant and maternal mortality rates in the

\textsuperscript{83}Langford, “Childbirth on the Canadian Prairies 1880-1930,” 291.

\textsuperscript{84}\textit{Annual Report for the Department of Public Health for the Province of Saskatchewan 1924}
province. In fact, statistics reveal that infant and maternal mortality continued to rise during this period despite these maternal education initiatives.
Conclusion

During the settlement period in Saskatchewan, a number of factors converged to make childbirth a frightening and often very dangerous experience for homestead women and their babies. These included geographic isolation, the high cost of doctor’s care, the poor trails and slow means of transportation, the unpredictable weather, and the lack of government structures in place to respond to settlers’ needs. In short, the inaccessibility to medical care. Women’s organizations, the medical profession and the provincial government all tried to address the maternity needs of prairie women to varying degrees and with limited results. In the end, several historical developments occurring simultaneously would affect the type of response taken to address the high infant and maternal mortality rates in Saskatchewan in the early twentieth century.

The National Council of Women, led by Lady Aberdeen, started fighting for medical aid for homestead women in the late nineteenth century. Beverly Boutilier asserts that members of the NCW strongly identified with the new generation of largely Anglo-Saxon women who were starting a new life on the Canadian prairies. They believed these women played a critical role in the nation-building process. While men worked the land to generate economic wealth, only “women’s reproductivity could truly establish a new community and provide it with the moral and spiritual sustenance it needed to survive.”\(^1\) As a result, the maternal welfare of isolated homestead women became one of the most urgent national responsibilities of the newly formed organization. They came up with a scheme called the “Victorian Order of Home Helpers” in which local midwives were given additional training in modern childbirth techniques. The hope was that the Victorian Order of Home Helpers would enable prairie

\(^1\)Boutilier, “ Helpers or Heroines?” 32.
women to fulfill their patriotic duty as nation builders by helping them survive childbirth. But because of the strong opposition to the plan from the medical community and nursing associations, the NCWC were forced to devise a new plan, one of district nursing called the Victorian Order of Nurses. While the Victorian Order of Nurses served an important health care need, they ended up working primarily out of cottage hospitals in urban areas. As a result, the Order was never able to live up to Lady Aberdeen’s original vision of providing maternity care to women in isolated western communities.

Violet McNaughton and the Women’s Grain Growers also spent a great deal of time and energy trying to obtain more medical services for those living in rural areas by leading a campaign called “Medical Aid in Reach of All.” By forming alliances with the two most powerful organizations in the province, McNaughton was able to force the government to pass legislation giving the municipalities more power in obtaining doctors and nurses, as well as establishing hospitals. However, she realized that a more immediate solution to the maternity needs of homestead women was required. She decided to focus her attention on getting a Midwives Act passed in the province. With the assistance of the Colonial Overseas Nursing Association in London, and Chief Superintendent of the VON, Charlotte Hanington, she too tried her hand at importing British Midwives to work in Saskatchewan. However, in the end, the “powers that be” strongly opposed the scheme. During her campaign, McNaughton would find herself at odds with the provincial government, the Canadian Association of Graduate Nurses, and the medical profession, all of whom were vying for control in the field of health care.

The issue of midwifery became a subject of intense debate among women’s groups and health care providers in the early twentieth century.
Homesteader Peggy Holmes wrote:

There were so many bereavements in the district. Two widowers were left with seven children each. That made 14 more motherless children to be care for. Most of the deaths were caused by neglect at childbirth and still the government would not allow midwives to be licensed in Canada. Why I wonder?²

Why was the medical community in Canada so firmly opposed to the licensing of midwives in the early twentieth century, even though, trained midwives were an important component of maternal welfare campaigns in several other countries at the time, including Great Britain. During this period, both doctors and nurses were trying to establish themselves more firmly in their professions. The rise of medical professionalization in the early twentieth century greatly contributed to physicians’ dominance in health care. In turn, this ensured that their professional interests shaped any public health measures that were eventually passed.³

