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ADVISING THE PARENTS:

CHILD REARING IN BRITISH COLUMBIA DURING THE INTER-WAR YEARS

by

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Abstract

During the inter-war years, health professionals and child care advisors in the industrialized world urged parents to reject traditional child rearing practices and to apply a scientific approach to child rearing. Basing some of their advice on research in medical science and studies in child development, these advisors assured parents that, if they adopted the scientific approach to child rearing, their children would have a greater possibility of growing into healthier, happier, more morally upright, productive members of society than had children of any previous generation. In British Columbia, many voices joined together to advise parents. These advisors included professional and non-professional individuals, members of government boards and departments, employees of public and private agencies, members of community and women's organizations and service clubs, and public relations personnel for food production and life insurance companies.

In their efforts to reach parents in all areas of British Columbia, advisors utilized a variety of approaches: they published and distributed pamphlets, newsletters, and child care manuals; they showed films in local movie theatres and schools; they prepared broadcasts for local radio stations. This study examines the individuals and the agencies that provided child rearing advice to British Columbia's parents, and the methods and media used to disseminate this advice.

Advice to parents centred on four age groups, the prenatal stage, the infant, the preschool child, and the school child. Because expectant mothers tended to be secretive about their pregnancies, advisors found it difficult to reach them with the message that through proper care, child-

bed deaths were preventable and that healthy mothers produced healthy babies. Advisors found, however, that women reluctant to seek advice for themselves were often willing to accept assistance and advice on the care and rearing of their infants. Determined to lower the province's mortality rate, advisors urged parents to adopt a systematic, regimented, scientific approach to the feeding, caring, and training of their infants. When children passed from infancy to the preschool stage, both parents and advisors believed they no longer required the intensive care they had received as infants. Thus, less advice was available to parents on rearing preschool children than for rearing infants. Once children moved into the provincial school system, their health was monitored through annual medical inspections by a medical health officer and by regular examinations by a school nurse. At this stage, advisors were concerned with the health of school children, although they also viewed such children as instruments and the school as an agency through which to educate parents to the scientific approach to child rearing. Advisors believed the way to produce a strong, healthy citizen for the future was by expanding existing and developing aditional health care and child care programs for the child, and by changing the child rearing practices of the British Columbia parent.

Although advisors proposed to educate all parents in new modes of child rearing, the nature, content, and amount of advice directed towards each age group varied considerably. This study identifies the sources of child care and child rearing advice for each age group. It shows, furthermore, that as advisors' knowledge of child development increased, their perceptions of child care changed, and the nature and content of child rearing advice also changed. This study identifies changes in the focus of advice to parents during the 1920's and 1930's. Additionally, it shows that during the inter-war years, the amount of advice to

parents increased both in quantity available and in the number of sources through which information was disseminated to parents.

Many British Columbia health professionals and child care advisors were committed to changing child rearing techniques used by parents, and they justified their claims by pointing to a steadily declining child mortality and morbidity rate. Not only did they desire these changes for children growing during the 1920's and the 1930's, but also they believed their influence would be manifest in the child rearing practices of the next generation. Motivated by political, economic, and humanitarian considerations, advisors worked to provide conditions that would produce children that were an asset to the rapidly developing province of British Columbia.

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Chapter 1 Advice To The Parents: Utilizing The Media

During the inter-war years, health professionals and child care advisors expended considerable time and energy persuading British Columbia parents to change their child rearing techniques. Advisors believed that if they could change child rearing practices of the 1920's and 1930's, the generation growing up would be healthier, happier and more productive than their parents had been.[1] To effect these changes, advisors told parents they could no longer rely on their traditional practices or their natural parenting instincts; rather, parents must adopt the new scientific approach to child care and child rearing. Advisors believed that once the new methods were demonstrated, their value was so rational and so obvious that parents would immediately adopt the new techniques and procedures. With great enthusiasm, health professionals and child care advisors set out to change child rearing practices.[2]

Advising parents is not a phenomenon of the twentieth century. Indeed there have always been advisors willing to tell parents how to rear their child. Over the centuries, however, the changing concept of child nature and development has effected changes in both the focus and the content of advice given parents.[3] For example, for much of the nineteenth century, advice focused on the development of the child's moral character. For most children, life was tenuous, if not short, and parents were urged to prepare their child for the next life.[4] Developments in disease control and prevention between the 1880's and the 1920's shifted attention to the child's feeding and physical care.[5] Whereas advisors of the early nineteenth century were clergymen, educators, and upper class women, advisors of the period 1880 to 1920 were physicians, educators, and social workers. During the 1920's and 1930's, the concept of child nature and child develop-

ment continued to change as child psychologists and nursery school educationalists studied the social and the emotional development of the child.[6] In response to this new focus, parents of the 1930's were urged to consider their child's care and rearing in quite a different way than had their mothers or grandmothers. Indeed, by 1930, the child was not only perceived as having a soul but also a body, an intellect, and a social and emotional nature.

British Columbians did not suddenly become aware of children and their needs after World War I. Neil Sutherland has examined in detail the efforts of Canadian reformers to provide better health care, better educational programs, and more rights before the law for Canadian children for the period 1880 to 1920.[7] Why, then, in the years immediately after the war was there so much stress on educating parents to new child rearing practices and in providing health care services for children?

The "war to end all wars" was over, and Canadians filled with self-confidence and optimism, saw Canada as a vigorous and growing nation. Politicians, academics, and social reformers talked and wrote of a developing Canada in a new age, where social ills could at least be ameliorated if not eradicated. Governments were urged to assume more responsibility for the care and welfare of all their citizens.[8] Government administrations at all levels began to organize and maintain services designed to provide health care, education, and welfare programs for children and child rearing education for parents. Voluntary organizations such as the Red Cross, Victorian Order of Nurses, and the Women's Institute, channelled their

energies toward peacetime work and sought to coordinate their work with the governmental agencies.[9] As the nation's future citizen, the child was the recipient of their efforts.

Nationalism was not the only influence in post-war Canada. International developments in scientific and medical research during the period 1870 to 1920 had given science and scientific management a position of respectability and a place of preminence. By 1920, both the knowledge and the tools existed to improve health care and reduce the incidence of disease among children. Advisors set about organizing child care services and parents' education through the application of the principles of scientific management. Although the principles of scientific management were designed by American Frederick W. Taylor to achieve maximum industrial productivity, Taylor believed the same principles could be applied with equal success to the operation of governmental agencies, educational programs, home management or family life.[10] The use of scientific management was considered not only pragmatic but also patriotic, intended to provide the panacea for all society's ills.[11] For health professionals, use of scientific management meant educating parents to new methods of disease prevention and control, and the scientific methods of feeding, training, and caring for the child. It also meant establishing public health services and educating the public to good health habits. For educators, the use of scientific management meant the process of shaping the minds of the public at large, a task that could be effected as scientifically as shaping steel rails.[12] The propaganda techniques which had proved so efficient in moulding public opinion during World War I were quickly adopted to teach parents new principles of child care and child rearing.[13] The immediate post-war period in Canada was not only a time of rising nationalism, but also a time when science and scientific management pereated every aspect of life.[14]

The practice of advising British Columbia parents of their duties was not new, but changes in post-war British Columbia society changed the focus of advice. For instance, in 1911, Alice Ravenhill, advisor to the Women's Institute, believed a good family fulfilled four essential functions: it provided shelter and support for both young and old; it educated the young in useful habits and life skills; it provided both physical and spiritual care and nourishment for the young; it provided training in mutual love, self-control and service for others.[15] In the post First World War years, the family was increasingly under attack for its failure to provide good physical care for the child. In a 1916 address to the members of the Summerland Women's Institute, Dr. F. W. Andrew, a Summerland physician, defended the practice of medical inspection of school children on the grounds that some parents were either ignorant or unable to detect physical defects in their child. This failure, Andrew stated,

> led the State to step in, call attention to the child's condition, and emphasize the importance of treatment so that ignorance should no longer be the parent's excuse for not raising as sound children as possible.[16]

During the first World War, Andrew argued, the military discovered "that one third of the men presenting themselves for service overseas were physically unfit, that eighty percent of that number owed their condition to defects which could have been remedied in childhood."[17] Armed with this information, advisors of the early 1920's focused their attention on teaching parents how to provide for their child's physical needs.[18]

By the end of the 1920's as the focus shifted from the child's physical care to his social and emotional development, advisors believed parents had to be educated to understand these other facets of their child's development, and educational programs were developed to help parents meet this change. In 1928, Frances Lucy Johnson, Director of Parent Education, St.

George's Child Study Centre, Toronto, noted that a scientifically based parent education program was available to teach parents how to study thier children so they could guide their development.[19]

As researchers became more aware of the importance of the early years in a child's overall development, they considered parents to be increasingly less competent as child rearers, and they were quick to blame parents for any difficulties the child might encounter.[20] In 1927, for example, the Public Health Journal asked ten prominent Canadian jurists, educators, and clergymen to respond to six questions relating to the proper home training of children, and to explore the need for parent education. Their responses were evenly divided as to whether parents of 1927 compared favourably or unfavourably with parents of past generations. Seven of those responding believed parents could be held responsible for their children becoming juvenile delinquents, and an equal number believed parents could mould the character of their children by controlling the environment in which they lived, and by selecting the companions with whom they played. All ten responded that they agreed with the principle of parent education, all believed it should begin long before the infant arrived, and some even suggested that training for parenthood should begin as early as age twelve.[21] Responses of this nature did little to enhance the image of or build confidence in parents in the 1920's and 1930's.

II

Health professionals and child care advisors saw their duty as two-fold: establishing health care services for children and educating parents to new methods of child rearing. What institutions and servies were developed to provide health care to the child and child rearing advice to the parents?

Until the creation of the Provincial Board of Health and local boards of health in urban areas of the province in 1893, no permanent agency existed in British Columbia to direct health care services.[22] Once established, the Board issued and enforced modern health regulations for the control and prevention of contagious and infectious diseases.[23] In 1899, Dr. C. J. Fagan was appointed Provincial Health Officer, a position he held until 1914. He recommended amendments to the Health Act which included a ban on the use and sale of milk from tubercular cows, the reporting and treatment of all cases of tuberculosis, and the notification of any cases of infectious or contagious diseases.[24]

Dr. Fagan's supervisor and successor, Dr. Henry Esson Young, was the major architect who developed British Columbia's public health service on the foundation laid by Dr. Fagan. From the time of Dr. Young's appointment as Provincial Secretary and Minister of Education in 1907, his appointment as Provincial Health Officer in 1916, and his death in 1939, the basic framework of British Columbia's public health services grew and developed.[25] Young, a physician by profession, saw public health as preventive work covering four broad areas: school work; child welfare clinics; public education; health clinics for the general public.[26]

Although Young and the board had not been idle during the war years, it was in the immediate post-war period that he set out to organize an expanded and efficient public health system throughout British Columbia. To accomplish this goal he required a trained staff and money. The problem of trained staff was partially solved in 1919 when Dr. Young, supported by Dr. Malcolm T. MacEachern, Medical Superintendent of Vancouver General Hospital, and Dr. R. E. McKechnie, Chancellor of the University of British

Columbia, encouraged and financially assisted by the British Columbia Branch of the Canadian Red Cross, established a Department of Nursing at the University of British Columbia.[27] The nursing program, organized by Ethel Johns, was a five year program leading to a Baccalaureate in Nursing. It offered specialization in either public health work or nursing education. At the request of the British Columbia Hospital Association, Ethel Johns also organized a four month post-graduate program in public health nursing for registered nurses.[28] The course was popular, and by 1923 Young reported that fifty-six graduates from the post-graduate program were working in the province's schools and health units, and there was still a need for more nurses. In addition to nurses employed by the Victorian Order and the Red Cross, by 1937 ninety public health nurses were working in the province.[29]

In an effort to strengthen the work of the developing health units, the Provincial Board of Health appointed full-time medical officers to smaller urban areas to initiate and coordinate health services and educational programs.[30] The Tuberculosis Control Division, established in 1923, was extended to a province wide-district based control and educational program in 1928.[31]

By 1930 public health services were well established in the province. In addition to six full-time rural health units, the rural areas of the province were served either by the public health nursing service, the Victorian Order of Nurses, the Red Cross Outpost Hospitals, or by medical services provided by religious organizations.[32] Unfortunately, the great depression placed serious constraints on the growth of public health services. Like all provincial departments, between 1931 and 1934 the Board's budget was reduced in spite of its increased requirements caused by a significant

influx of unemployed people. In 1932, the actual amount spent by the Board amounted to fifteen cents for each resident of the province - "barely sufficient to maintain our work."[33] Not until 1935 was Dr. Young able to announce any material progress in the Board's work, yet, in spite of the depression, British Columbia did not suffer a major outbreak of infectious or contagious disease, nor the consequences of widespread malnutrition.[34] From 1936 until the end of the decade, three more health units were opened. In 1937 the Vancouver Metropolitan Health Unit, an amalgamation of Greater Vancouver health units, was organized, and additional plans were underway to open health units in several other areas of the province.[35]

In the urban areas of the province, the city administration assumed the initiative in developing health care services and child care facilities. Although the Vancouver Division of Child Hygiene was not organized until 1919, as early as 1910 Dr. F. T. Underhill, the city's medical health officer, reported his concern for the health of the city's children.[36] He believed the high infant mortality rate was caused by the great number of flies, the open manure boxes about the city, and the deplorable tenement housing in which many families were forced to live.[37] In 1912, the city opened a creche, or day nursery, designed to provide care for children of working mothers,[38] but, until 1919, there were no clinics designed specifically for children, although sick children were treated at either the Infant's Hospital on Haro Street or at the Vancouver General Hospital.[39]

The Division of Child Hygiene of the Vancouver Board of Health, formed in 1919, provided a well-baby clinic at the Infant's Hospital, an infant's clinic at Community House, and a pediatrics clinic at Vancouver General Hospital.[40] The newly formed division carefully analyzed the causes of infant and child deaths, and then focused its efforts toward eliminating

or alleviating the causes (Table 1.1). The Division was able to report success for its efforts, as the rate for infant deaths in Vancouver under one year of age caused by gastro enteritis and acute chronic indigestion dropped from 13.4% of infant deaths in 1920 to 4.5% in 1938, and deaths caused by acute infectious diseases declined from 9.1% in 1920 to 1.7% in 1939.[41]

The Division also carried on an extensive home visitation program. The Division's nurses believed the most effective way to work with mothers was on a one-to-one basis in the home. In 1920, the nurses made 2,847 house calls and in 1932 they made their maximum number of calls - a total of 16,112. The steady decline in the infant mortality rate from 55.76 per 1000 live births in 1920 to 26.84 in 1939 must have been intensely encouraging to Division nurses.[42] Also, the nurses inspected child care institutions where children were sheltered, and the registered homes where dependent or neglected children were housed. Not only were the nurses concerned for the quality of care, but also they worked to eliminate the disastrous practice of baby farming.[43]

Not until the formation of the Vancouver Metropolitan Health Unit in 1936 were Vancouver's school nurses and Division of Child Welfare nurses brought under the same administration.[44] In 1920, the medical health officer had concentrated the efforts of his staff on improving the physical health of the city's children; by 1939, a far wider range of services was available for children, including the addition of a mental hygienist.[45]

While provincial and municipal health workers were developing health care services, they were also disseminating health care and childrearing information to parents. They devoted attention and care both in the choice

INFANT HEALTH CARE - DIVISION OF CHILD HYGIENE
VANCOUVER CITY 1919-39 - METROPOLITAN HEALTH UNIT 1937-39

Table 1.1

Year	Total Births	No. of Clinics Sites: Sick Baby	Well Baby	Total Number of Clinics	New Admissions	Total Attendance	Preschool Age Attending Clinics	Home Visits
1919	2706	2	1					
1920	3366	2	2	133		2194	171	2847
1921	3623	2	4	179	629	3425	231	6604
1922	2192	2	4	254	682	4344	249	6664
1923	3165	1	4	256	640	4367	161	6458
1924	3303	1		253	698	5147	203	6569
1925	3578	1		257	983	5605	706	5678
1926	3458	1		205	847	4617	546	6378
1927	3563	1		203	785	4608	387	5025
1928	3346	1		197	747	5463	408	5632
1929	4354	1	3	152	763	6226	547	6227
1930	4539	1	5	243	1311	10412	874	13435
1931	4241			247	1365	11070		14459
1932	3597			251	1363	11977		16112
1933	3232		2 closed	202	1261	8060		14884
1934	3407		4	199	938	8118		13694
1935	3587		6	272	1066	8823		14878
*1936	3577		5	299	1121	9884		15878
**			12	508	2057	14891		13717
**1937	3951		5	614	2452	16234		
*1938	4226		13	583		19591		
**			21	801		22818		
*1939	4359			601	1908	20906	2584	8733
**			25	894	2367	24906	4084	10051

SOURCE: Vancouver Board of Health, Report, 1919-1939. Where no numbers are available the spaces are left blank.