Financially, it was not in the best interests of doctors to legalize midwifery. For a physician, delivering a baby was often the first point of contact with a family and thus an opportunity to secure the family’s future health care needs. Although there was a shortage of doctors in rural Saskatchewan, by the early twentieth century in Canada as a whole there was a surplus of doctors who were increasingly competitive, particularly in Central Canada. Veronica Strong-Boag claimed that “professional journals regularly grumbled about overcrowding in the occupation, and pointed to a surplus of male practitioners which already made it difficult for young doctors to secure a living.”⁴ Consequently, the medical profession refused to endorse any type of formal education for midwives that might rival their own. In addition, with the rising feminist movement, male

physicians feared that more women would prefer an attendant of their own sex for obstetrical matters. For this reason it was suggested by members of the profession that female doctors should replace midwives. Boag argues that it was a brilliant ploy to propose exchanging the far more numerous midwives with the small number of female physicians in practice at the time.\(^5\) Most women would be forced to enlist the services of a male physician as there would be no other alternative.

Moreover, the concurrent early twentieth century push for professionalization of nursing served to assist doctors in reaching their own objectives. By distancing themselves from the unscientific and uneducated midwife, nurses were trying to improve their professional position within the medical hierarchy. In the process, they collaborated in the medicalization of childbirth, even though it reinforced their own subordination to the medical profession. The Canadian National Association of Trained Nurses deferred to male-determined norms of professionalism in their drive to create a respectable, middle-class nursing profession. They wanted to distance themselves from the midwife whom they associated with domesticity, low status and dubious legitimacy. Dianne Dodd claims that its domestic roots haunted nursing as it slowly evolved into a profession “attempting to cloak itself in the authority of science.”\(^6\)

However, not all nurses agreed with the position of CNATN. Charlotte Hanington, who was Chief Superintendent of the VON, supported the introduction of midwives as a temporary measure. However, she alone could not convince the nurses’ association to step out of their subordinate sphere and take a stand to mitigate the high infant and maternal mortality rates in Western

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\(^5\)Ibid.

\(^6\)Dodd, *Caring and Curing*, 2.
Canada.\textsuperscript{7} In her essay “Doctors or Midwives?” Suzanne Buckley asserts that despite nurses’ professed concern for prairie women, their professional needs were clearly more important. She argues that nurses’ much glorified dedication to service ended when their professional exclusivity was threatened.\textsuperscript{8}

Thus, women’s organizations across the country attempted again and again to lobby for trained midwives, but to no avail. When the Imperial Order of the Daughters of the Empire passed a resolution in 1922 that trained midwives be sent to sparsely settled areas of Ontario, Dr. H. Amyot of the Dominion Council of Health expressed his ardent disapproval. He argued that “on account of the difficulty of controlling midwives it is one of those things one should not encourage at all. Midwives are pretty dangerous individuals and owing to their fixed ideas it is pretty hard to train them.”\textsuperscript{9} The Dominion Council of Health was comprised of the chief medical officer of each province and four lay appointments representing labour, agriculture and women’s organizations. Its primary purpose was to bring the provincial health officers together regularly in the hope of attaining uniformity throughout Canada.\textsuperscript{10} According to Cynthia Comacchio, medical dominance on the Council outweighed the views of the lay women, effectively ending any further pleas from women’s organizations for midwives in rural areas, despite the obvious need.\textsuperscript{11}

The increase in medical professionalization and specialization in the late nineteenth century effectively boosted medical dominance on the issues of child and maternal welfare. According to Comacchio, medical dominance involves not only the superiority of the physician in relation to other medical occupations, most

\textsuperscript{7}Buckley, “Ladies or Midwives?” 149.
\textsuperscript{8}Ibid.
\textsuperscript{9}Dr. H. Amyot cited in Comacchio, Nations Are Built of Babies, 78.
\textsuperscript{10}Ibid., 26.
\textsuperscript{11}Ibid., 78.
notably nursing and midwifery, but also a privileged position within the class structure. As the medical profession’s authority within the health care field increased doctors gradually came to realize that their social utility extended beyond the field of public health to a broader interest in social and moral regeneration. Doctors took a leading role in the turn-of-century reform movement calling for a reorganization of society in accordance with scientific principles. Applying what they considered appropriate scientific techniques to social maladies, doctors hoped to rid society of the “degenerative” influences of crime, insanity, gender conflict, and class antagonism. According to David Naylor, the medical profession’s involvement in the reform movement contributed to the medicalization of concerns that hitherto had been the jurisdiction of the family, the church, the institutions of criminal justice, and the patronage-based party system and represents the first step in the direction of the modern-day welfare state.