* Vancouver City
** Metropolitan Health

of information imparted and the type of media utilized.[46] As early as 1912-13, the British Columbia Board of Health pamphlet "Instructions to Parents regarding the Care of Teeth" was issued to school children at the time of their annual school medical inspections.[47] Throughout the 1920's and 1930's, the Board distributed printed materials, some of which were prepared and produced by the Board, other materials were reprinted from publications produced in other provinces, other countries, or by other agencies.[48] The Board's main concern was to get the information to parents regardless of who produced it. By 1920, the Board had produced a set of ten advisory letters and five diet folders for distribution to expectant mothers. These materials were mailed at monthly intervals, one prenatal letter at a time, in plain brown envelopes, to mothers-to-be. After the release of the Child Welfare Division's The Canadian Mother's Book, in 1921, it was also included in the information mailed to prospective mothers.[49] The one major problem faced by the Board was to obtain names and addresses of pregnant women so materials could be mailed to them.[50] In 1920, the Women's Institute assumed responsibility for submitting names of expectant mothers, but they too encountered the same difficulty as the Board.[51] Printed materials were also distributed during the nurse's home visits, at baby, dental and T. B. Clinics, at demonstrations and exhibits, and at fall fairs.[52] As Dr. Lamb noted in the 1927-29 Annual Report of the Provincial Board of Health, "We average a distribution of 30,000 pamphlets a month and this is growing each month."[53] In 1929-30, Dr. Young noted that in addition to numerous talks, lectures, and demonstrations given during the year by public health workers, 240,000 bulletins and pamphlets had been distributed, an average of 20,000 each month.[54] Only at the height of the depression did the Board reduce its quantity of pamphlets and bulletins printed and distributed.[55] With improved economic conditions, the distribution of literature again increased and by 1939,

1,705 sets of prenatal letters, 3,642 sets of postnatal letters, 1,108 sets of preschool letters and 604 sets of school child letters were mailed to people in the province.[56] These numbers did not include the thousands of pamphlets, bulletins and other printed materials distributed through local health units, other health care and welfare agencies, or by community workers. Between 1919 and 1939, hundreds of thousands of pamphlets and bulletins that covered a wide range of topics were distributed throughout the province.[57]

Health workers also utilized other forms of media. In 1914, Dr. Fagan indicated his intention to purchase a set of moving picture films dealing with health subjects.[58] As early as 1925, Mrs. C. A. Lucas, nurse-in-charge of the Saanich Health Unit, used a Victoria radio station to speak to listeners in the Saanich Municipality about the Saanich public health program.[59] "The Health Officer Suggests..." was the title of a twenty-four part series of radio talks, given in 1939 by health professionals over Victoria radio station CFCT. The talks touched on all aspects of the public health program, and included separate broadcasts to discuss each age group of children: infants; preschoolers; school children.[60]

Owners and operators of privately owned radio stations frequently donated airtime for the broadcast of health bulletins and talks and health workers were quick to accept the opportunity.[61] In response to local needs, public health workers developed specific programs. In 1933, during Chilliwack's "Health Week" publicity campaign, two public nurses organized five, fifteen minute talks on child and health care to be carried on the local Chilliwack radio station at the supper hour; the nurses believed a radio broadcast at that hour would reach an immediate audience of ten thousand listeners.[62] In fact, local health workers used public

talks, demonstrations, classes and group studies, dramas and window displays in their efforts to reach the public.[63] They not only distributed materials produced by other agencies, but also materials they produced themselves. The Vancouver Metropolitan Health Unit's booklet on child care was given to each new mother at the time of the nurse's first visit.[64] In 1939, Peace River Health workers, concerned about a recurring outbreak of acute enteritis, prepared and distributed detailed instructions for home water chlorination and rural home sanitation.[65] Materials prepared by local units were designed to meet local needs and to supplement the materials produced by other agencies.

III

But not all health care and child care problems were of a local nature; many of the same problems affected all areas of Canada. In response to demands for a central agency to coordinate and initiate Canada wide health programs and services, the Federal Department of Health was created by Act of Parliament on June 6, 1919.[66] Among the duties assigned the new department was that of coordinating provincial and territorial health services to preserve and improve public health, conserve child life, and promote child welfare.[67] In direct response to the concern for child health, the Child Welfare Division, with Dr. Helen MacMurchy as director, was formed in May, 1920. MacMurchy immediately initiated a program designed to educate the public to better child care-child rearing practices through the dissemination of relevant information.[68] The first publication produced, The Canadian Mother's Book, was released March 3, 1921. This book was an immediate success and by March 31, 1921, a total of 12,000 copies had been dispensed.[69] By 1923, 220,000 copies in both French and English were distributed to Canadian mothers through the Child Welfare Division, provincial and local boards of health, municipal

officials, registrars of birth, members of the clergy, women's organizations, policemen and private citizens.[70] The Canadian Mother's Book was soon translated into several other languages for use with immigrant women in Canada and in other countries.[71] Newspapers in Newfoundland (not yet a Canadian province), Great Britain, the United States, and India quoted from the book and reproduced sections in serial form for their own national readers.[72] Helen MacMurchy pointed out that, "No one will ever convince the Canadian Department of Health that mothers do not want to learn. Thousands of mother's letters are on the department files to prove the contrary."[73] In 1924, the Child Welfare Division prepared A Supplement to The Canadian Mother's Book for use by health workers in Outpost Hospitals and in other isolated areas of Canada.[74] Only one run of one thousand copies was made of the Supplement.[75]

Encouraged by the success of The Canadian Mother's Book, the Child Welfare Division produced a series of booklets called "The Little Blue Books".[76] The first series of fourteen titles was published in October, 1921, when 10,000 copies were distributed in the first few weeks; by 1923, the series was into its fourth edition.[77] The series was continually revamped and expanded to meet the changing needs and interests of both health workers and parents. For example, in 1926, booklets were added which were

> especially suitable for adolescents, for use in schools, for benefit of children needing special care, and for parents of children who are brought before the Juvenile Courts or are dealt with by probation officers.[78]

Two publications released in 1930 "Be Prepared to Prevent Infantile Paralysis" and "Maternal Care" were addressed to specific concerns of the time.[79] Two other publications, A Handbook of Child Welfare Work in Canada, (1923) and An Enquiry into Maternal Mortality in Canada, (1927), were

published in response to specific conditions.[80] The first reviewed the state of child welfare work across Canada. The second investigated the causes of death among Canadian mothers between July 1, 1925 and July 1, 1926, and recommended measures that should be taken to reduce the maternal death rate. Other types of materials produced by the Division included lithographed posters prepared for displays at fairs and baby health demonstrations. Each poster provided health information, a list of free publications available from the Federal Department of Health, and a set of post cards addressed to the Department of Health. By simply mailing the card to the Department of Health, a woman would receive her own free copy of the Division's publications. In the first month of the poster program, 1,400 posters and 40,000 cards were sent out and 7,315 post cards were returned with requests for free literature.[81] MacMurchy reported that during the fiscal year 1922-23, the Child Welfare Division had distributed 365,503 publications to Canadian parents.[82]

The Child Welfare Division recognized the potential of other forms of media. Only fifteen months after the release of The Canadian Mother's Book, the Canadian Government Film Service (Canadian Government Motion Picture Bureau (forerunner of the National Film Board) released Film No. 98. This film, showing some of the pictures and pages from The Canadian Mother's Book, was distributed for viewing in movie theatres across Canada.[83] MacMurchy and her staff also used radio to reach Canadian mothers. In 1932, MacMurchy met with the director of the newly formed Canadian Radio Commission to arrange with him the broadcast of health information on the new network. Less than a year later, February 7, 1933, the first broadcast presenting the work of the Child Welfare Division was aired.[84] In 1934, the Child Welfare Division was disbanded and many of its activities, including the dissemination of information, was assumed by the Canadian Council

on Child Welfare. The Federal Department of Health, however, continued to distribute The Canadian Mother's Book.[85]

In response to pressure from various voluntary organizations concerned with child welfare, in October, 1920, Helen MacMurchy convened an Ottawa conference of health professionals, social workers, educators, religious specialists, jurists, labour leaders, representatives of women's organizations, social agencies, and service clubs. Out of that meeting was formed the Canadian Council on Child Welfare.[86] The Council was not a government agency, although it functioned under the wing of the Child Welfare Division until 1924, when the Council established a national office with Miss Charlotte E. Whitton as Executive Secretary.[87]

Social historian Tamara Hareven described the Council as the most important Canadian welfare agency of the 1920's and 1930's.[88] As a national organization, it coordinated the work of public and private child care agencies, it provided leadership in organizing child care programs, and worked as a pressure group to effect changes in five areas: child health; child labour; education and recreation; the child with special needs; the ethical and spiritual development of the child.[89] It published and distributed a wide range of informational materials that reflected its diverse interest. In 1935, for instance, the list of free materials available from the Canadian Welfare Council totalled eighty-one publications, sixteen wall charts, seven posters, prenatal, postnatal and preschool letters, a series of six pamphlets in habit formation and training, patterns of layettes, abdominal and hose supports, six diet pamphlets, health record forms, three forms for use by child care agencies or child care institutions, the proceedings of the Annual Meetings and

conferences of the Child Welfare Council and The Child and Family Welfare, and the bimonthly news publication of the Council.[90] The Council appears to have been indefatigable in its efforts to get materials to the public through press notices and advertisements in newspapers and magazines.[91] The May, 1934, issue of The Child and Family Welfare News noted that "The regular press notices carried in the Chatelaine, the Canadian Home Journal, La Revue Moderne, The Free Press Prairie Farmer, continue to prove a source of requests."[92]

How successful was the Council in distributing its materials to the public? Between the inception of the prenatal letter service in April, 1926 and May, 1931, 58,000 sets of prenatal letters were distributed to Canadian mothers and another 50,000 were on order. Between the initiation of the postnatal letter service in August, 1930, and May, 1931, 7,810 sets of the postnatal letters and 25,000 sets of the diet folders had been distributed across Canada.[93] No one is able to determine what percentage of these publications reached British Columbia, but by 1937 the British Columbia Board of Health was distributing the prenatal and postnatal letters prepared by the Council with its own introduction attached to the letters.

IV

Voluntary organizations played a vital role in the development of child care programs in British Columbia. Three leading organizations in this process were the Women's Institute, the British Columbia Division of the Red Cross, and the Victorian Order of Nurses (VON). The Women's Institute was formed in Ontario in 1897 and by 1909 had established several other institutes in British Columbia.[94] The Women's Institute believed a woman's responsibilities were to her family, her home, and her

community, and its purpose was to improve living conditions for rural families.[95] Both Institute members and politicians recognized the Institute's potential for providing community leadership and for moulding public opinion.[96] For example, in 1916, the Institute recommended the inclusion of household science training in the public school curriculum and urged the general enforcement of the "Medical Inspection of Schools Act".[97] It supported the appointment of a district nurse to Saanich in 1917, and the establishment of Saanich Rural Health Centre in 1921. It continued to provide local leadership in the development of rural health programs throughout the province during the 1920's and 1930's.[98] In 1924, it urged women to seek election to local School Boards.[99] Throughout the two decades it demanded health care for children of all ages and for their mothers.[100] It worked through the 1920's and 1930's to improve sanitary conditions and water supplies for rural schools, and purchased equipment for hot lunches, first aid supplies, and playground apparatus. It provided library books, prints by the great masters, gramaphones, weighing scales for schools, and encouraged beautifying school grounds. It also demanded domestic science and manual training in both elementary and high schools,[101] and organized well-baby clinics and health crusades in schools and communities.[102] It frequently provided funds for dental treatment for children. In 1935, for example, the Women's Institute in the Hazelmere District paid the total cost of dental treatment for 127 children, paid half the cost of dental care for 1,608 Surrey children, and made substantial contributions toward dental care in Kaslo, Gibsons, and several other areas of the province. It also assisted children in need of corrective treatment of ears, eyes, and tonsil defects.[103] The Queen Alexandra Solarium, opened in 1927, another Women's Institute project, provided essential treatment for children suffering from disabilities and deformities caused by tuberculosis, bone infections, infantile paralysis, and

anterior poliomyelitis.[104] There is ample evidence to indicate that the Women's Institute played an important role in supporting the development of health care and health services for the province's children.[105]

The second organization to provide leadership in health care in British Columbia was the Red Cross. Following the lead of the International Committee of Red Cross Societies, the British Columbia Division agreed to assume a peacetime program aimed at health improvement, disease prevention, and mitigation of suffering throughout the world.[106] The British Columbia Division saw its duties as providing aid to veterans, continuation of rural nursing service and Red Cross Health Centers, the organization of the Junior Red Cross, the extension of health work in schools, and the establishment of disaster relief depots throughout the province.[107] Public health work immediately became an important component of the peacetime program of the Red Cross. Drawing from its supply of nursing sisters returned from overseas in 1918, the Red Cross placed ten nurses in public health work in rural British Columbia in 1920.[108] Their duties included the regular examination of school children, the instruction of Little Mother's League classes, bedside visits, and prenatal and maternity visits. With the development of the Provincial Public Health Service, the Red Cross re-evaluated its role and, in 1922, decided that the society's activities would take the form of educational work rather than an extension of nursing service.[109] From 1923 to 1939, instruction in first aid and home nursing became the major thrust of the society, although it continued to operate well-baby clinics, distribute cod liver oil and/or milk where needed, and performed emergency crisis relief.[110] The Red Cross also sponsored the Junior Red Cross, a children's organization designed to promote good health, humanitarian ideals, good citizenship, and international friendliness.[111] The contributions by the Red Cross,

first, through the establishment of a Chair of Public Health, and secondly, through educational programs for both adults and children, were very important in the development of British Columbia's health care and health services.[112]

Another national organization active in British Columbia was the Victorian Order of Nurses. Established in 1897 to help improve the quality of maternal and child care, the VON quickly developed a nursing service composed of nurses trained in public health work. These nurses worked as district nurses and manned cottage hospitals in rural areas.[113] With the development of the province's public health services and training programs for public health nurses, the VON's district nursing service and cottage hospitals were no longer required. In 1921, the VON turned its energies to maternal and child care; it provided prenatal instruction, postnatal care, maternity nursing in homes, and general home nursing. In some areas of the province, the VON handled most of the maternity care as well as prenatal and postnatal care.[114] Additionally, the VON conducted an extensive educational program designed to advise and inform parents about child care and child rearing techniques through well-baby clinics, group talks, mothercraft classes, and home nursing classes.[115]

V

Health care agencies were not the only source of child care-child rearing information for parents of the 1920's and 1930's. On the contrary, publications and information services were available from a variety of sources: life insurance companies; drug manufacturers; newspapers and magazines; church organizations. For example, in 1925 the Metropolitan Life Insurance Company had "forty different health and disease subjects available for distribution on request".[116] These included pamphlets on

child care, the prevention and care of colds, the preparation and use of milk, and the establishment of good health habits.[117] In another example, during the fiscal year 1930-31 the Canadian Life Insurance Officers Association contributed $7,097.49 to assist financially the National Council on Child Welfare produce the prenatal letter series.[118] Undoubtedly, the motives of the insurance companies were highly mercenary, but their materials were free and parents and other agencies utilized them.[119]

Drug companies also provided both free information and materials.[120] Throughout the 1920's and 1930's Steedmans, producers of teething powders for babies, offered a free booklet titled Hints to Mothers.[121] During the difficult days of the depression, drug firms frequently provided free samples of cod liver oil and public health nurses distributed these samples to homes where they saw the need to encourage mothers to use cod liver oil.[122]

A feature of many pharmacies during the 1930's was a Baby Department where not only those items required or desired for infant care were sold, but also where a set of scales was available to weigh infants. In some pharmacies the scales could be borrowed or rented by the mother, and in others a weekly weighing day was announced and the mother brought her infant to be weighed. The weight was either recorded on cards kept in the dispensary, or by the mother herself. This service was not only useful for keeping a record of the infant's weight gain, but also for the nursing mother to weigh her infant before and after feeding to determine how much milk the infant consumed. Although baby departments were organized with merchandising baby care materials in mind, they provided an essential and well-used service to mothers.[123]

The press also joined the campaign to bring information to parents.[124] Mrs. V. MacLachlan, Secretary to the Women's Institutes of British Columbia believed the press to be a potent force, as she reported to the 1925 Conference on Child Welfare that "Day after day the press is at work in the mind and character of vast masses of this country and no other influence is to be compared with theirs in shaping the moral destinies of our nation."[125]

Seven publications were examined as part of this study. These included two Vancouver daily newspapers, The Daily Province (The Province), The Vancouver Sun (The Sun), one small urban weekly newspaper, The Vernon News, three weekly magazines, the Family Herald and Weekly Star (a farm paper), the Star Weekly, and the Canadian Churchman (the offical organ of the Church of England in Canada) and one monthly women's magazine, Chatelaine.[126] This small sample indicated that publications as diverse as these seven carried either a regular column addressed to parents, or pertinent items on child rearing and child care. The Vancouver Sun and Star Weekly, for example, carried a Hearst syndicated column written by Mrs. Myrtle Meyer Eldred. In addition to offering free advice through her column, "Your Baby and Mine", Mrs. Eldred offered free pamphlets on a variety of topics that included thumb-sucking, toilet training, bed-wetting and diets.[127] The Vancouver Sun and the Family Herald and Weekly Star carried the Bell syndicated column edited by Angelo Patri.[128] Why these papers carried syndicated American columnists is not clear, but it may have been more convenient or cheaper to utilize a syndicated outlet than a local consultant. The Family Herald and Weekly Star weekly "Mother and Baby" column which appeared in every issue was written by an unidentified Montreal physician.[129] From its inception in 1928, Chatelaine consistently carried a variety of items and articles written

by Canadian child care advisors and health professionals. From 1933 to 1939 "The Baby Clinic" edited by Dr. J. S. W. McCullough, Inspector of Health for Ontario was carried as a regular monthly feature.[130] The Star Weekly also carried regular weekly items and articles of interest to parents, but the writers of the information changed several times over the two decades.[131]

British Columbia's largest daily newspaper, The Vancouver Province, and Vernon's weekly, Vernon News, did not feature a regular column to parents, but they frequently carried pertinent news items and articles dealing with child rearing and child care.[132] For example, the October 1, 1924 issue of The Vancouver Province reported the results of the vaccination program in Vancouver schools. Amongst the local items from the Vernon area were reports of developing health services, dates of well baby clinics, and the appointment of VON and school nurses.[133] The encouraging and optimistic tone of these local news items must have encouraged community members to utilize the facilities and services available, or to request similar services for their own areas.