As the modern state emerged and began to take an interest in the health and well-being of its citizens, women, as the creators of those citizens were gradually encompassed within the sphere of the state and medical control. Historians have focused on the medical profession’s promotion of a maternalist ideology that confined women to the private sphere, while increasing medical authority over an ever growing medical domain. This began a process of greater state involvement in issues of family and women’s “natural” procreative role. Jane Ursel argues that the purpose of the reform movement was to force the state into a more active interventionist role specifically to protect reproductive

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12 Ibid., 22.
relations. She claims the medical profession was particularly outspoken on this issue and “added weighty voices to the defense of motherhood and the cry for the regeneration of the race.”14

Thus, by the turn of the century, the ideal of motherhood held sway in Canada and women were placed high on a pedestal tasked with the important responsibility of bearing and rearing the next generation of Canadians. Within a few decades, however, the medical establishment had determined that maternal instincts alone would no longer be sufficient to raise the imperial race and that women required education in modern motherhood. Katherine Arnup claims that, contradictory as it might appear, the “idealization of motherhood had set the stage for the ‘mother-blaming’ which began in the early decades of the twentieth century.”15 Based on the ideology of separate spheres it had been clearly established that women were responsible for the health and well-being of their children. Therefore, if babies were dying, it must be the result of faulty maternal care. Educating women in the scientific techniques of modern motherhood became the primary focus of much of the child and maternal welfare initiatives throughout the period. More than any other service in the interests of lowering the infant and maternal mortality rates, doctors and governments, designed, produced and distributed information on child health and welfare.

The government response to the high infant and maternal mortality rates in Saskatchewan was slow and inadequate. Not until 1916, and after a great deal of pressure from Violet McNaughton and the SGGA, did the provincial government come alive to its responsibility to provide health care in the sparsely populated districts of the province. Dr. Seymour reports, “In order to ensure

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better hospital care for the rural districts of the province, and especially to provide for maternity and emergency cases, an act was passed providing for the formation of rural municipal hospitals by which two or more municipalities could combine to form a hospital district."16 Seymour seemed to believe if women would just give birth in hospitals all would be solved. However, it took time for hospitals to be established, and when they were they proved to be a mixed blessing. The quality of care in hospitals at the time was not necessarily better than what could be obtained at home. In addition, the long journey in rough conditions to get to a hospital put many mothers and babies at risk. Ironically, during the medicalization of childbirth, many women died from incompetent medical attendance at the same time doctors were promoting the ideal that pregnancy and the birthing process were pathological conditions that required skilled supervision and assistance.

In terms of government initiatives aimed specifically at reducing the high infant and maternal mortality rates, Saskatchewan essentially followed Ontario’s lead. The prevailing view among medical practitioners was that motherhood had to be learned and that many diseases of infancy could be prevented if parents followed certain rules of infant hygiene and management. Saskatchewan adopted the maternal education strategy despite the fact that it was geared towards countering deaths from intestinal disorders most prevalent in the congested slums of large cities. Medically designed information on child health and rearing was delivered to mothers through advice literature, infant welfare conferences, exhibitions, and home nursing classes. Women received basic advice on child rearing, detailed instruction on nursing and artificial feeding, as well as descriptions of the symptoms of various childhood diseases. It was also

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made clear that expectant mothers should receive prenatal care and have medical assisted childbirth. However, the fact that most farm women were unable to do so, either because of the expense or inaccessibility to professional help, was never addressed.\textsuperscript{17} Caught in a medical system that insisted on a medical monopoly on obstetrics but failed to provide services to all Canadians, prairie women stood out as a major discrepancy between the ideal and reality. As Dodd points out, Dr. MacMurchy’s Supplement revealed her somewhat pathetic attempt to reconcile the interests of outpost women with those of her medical colleagues.\textsuperscript{18}

So why did the Public Health Bureau focus on maternal education as their main strategy in fighting infant and maternal mortality when it was clear that the real problem was inaccessibility to health care? According to Cynthia Comacchio, “they persisted in advocating education because options such as state provision for health care threatened their professional and class interests.”\textsuperscript{19} In other words it was the easiest and most cost-effective way of dealing with the problem without compromising their professional authority and livelihood. Certainly, Canadian doctors were never going to consider licensing midwives as a viable alternative to the lack of maternity care on the prairies. That such general educational efforts could compensate for the lack of direct health services is doubtful; nevertheless, education was the provincial government’s main strategy to combat infant and maternal mortality well into the 1930s.