Church organizations not only prepared and published, but actively distributed information and materials to their members. The materials prepared frequently reflected the problems and concerns of the time. For example, three bulletins available from the General Board of Religious Education of the Church of England in Canada were titled, "The Problem of the Moving Picture Theatre", "Eugenics", and "The Family".[134] In 1920, "Infant Mortality", "Juvenile Courts", and "Women and Child Labour" were added to the list.[135] A more direct approach was the distribution in 1923 of seventy thousand copies of a Lenten letter "Commandments to Parents" to the churches' 162,000 families.[136] In 1927, another Lenten

letter "Look to Your Children" was also distributed Canada-wide to Church of England families.[137] Additionally, the Church's Council of Social Service operated a lending library mail service from Toronto. Among the titles available for loan were City Planning for Girls by Henrietta Additson, Sterilization? Birth Control? by Helen MacMurchy, Teaching of Temperance and Self Control by E. C. Urwin, Psychology and Religion in Early Childhood by J. W. D. Smith, Parents and the Preschool Child by W. E. Blatz and Helen Bott, The Retarded Child and How to Help Him by Arnold Gesell, and The Unmarried Mother and Her Child by M. H. Notingly.[138] Certainly the choice of titles reflected the concerns of the era as well as the concerns of individual churchmen and women involved in child care and child welfare. These individuals included Charlotte Whitton, Secretary to the Canadian Council on Child Welfare and a member of the Church of England's Council for Social Service, and Dr. Helen MacMurchy, Director of the Child Welfare Division and an active member of the board of the Missionary and Deaconess Training School for the Presbyterian Church in Canada.[139]

Health professionals also recommended a substantial number of books and manuals on child rearing to parents.[140] The 1937 issue of the "Post-Natal Letters" recommended eight books. Included in the list were L. Emmett Holt's The Care and Feeding of Children, Alan Brown's The Normal Child, Jessie Fenton's The Practical Psychology of Babyhood, and Thom Small's Habit Training for Children.[141] Although many books were recommended to parents, there is little evidence they were extensively used.[142] Although the books may have been overly expensive for many parents, it is more likely that parents were looking for a more pragmatic type of manual on child care. The publications provided by the various health agencies were not only free, but also better suited to parents' needs.

The publicity surrounding the birth and childhood of the Dionne quintuplets provided another source of child rearing and child care information. Born in May, 1934, the "Quints" immediately became newsworthy, and every detail of their feeding, care, and development was broadcast to the world. Dr. A. R. Dafoe, the midwives, and the nurses associated with the Dionnes, were touted as experts, and several individuals associated with the early care and rearing of the Quints gave interviews in which they outlined the scientific method used to rear the five babies. In a series of articles in Chatelaine, Madam De Kiriline revealed in minute detail the feeding, care, and treatment given the Quints during their first two years.[143] As a guest on the Rudy Vallee radio show, Dr. Alan Dafoe outlined the minute-by-minute rigid daily schedule followed with the Quints, including the regular doses of orange juice, cod liver oil and daily naps in fresh air.[144] Any news about the Quints had a large listening, reading, or viewing audience on radio, in the press, or in newsreel films in the local movie theatres.

The Quints' endorsement of food and health care products such as milk, soap, toothpaste, cereal and cod liver oil certainly profited the sponsoring companies, but perhaps some infants were better fed or better cared for because they were fed Pablum, Carnation milk, or Puretest Cod-liver Oil as their parents imitated the feeding practices of the Quints.[145] In his book The Dionne Years, Pierre Berton points out what he believes to be the effect of the publicity surrounding the life of the Quints. "They influenced attitudes towards child rearing, inoculation, and adoption. They boosted the sales of condensed milk, toothpaste, disinfectant, and dozens of other products."[146] In 1936, the year the Quints were photographed receiving their diphtheria shots, the Toronto immunization clinics had the heaviest attendance in their history.[147] Whether the

published Quints' picture created the same effect in British Columbia is not clear, but Dr. Young notes in his 1936 Report for the Provincial Board of Health that "The distribution of vaccines and serums by the Provincial Board of Health shows an increase for those required for preventative work and a decrease in the curative branch..."[148] Young attributed the gain to the cumulative work of public health workers; he probably never considered the possibility of the Quints having an influence on immunization numbers in British Columbia.

VI

The inter-war years saw the development of health care and child care services as government departments, voluntary agencies and organizations consolidated and coordinated their services for children. With the recognition by politicians and civil servants that the State had a responsibility for the growth and development of its future citizens came the development of public health services and health information programs organized and financed by all levels of government. Voluntary agencies, women's organizations, church groups, individual health professionals, jurists and social workers coordinated their efforts under one large, active and influential organization, the Canadian Council on Child Welfare. The concerns of the Council extended beyond health care to education and recreation, labour, ethical and spiritual development, and children with special needs. Voluntary agencies, such as the VON, Red Cross and Women's Institute, continued to work at the community level where they observed and attempted to meet community needs by providing either specific types of services themselves, or by rendering financial assistance to other organizations to provide services.

Health professionals and child care advisors firmly believed parents

could be educated to the new scientific approach to health care and child rearing. To accomplish this end, they utilized every form of communication media available to them: printed materials; radio; films; exhibits and displays. Throughout the 1920's and 1930's, hundreds of thousands of pieces of free literature were distributed through the public school system, public health units, voluntary agencies, insurance companies and food and drug companies.

Was the use of the media influential in altering child rearing practices of British Columbia's parents? There seems little doubt that the answer is "yes". Educator Urie Bronfenbrenner points out, "the fact remains that changes in values and practices advocated by prestigeful professionals can be substantially accelerated by rapid and widespread dissemination through the press, mass media of communication and public discussion."[149] There is ample evidence that the media played a role in effecting change in the child rearing practices of British Columbian parents.

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Chapter 2 Motherhood: In the Service of the Nation

By 1920, health professionals and child care advisors recognized that if they were to change child rearing practices of British Columbia parents, they must begin working with expectant parents before parturition. Developments in medical research and health care not only ensured a greater chance of survival for the infant, but also a healthier pregnancy, a less dangerous delivery, and a greater chance of survival for the mother than had previously been the case.[1] Advisors were aware that the foetal stage was an extremely important period in the child's total development, and that the mother's health was the most important factor in determining the chances of survival for both the infant and the mother. Furthermore, health professionals knew puerperal septicaemia (child-bed fever), the greatest killer of new mothers, was preventable through good personal health care and cleanliness by the mother and proper hygienic precautions by the attending physician or midwife. Deaths caused by abortion (induced or natural), haemorrhage, bleeding during pregnancy or labour, uncontrolled vomiting, eclampsia, and nephritis, were at least controllable if not preventable. A difficult labour could be anticipated, and birth complications could be sometimes predicted before the woman actually went into labour.[2] Throughout the 1920's and 1930's, British Columbia mothers were urged to seek prenatal care not only as a way of reducing the number of physical defects and deaths among their infants, but also as a means of ensuring their own survival.[3]

I

During the earlier part of the twentieth-century, British Columbia's health professionals had expressed concern with the high rates of maternal and infant deaths. For example, in 1912, Dr. F. T. Underhill, Vancouver's

medical health officer, drew attention to the city's high mortality rates. He argued that deaths of both infants and mothers were directly related to the quality of life in the city's tenements, which he believed lacked fresh air, natural light, proper sanitation, and sufficient living space. Underhill argued that these conditions created "within the expectant mother a dread and abhorrence of children, very often ending in disastrous results for both herself and the child."[4]

But Vancouver's health professionals were not the only groups aware of the problem, and in November, 1919, the British Columbia Government appointed a Commission on Health Insurance to investigate, among other things, the subject of maternity insurance. The Report of the Committee on Maternity Insurance and Public Nursing (1921)revealed a province-wide concern by women's organizations, religious specialists, and other members of British Columbia's society at the lack of medical facilities and financial assistance for expectant mothers.[5] At the national level, a statistical analysis of births, infant deaths, and maternal deaths in the 1921 Dominion Census brought into sharp focus the magnitude of the problem.[6] As Helen MacMurchy pointed out, "On the list seventeen civilized nations averaged in order as regards maternal mortality, Canada and the United States were at the foot of the list."[7] Switzerland, Norway, and the Netherlands, countries which provided compulsory maternity benefits for their mothers, had the lowest maternal mortality rates.[8] Statistically, British Columbia's 1921 maternal mortality rate of 4.78 per 1000 live births was only slightly higher than the national rate of 4.70, although the infant mortality rate of 56.5 was considerably lower than the national rate of 102.0 per 1000 live births.[9] But these statistics must not be accepted without reservations; H. B. French, Provincial Deputy Minister of Births, Deaths, and Marriages, pointed out that, because of the widely spread - sparsely settled populat-

ion in some areas, and the migratory nature of the population in other areas, accurate vital statistics were not only delayed but also difficult to collect.[10] Nevertheless, the statistics derived from the 1921 Dominion Census did alert health professionals, public health workers, politicians, and concerned laymen to the extent of infant and maternal deaths. Once aware of the magnitude of the maternal mortality problem, the 1924 Conference on Medical Services in Canada passed a resolution requesting the Federal Department of Health make a comprehensive enquiry into the causes of maternal mortality.[11]

Dr. Helen MacMurchy and the staff of the Child Welfare Division began the requested enquiry in Janury, 1925. They examined two types of data: the death certificates of all Canadian women aged fifteen to fifty years who died between July 1, 1925 and July 1, 1926; the responses of six hundred forty-one Canadian physicians to a questionnaire sent out by the Division in May, 1925.[12] The enquiry found that of the approximately 11,000 deaths of Canadian women of child-bearing age, 1532 deaths could be directly attributed to complications of pregnancy, labour, or post-parturition infections. There were an additional 2,800 deaths which might or might not be attributed to complications arising from pregnancy. Of the 1532 deaths, only 230 (twelve percent) of the women involved had sought prenatal care.[13] The enquiry also disclosed that complications arising during pregnancy or childbirth were the second greatest cause of death among Canadian women, tuberculosis being the most common cause.[14]

Although concerned for all mothers, health professionals were particularly anxious to reach those women who neglected to consult a physician during pregnancy, could not afford medical care, or lived in isolated areas where medical assistance was not available.[15] But, as the research shows,

not all women neglected to seek prenatal care. In a study of medical attendance in Vancouver between 1886 and 1920, social historian Margaret Andrews focused on the medical practice of Vancouver physician Henri Evariste Langis. Among other details of Langis' practice, Andrews found that for the time periods 1893 to 1894 and 1903 to 1904, seventy percent of the women whom Langis attended at child-birth had seen him before the onset of labour. Andrews concluded these women "had the advantage of some prenatal care."[16] She also noted that it was neither ethnic background, economic position, nor occupation, that determined which women sought Langis' services before their confinement, but rather a high proportion were women who either experienced or anticipated difficulties during pregnancy or labour.[17] Although Andrews found that seventy percent of Langis' obstetrical cases sought prenatal advice, this was not the case for most of the province's expectant mothers, therefore, among other recommendations the Report on Maternity Insurance and Public Nursing (1921) called for the initiation of a vigorous educational child-birth program by the Board of Health. The report also recommended provision be made for medical, surgical, and obstetrical services and materials wherever necessary to ensure a safe pregnancy and delivery for every British Columbia mother.[18] The Report of the Enquiry into Maternal Mortality confirmed that a large number of women did not seek prenatal care, and it clearly demonstrated that most maternal deaths (eighty-eight percent) occurred among women who had no prenatal care.[19] Although mothers were urged to visit their family physician early in their pregnancies and to continue regular visits throughout their nine month gestation period, the veil of secrecy and embarassment that surrounded pregnancy made mothers reluctant to do so. Health workers were constantly appalled by the large number of maternal deaths that need not have occurred.[20]

Because health workers believed most maternal deaths, and frequently the deaths of infants, could be prevented through prenatal care, they saw their primary task as one of convincing British Columbia women that the number of deaths of both mothers and infants could be greatly reduced through proper prenatal care.[21] They saw their second task as that of teaching women that a healthy mother produced a healthy infant. Their third task was that of persuading expectant mothers (and fathers) to seek medical advice long before women went into labour, and certainly long before complications developed during labour.[22] Health professionals attempted to provide prenatal care and advice to expectant mothers by three different methods: having women attend prenatal clinics; through home visits made by nurses; through the distribution of relevant literature.

Throughout the 1920's and 1930's, public health, VON, and Red Cross nurses attempted to establish prenatal clinics throughout the province, but they found it a slow and difficult process. For example, the Saanich Health Centre made plans to establish a prenatal clinic as early as 1922, but its organization took two years to complete, and then attendance was ensured only if the nursing staff drove women to and from the clinics.[23] Saanich's medical health officer reported that nurses found this practice time consuming in proportion to the number of expectant mothers delivered to the clinic, therefore, in 1927, the nurses began to make home visits to expectant mothers.[24] In his 1925 report to the Child Hygiene Section of the Canadian Conference on Child Welfare, Hon. W. F. Roberts, Minister of Health for New Brunswick, expressed the opinion that prenatal clinics were difficult to establish because it was not easy to convince women to attend.[25] Roberts observed that mothers were willing to bring their infants to well-baby clinics, but unwilling to attend prenatal clinics.[26] Two years later, Miss A. G. Wells of the

Manitoba Board of Health, reported to the Canadian Council on Child Welfare that prenatal clinics were still lacking in rural areas of the western provinces, although rural mothers certainly needed access to prenatal information and advice.[27] In 1930, Olive Garrood, the indefatigable public health nurse in Kamloops, attempted to establish a prenatal clinic, but she also encountered difficulty convincing mothers to attend. She reported that pregnant mothers still did not seem to understand the importance of prenatal care.[28]

Attempts to establish prenatal clinics in urban areas met with little more success than in rural areas. The 1920 organizational plan for the Vancouver Division of Child Hygiene included a weekly prenatal clinic at Vancouver General Hospital, and the Vancouver Board of Health annual report optimistically stated, "The Department commences with the expectant mother ..."[29] The 1921 report and all subsequent reports up to 1939 do not mention a prenatal clinic. Furthermore, as late as 1937, Dr. Stewart Murray, Director of Child Hygiene for Vancouver, reported that Vancouver public health unit still had no definite prenatal care program, and wherever maternity cases were found they were referred either to the woman's personal physician or were directed to VON clinics.[30]

In post-First World War British Columbia, the Victorian Order of Nurses shifted its focus from district work to home nursing. By 1924, Elizabeth L. Smellie, Superintendent of the Victorian Order, reported that sixty percent of the Order's work was in obstetrics.[31] Until the mid-1930's, all prenatal work by the VON was on a one-to-one basis through house calls made to expectant mothers, but during the mid-1930's the VON organized its first regular prenatal clinic in Vancouver.[32] Although the Vancouver branch of the Junior League assumed operational responsibility

for the prenatal clinic, in 1935, a Victorian Order Nurse was always in attendance to give prenatal instruction and advice to prospective mothers. VON Superintendent Margaret Duffield stated, "it has become one of (our) most active and best attended classes..."[33] The clinic's program consisted of a lecture on prenatal care, instructions and distribution of materials for making layettes, and a social time over a cup of tea.[34] Yet this one clinic appears to have been the only regular prenatal clinic operating in the City of Vancouver. In spite of the repeated attempts by British Columbia's health professionals and public health workers to establish care for the expectant mother in various areas of the province, prenatal clinics appear to have been the most difficult type to initiate and to maintain.

The second method used by health workers to reach expectant mothers was through home visits, but the reluctance of expectant mothers to contact the nurse made it difficult for the nurse to contact them.[35] In 1921, Dr. Young noted that (unnamed) voluntary organizations were trying to introduce the practice of voluntary registration of pregnancies, however, the practice was never implemented and health workers had no sure method of locating mothers-to-be.[36] They frequently relied on the less-than-effective method of word-of-mouth communications for relating prenatal services to expectant mothers and for supplying the names of known pregnant women to health professionals. For example, in 1927-28, nurses in the Kelowna Rural District recorded four prenatal cases to whom they made 21 home visits. In 1929-30, the nurses recorded four prenatal cases to whom they made 11 home visits. In 1930-31, they reported no prenatal visits, although 289 infants were brought to the well-baby clinics during this time.[37] Obviously, nurses were not reaching even a small portion of the expectant mothers in the area, as the Reports of the Department of Vital

Statistics indicates that 137 births were registered in the Kelowna area in 1927, 153 births in 1928, 156 births in 1929, 144 births in 1930, and 166 births in 1931.[38] Although these numbers include births in both rural and urban areas of the Kelowna District, they also indicate public health nurses were making scant inroads into prenatal work.

Public health workers in the Peace River area used records of the local relief officer to locate names of expectant mothers that should be visited.[39] This method proved quite successful for in 1936, nurses made 325 prenatal calls, and in 1937 they made 220 prenatal calls.[40] In other areas of the province where relief work was one of the public health nurses' many responsibilities, nurses frequently contacted pregnant clients through routine social service calls.[41] In terms of reaching prenatal cases, home visits were probably more effective than prenatal clinics, but nurses certainly did not locate all pregnant women. This was partly because of the failure of women to seek prenatal aid from public health workers, and the growing tendency during the 1920's and 1930's for women to go to hospitals for deliveries. In 1931, Audrey Payne, Saanich Public Health nurse, noted that even in rural districts of the province the majority of women seemed to think two or three visits to their physician was all the prenatal care necessary during their pregnancies.[42] These women often did not bother to contact the public health nurse until after their babies were born.[43]

The third method used to advise expectant mothers was through the distribution of printed materials. The first prenatal advice issued by the British Columbia Board of Health was a set of ten prenatal letters prepared in 1920.[44] Throughout the 1920's and 1930's, the Provincial Board of Health, the Vancouver Board of Health, and the Victorian Order of Nurses

distributed materials either prepared by their own agencies or reprinted from materials prepared by New Zealand, British, or American health agencies.[45] These materials were distributed free to British Columbia mothers through health care agencies or by health care workers. Although prenatal materials were available through health care agencies, only occasionally did newspapers and magazines provide prenatal advice or urge mothers to seek medical advice early in their pregnancies. For example, in ninety-eight issues of Chatelaine magazine examined for this study, only six articles dealt with some aspect of prenatal care.[46] Nor were specific products recommended to expectant mothers. Among the materials examined, only one advertisement (by the Ovaltine Company) recommended mothers begin drinking its product about two months before the birth of their child. Drinking Ovaltine, the advertisement stated, would ensure an abundant milk supply and a faster recovery after parturition.[47] Not only was prenatal advice minimal in amount as compared to that available on infant care, but also most prenatal advice came either through direct contact with health workers or through the distribution of pamphlets, letters, or materials prepared by health agencies.