Canadian doctors, nurses and governments did not give the suggestions of women such as Lady Aberdeen, Marion Cran and Violet McNaughton, who were most familiar with the health care needs and circumstances of farm women,

\textsuperscript{17} Comacchio, \textit{Nations Are Built of Babies}, 76.
\textsuperscript{18} Dodd, “Helen MacMurchy,” 159.
\textsuperscript{19} Ibid., 13.
adequate consideration in the development of their child welfare programs. These women all knew that the only practical and effective solution to the maternity needs of homestead women during the settlement period were trained midwives. However, many factors came together to conspire against these aspirations, including short sightedness on the part of the government; the professionalization of both medicine and nursing; the medicalization of childbirth; and women’s lack of political power, despite the fact they were granted the franchise in 1916.

In her article “Women in Saskatchewan Politics, 1916-1919,” Elizabeth Kalmakoff asks the question why feminists like Violet McNaughton were unable to use the newly acquired weapon of the vote to achieve their common goals. In her analysis of the 1917 provincial election, she claims that the important division among women reformers was not between Liberals and Conservatives but between Liberals and nonpartisans. Nonpartisans, such as Violet McNaughton, believed that women had a responsibility to vote on the basis of principle rather than on the basis of party affiliation. In theory, if women followed these instructions they would vote for the candidates who best represented their views on women’s issues. In practice, however, the positions of the Liberal and Conservative parties on gender issues were remarkably similar. Therefore, women had not been able to choose between the parties on the basis of common issues. As a result, in the 1917 provincial election, the Liberals received the same percentage of the vote as they had in the previous election, despite an electorate more than double the size. Kalmakoff concludes that the suffragists were divided along the same political lines as was the larger progressive movement during those years. She argues that because many of the suffragists advocated the abolition of the party system, they were unable to
make a “concerted assault on the centres of political power within the existing parties.”\textsuperscript{20} Kalmakoff asserts that such an assault would have been necessary for the suffragists to achieve political power in Saskatchewan.

More generally, Carol Bacchi argues that most Canadian suffragists wanted the vote in order to impress certain values upon society. She claims that very few were interested in the more radical feminist demands for educational and occupational equality.\textsuperscript{21} For this reason, she argues it would not be accurate to describe the women’s movement in Canada in the early twentieth century as a failure. She claims the primary goal of most reformers was to strengthen the family, which they considered the foundation of their new social order. They saw the vote simply as a public voice for their domestic issues and envisioned no real change in gender roles. According to Bacchi, “the reform ethos captured the suffrage movement and transformed it into a defender of the social status quo.”\textsuperscript{22} As a result Canadian women continued to take a secondary place to men, particularly in the realm of politics.

In the end, farm women provided each other with the emotional and practical support that childbirth demanded because they were the only ones available to do so. The lack of medical assistance in childbirth resulted in the loss of life for many prairie mothers and babies. One wonders how many might have been saved if trained midwives had been available to homestead women during the settlement period.

It is hoped that this study will add to the literature on the infant and maternal welfare movement in Canada at the beginning of the twentieth century as well as provide a useful resource. With this study, I also wanted to pay

\textsuperscript{20}Ibid., 15.
\textsuperscript{21}Bacchi, Liberation Deferred? 3.
\textsuperscript{22}Ibid., 24.
homage to homestead women for their amazing spirit and resilience in the face of incredible odds. With the limited resources available, I tried to depict as accurate a portrayal as possible of what it was like for women to give birth on isolated Saskatchewan homesteads during the settlement period.


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Appendix 1:
Copy of letter submitted to several small town newspapers

To the Editor:

I am seeking information from your readership in order to complete my Masters degree at the University of Regina. The subject of my thesis is infant and maternal mortality in early 20th century Saskatchewan. During the settlement period, little thought had been given in settlement policy to the needs of women, in particular, accessibility to medical care to ensure for safe childbirth. By looking at letters, diaries, oral histories and memoirs of homestead women I will try to reveal what the experience of childbirth was like for Saskatchewan women during this period (1900 – 1930). Unfortunately, there is very little information available on this topic as it was a subject that women did not discuss. My hope is that some of your readers would be willing to share any stories, letters, or diaries that have been passed down through the generations which touch on this subject. Of particular interest to me are the many challenges these women were forced to overcome in their preparations for childbirth as well as the tragic losses they had to endure. Readers can contact me at the address below and I would appreciate it if they would include their mailing address or email and phone numbers so I can get in touch with them.