III

The advice for mothers-to-be carried both an idealistic and a practical message. The idealistic message was that mothers were the backbone of the nation and child rearing was part of a woman's national service.[48] As Helen MacMurchy stated, "No baby - no nation."[49] Motherhood was not only a desirable state but also a sacred right,[50] and a woman's special mission in life was to protect the home, the family, and the child.[51] In fulfilling this role, MacMurchy wrote, the mother "...is the one important factor in the future health of the nation, morally and physically."[52] In

her address to the 1918 convention of the Child Welfare Association of British Columbia, Mrs. Mary Ellen Smith, M.L.A. for Vancouver, stated that she believed all girls should be looked upon as potential mothers to be educated to fulfill their duties as the future mothers of the race.[53] At the same convention, Dr. Ernest Hall, of Victoria, recommended the immediate passage of the Mother's Pension Bill in British Columbia "as a recognition of the divine right of motherhood to be recognized as the highest service to the state."[54]

The practical message to women was that child bearing was a normal, natural process that need not be hazardous to either mother or infant. Yet, to reduce the hazards of child births, public health personnel recognized the need to provide both prenatal and postnatal services in all areas of the province.[55] In an address to the 1917 meeting of British Columbia Medical Health Officers, Dr. Isabel Arthur, Nelson's Medical Health Officer, stated "In order to have the healthy child we must have healthy parents so that the care of the child is prenatal."[56] The Report on Maternity Insurance and Public Health Nursing (1921) argued that the provision of prenatal care by public health agencies was a patriotic duty, and the committee's investigations demonstrated "...that child birth under favorable conditions is vastly more important to the nation than is child birth under adverse conditions."[57]

Rather than seek professional advice, young women accepted the half-truths and misinformation passed on by other women. This advice was rarely based on medical knowledge or research, therefore, health workers tried to educate women about medical facts about pregnancy, to make them aware of normal bodily changes that occurred during pregnancy, and to recognize which changes were abnormal and required medical treatment.

While working with expectant mothers, health workers discussed the need for regular medical supervision, expected changes in weight and general appearance, changes in temperature, pulse rate and respiration with expectant mothers. Women were warned to keep their bowels regular, and to seek medical assistance at the first signs of oedema, disturbed vision, vaginal discharge, protracted nausea or vomiting, persistent headaches, excessive flatulence or disponea, or varicose veins.[58] Women were taught to care for their breasts so they could breast feed their infants. They were told to get sufficient fresh air and exercise, eat a nutritious diet, and to get adequate rest. Health workers described the development of foetal life so mothers would be better prepared both physically and mentally for motherhood.[59] Frequently, health workers taught mothers how to prepare for delivery at home, and how to sew and gather a layette for their expected infants.[60]

IV

How successful were health workers in educating expectant mothers and in decreasing the mortality rate? In spite of the health worker's efforts, the official maternal mortality rate for British Columbia showed no significant decline until 1936. The maternal mortality rate of 5.0 per 1000 live births in 1920 rose to a maximum rate of 6.8 per 1000 live births in 1924, and then declined to 5.1 in 1935.[61] Until 1936, the only significant deviation in the maternal death rate was in 1933, when the maternal death rate declined to 4.7 per 1000 live births, however, the decline in the birth rate from 10,867 live births in 1930 to 9,583 live births in 1933 could account for the decline.[62] From 1934 to the end of the decade, the province's birth rate steadily increased to a high of 12,373 live births in 1939, yet the maternal death rate continued to steadily decline to a new low of 3.8 per 1000 live births in 1939.[63] British Columbia's maternal

mortality rate showed improvement two years before the national rate, and the province's 1938 rate of 3.8 per 1000 live births was encouragingly lower than the 4.2 national rate.[64] Even more encouraging was the continued downward trend, and by 1943 the province's maternal mortality rate dropped to 2.5 per 1000 live births.[65] (Table 2.1).

Although the mortality rate for the City of Vancouver declined significantly from a high of 5.5 in 1922 to a low of 2.3 per 1000 live births in 1939, the decline was not continuous because of the low numbers involved. Small variations in the number of deaths made dramatic changes in the death rates. For example, the deaths of four non-resident women in 1930 sent the Vancouver maternal mortality rate up from 4.1 to 4.3 per 1000 live births. The following year the rate dropped to 2.9.[66] Again, in 1932 the actual births dropped by 365 births from the previous year, yet the maternal mortality rate rose from 1.1 to 3.5 per 1000 live births.[67] What was the reason for the increased maternal mortality in 1933? Although no health workers, either provincial or municipal, point to the depression as the direct cause, they consistently point to the lack of proper diets and health care among both adults and children[68] (Table 2.2).

Why was there no significant decline in maternal death rates prior to 1936? Part of the explanation may be that statistics collected after 1926 reflected a more accurate and complete registration and classification of the causes of deaths. Helen MacMurchy pointed out in 1931 that in spite of the apparent increase in the maternal death rate, she believed the rate to be decreasing. MacMurchy asserted that greater accuracy and completeness in reporting and registering maternal deaths accounted for the apparent increase in maternal mortality rates between 1926 and 1929. During that time period, the Dominion Bureau of Statistics made further enquiries

Table 2.1

MATERNAL MORTALITY - PROVINCE OF BRITISH COLUMBIA

1920 - 1939

Year	Total Deaths	Maternal Deaths	Percentage of Maternal Deaths	Total Live Births	Death Rate Per 1000 Live Births
1920	4888	47	.96	9308	5.0
1921	4489	63	1.40	10687	5.9
1922	4748	63	1.32	11197	5.6
1923	4906	63	1.26	10001	6.3
1924	5004	69	1.87	10119	6.8
1925	4945	60	1.21	10342	5.9
1926	5474	65	1.18	10063	6.4
1927	5750	68	1.18	10084	6.7
1928	5910	61	1.15	10385	5.8
1929	6397	58	.90	10378	5.6
1930	6400	63	.98	10867	5.8
1931	6114	66	1.07	10404	6.3
1932	6150	54	.87	10214	5.2
1933	6221	45	.72	9583	4.7
1934	6400	50	.78	9813	5.0
1935	6857	52	.75	10013	5.1
1936	7222	50	.69	10171	4.7
1937	7973	51	.63	11279	4.5
1938	7450	48	.64	12476	3.8
1939	7515	38	.50	12373	3.8
1940	8315	43	.51	13830	3.1
1941	8505	31	.36	15038	2.7
1942	8869	45	.50	16808	2.7
1943	10012	47	.46	18802	2.5

SOURCES: British Columbia Board of Health, Reports, 1920 to 1939; British Columbia Department of Vital Statistics, Reports, 1927 to 1943.

Table 2.2

MATERNAL MORTALITY - CITY OF VANCOUVER

1919 - 1939

Year	Total Deaths	No. of Births	Death Rate Per 1000 Live Births
1919	9	2776	3.3
1920	15	3366	4.5
1921	20*	3623	5.5
1922	10	3192	3.1
1923	14	3165	4.4
1924	16	3303	4.8
1925	11	3578	3.1
1926	14	3458	4.0
1927	13	3563	3.6
1928	11	3346	3.3
1929	18	4354	4.1
1930	20	4539	4.3
1931	13	4241	2.9
1932	4	3597	1.1
1933	14	3232	3.5
1934	12	3407	3.5
1935	12	3587	3.3
1936	18	3577	5.0
1937	11	3951	2.8
1938	11	4226	6.2
1939	10	4359	2.3

* Four of these deaths were non-residents of Vancouver City.