Sincerely,

Tracy Steele

3534 Argyle Road
Regina, Saskatchewan
S4S 2B8

tracy.steele@sasktel.net

(306) 585-6360
Appendix 2:

Approval letter from Research Ethics Board

DATE: October 21, 2010

TO: Tracy Steele
    3534 Argyle Road
    Regina, SK S4S 2B8

FROM: Dr. Bruce Plouffe
      Chair, Research Ethics Board

Re: Infant and Maternal Mortality in Early 20th Century Saskatchewan (File # 23S1011)

Please be advised that the University of Regina Research Ethics Board has reviewed your proposal and found it to be:

☐ 1. APPROVED AS SUBMITTED. Only applicants with this designation have ethical approval to proceed with their research as described in their applications. For research lasting more than one year (Section 1F), ETHICAL APPROVAL MUST BE RENEWED BY SUBMITTING A BRIEF STATUS REPORT EVERY TWELVE MONTHS. Approval will be revoked unless a satisfactory status report is received. Any substantive changes in methodology or instrumentation must also be approved prior to their implementation.

☐ 2. ACCEPTABLE SUBJECT TO MINOR CHANGES AND PRECAUTIONS (SEE ATTACHED). Changes must be submitted to the REB and approved prior to beginning research. Please submit a supplementary memo addressing the concerns to the Chair of the REB. **Do not submit a new application. Once changes are deemed acceptable, ethical approval will be granted.

☐ 3. ACCEPTABLE SUBJECT TO CHANGES AND PRECAUTIONS (SEE ATTACHED). Changes must be submitted to the REB and approved prior to beginning research. Please submit a supplementary memo addressing the concerns to the Chair of the REB. **Do not submit a new application. Once changes are deemed acceptable, ethical approval will be granted.

☐ 4. UNACCEPTABLE AS SUBMITTED. The proposal requires substantial additions or redesign. Please contact the Chair of the REB for advice on how the project proposal might be revised.

Dr. Bruce Plouffe

cc: Dr. James Pitsula - History

**supplementary memo should be forwarded to the Chair of the Research Ethics Board at the Office of Research Services (Research and Innovation Centre, Room 109) or by e-mail to research.ethics@uregina.ca"
Appendix 3:
Participant Consent Form

Project Title: Infant and Maternal Mortality in Early 20th Century Saskatchewan

Researcher: Tracy Steele, Graduate Student, Department of History, 585-6360, tracy.steele@sasktel.net

Supervisor: Dr. J.M. Pitsula, Department of History, 585-4212, James.Pitsula@uregina.ca

Purpose and Objective of the Research: To obtain information on what the experience of childbirth was like during the settlement period in Saskatchewan.

Potential Risks: There are no known or anticipated risks to you by participating in this research project.

Consent: Consenting to this agreement indicates that the participant can be used as a source by the interviewer for her thesis at the University of Regina.

Further I give the interviewer permission to publish said thesis.

This permission is given with the understanding that the interviewer will follow established and recognized practices of historical scholarship and is subject to the following restrictions:

1) Participants will be recognized in the bibliography and when referenced in the thesis in footnotes. Participants have the option of being recognized as an anonymous source.
2) Your participation is voluntary and you can answer only those questions that you are comfortable with. You may withdraw from the research project for any reason, at any time without explanation or penalty of any sort.

Please note the following:

- The interviewer will respond to any questions regarding the procedures and goals of this paper.
- This research project has been approved on ethical grounds by the University of Regina Research Ethics Board. Any questions regarding your rights as a participant may be addressed to the committee at [585-4775 or research.ethics@uregina.ca]. Out of town participants may call collect.
Your signature below indicates that you have read and understand the description provided; I have had an opportunity to ask questions and my/our questions have been answered. I consent to participate in the research project. A copy of this Consent Form has been given to me for my records.

_____________________________
Name of Participant

_____________________________
Signature

_____________________________
Date

A copy of this consent will be left with you, and a copy will be taken by the researcher.