SOURCES: British Columbia Board of Health, Reports, 1919 to 1939; British Columbia Department of Vital Statistics, Reports, 1926 to 1939; Vancouver Board of Health, Reports, 1919 to 1939.

into the recorded death of every woman of child-bearing age where puerperal causes might be involved, even though puerperal causes might not be stated on the death certificate. Initially, as a result of this intensive enquiry, the number of reported maternal deaths increased.[69] In 1936, the maternal mortality rate for British Columbia, as well as for the three other western provinces, began to decline steadily, and in 1938 the rate for Canada as a whole began a decline that continued throughout the 1940's and 1950's. In July, 1940, the editor of the Canadian Public Health Journal pointed out that the decrease in maternal deaths resulted from a forty percent reduction in deaths caused by puerperal sepsis, the direct result of greater efforts to prevent infection at the time of delivery and the use of sulphanilamide.[70] A few months earlier, Dr. A. Hardisty Sellers, Statistician for the Ontario Department of Health, also noted a thirty-five percent reduction in the number of maternal deaths caused by puerperal haemorrhage, and a thirty-six percent reduction in the number of deaths caused by puerperal toxemia.[71] But, as the editor of the Canadian Public Health Journal pointed out, most of the maternal deaths between 1936 and 1939 were caused by puerperal haemorrhage, puerperal sepsis and toxemia, and that practically none of these women had received any prenatal care before their confinement.[72] Dr. Sellers also stated that no province in Canada could point to any specific changes in either policy or practice that accounted for the steady decline in maternal mortality.[73] What Dr. Sellers failed to note was that between 1920 and 1939, parturition was treated as a medical problem, and more and more British Columbia women went to a maternity home or hospital for delivery. No statistics are available for the early 1920's, however, by 1927, sixty percent of births occurred in an institution that provided medical care. This number increased to eighty-two percent by 1937, and to ninety-two percent of all births in 1939.[74] (Hospital births in Canada for 1927

was 19.3 percent of births, for 1937 was 36.4 percent, and for 1939 only 41.7 percent of births - rates far below that for British Columbia).[75] Saanich nurse Audrey Payne reported in 1931 that even in rural districts of the province the majority of maternity cases were sent to hospitals. Little doubt exists that better care and more hygienic conditions at the time of delivery saved the lives of many mothers and infants.[76]

V

Between 1920 and 1939, British Columbia women were urged by health professionals and child care advisors to provide proper care both for themselves and their unborn infants. Mothers were assured that a healthy woman did not risk her own life to produce a healthy baby, and by maintaining a nutritious diet she did not have to sacrifice a tooth for every child. Although public health workers, the VON, and Red Cross nurses urged mothers to seek prenatal care for themselves and their unborn child, less progress was made in this area than in any other stage of child development. Whether from embarassment or from financial constraints, many women were reluctant to attend prenatal clinics or seek prenatal care. If women sought prenatal care, it was more likely to be from their family physician than through a prenatal clinic, and they were more likely to seek prenatal care if they either anticipated or experienced difficulties during pregnancy or if they planned to give birth in a hospital or a maternity home. Obstetrical cases in maternity homes or hospitals were treated as medical cases, and there the mother received medical care. This kind of treatment greatly reduced the number of deaths caused by childbed fever, toxemia, or haemorrhage. Although health professionals were not able to convince all mothers of the efficacy of prenatal care, one change was evident: expectant mothers of 1939 had prenatal medical services and health care available that enabled them to face childbirth with less fear and trembling than had

mothers a generation before.

Footnotes

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Chapter 3 Rearing the Infant: The Little Machine

The 1920's and 1930's witnessed many new and dramatic changes in child rearing practices in both british Columbia and elsewhere in the English-speaking world. Two major factors accounted for these changes: shifts in health professionals understanding of the fundamental nature of childhood; attempts by health advisors to have parents rear their children by principles of scientific management rather than by former traditional methods.[1] For the first time in history, infants had a good chance of surviving to become healthy, happy, individuals if their parents adopted the new scientific methods of child rearing.[2] Mothers were counselled to no longer rely on maternal instinct or on traditional child rearing techniques for, in the words of one advisor, "Maternal instinct is erratic, irregular, and altogether untrustworthy."[3] Rather, parents were urged to seek solutions to child care problems by rational means instead of relying on "traditional, personal experience and self-abrogated wisdom. . . ."[4]

Historian Lynn Bloom characterized the change in child rearing techniques during the first three decades of this century as a shift from a religious to a secular orientation where science and not Providence determined the chances of the child's survival.[5] Indeed, the appeal to parents by child care advisors to adopt the new scientific methods was so successful that many rejected their traditional practices in favour of the systematic, regimented approach that, according to critics, seemed to turn the infant into a "little machine."[6]

By 1920, developments in medical research, advances in child care, and studies in child psychology convinced advisors they must educate the public to new ways of feeding, caring, and training the child.[7] For example, Mrs. V. S. MacLachlan, Secretary to British Columbia Women's Institutes, told the November , 1919, Okanagan Convention that "every woman in British Columbia had the right to know the facts which science has made certain for the protection of child life,"[8] and that each woman, out of patriotic duty, should demand to know any information that would make her a better informed and more intelligent mother. This chapter will examine the sources of changes in child rearing practices as they relate to the infant during the 1920's and 1930's, identify the changes that were advocated, and examine the nature and content of advice on feeding and diets, toilet training and elimination, and habit training.

I

The work and research of three physicians, L. Emmett Holt of New York, F. Truby King of New Zealand and Eric Pritchard of the Marylebone District of London, and the research of psychologist John B. Watson, formed the nucleus of the theoretical advice given to parents of the 1920's and 1930's on the feeding and care of infants by British Columbia's public health workers and child care advisors.[9] Probably more than any other individual, Dr. Holt was responsible for establishing the new systematic scientific method of child care and child rearing. While serving as a professor on children's diseases at Columbia University and as an attending physician at both the New York Babies and Foundlings Hospitals, Holt wrote his systematic approach to child care in a simple manual, Catechism for Nurses. Originally prepared in 1889 for

use in training nursery maids, in 1894 Holt expanded the catechism into a book called The Care and Feeding of Children. Holt emphasized the physical aspects of child care because he believed the high infant mortality rate was caused either by ignorance or the carelessness of mothers. Holt laid out in meticulous detail how he believed infants should be fed, rested, clothed, exercised, bathed, and taught how to eliminate.[10]

Holt's work initiated the tightly scheduled, systematic approach to infant care that was to dominate the 1920's and 1930's.[11] But it was King and Pritchard who developed community based health care-health education programs designed to provide care for both infants and mothers. As a result of the efforts of King, the Royal New Zealand Society for the Health of Women and Children (Plunket Society) was formed in Dunedin, New Zealand, in 1907.[12] The Plunket Society (named after the then governor general of New Zealand) was an organization devoted to reducing both infant and maternal mortality rates. By 1911, through the efforts of King and the Plunket Society, the New Zealand infant mortality rate was reduced to the lowest in the world.[13] Because of the success of his work in New Zealand, in 1917, King was invited to England to establish an infants' hospital and mothers' training centre at Earls Court. Subsequently, Plunket centres were established in South Africa, Australia, Brazil, and Canada.[14]

Among other aspects of child care, King's book focused on the feeding of infants.[15] His research during the period 1900 to 1910 provided information in two areas: techniques and procedures used by mothers to initiate and maintain their ability to breast feed; the development of artificial formulas, which King called modified milk, for use with

infants who were not breast fed.[16] King outlined not only the components for four "humanized milk" formulas, but also provided instructions for the preparation and handling of each component of the formula such as lime water, whey, dextri-glucose, and emulsion.[17] The work and research of King and the Plunket Society was utilized by British Columbia's public health nurses in their work with mothers and infants, and the publications of the Plunket Society were distributed throughout the province by the Provincial Board of Health.[18]

The St. Marylebone Health Society of England, initiated in 1906, focused on two aspects of health care: the prevention of the spread of tuberculosis; the reduction of infant mortality among the poor within the Marylebone District of London. The infant program, under the direction of Eric Pritchard, a prominent London pediatrician, instituted an active campaign to educate and instruct mothers in the feeding and care of their children.[19] Pritchard demonstrated that a successful parent education - child care program required three essential elements: trained and competent staff; uniformity and continuity of methods and materials; advice that dealt with both the care and management of the infant and the mother's general health.[20] British Columbia's public health workers utilized both the research methods employed and the materials produced by these three physicians and they insisted mothers put their infants on rigid schedules, maintain scrupulous cleanliness in their care and feeding, and breast feed their infants for at least the first nine months of the baby's life.[21]

Although the major concern during the 1920's was physical care of infants, there was a gradual but growing concern for their psycho-

logical development. In 1928, John B. Watson, professor of psychology at Johns Hopkins University, published Psychological Care of the Infant and Child, a book Watson described as a complementary volume to Holt's book The Care and Feeding of Children.[22] Watson believed the "psychological care of the child to be as necessary as the physical care."[23] He saw parents as the shapers of their child's personality and character; once a child's character had been spoiled by bad handling, it was possible the damage could never be repaired.[24] According to Watson, "No one today knows enough to raise a child."[25] The purpose of his book was to help mothers rear a happy, independent, non-demonstrative child whose manners and actions were acceptable to adults.[26]

Canada is not without its own medical authority on child care. In his book, articles, and speeches, internationally known pediatrician Alan Brown, physician-in-charge at Toronto's Hospital for Sick Children, head of the Department of Pediatrics of the University of Toronto Medical School, and one of the inventors of Pablum, preached child rearing techniques to Canadian Parents.[27] Although Brown's book, The Normal Child: Its Care and Its Feeding, focused on the physical aspects of child care, he also dealt with the topics of discipline and habit training.[28] The Normal Child was enthusiastically reviewed by The Canadian Churchman as the only book of its kind written by a Canadian containing "just what every mother should know, from the birth of the child - the care and feeding during infancy, etc., and a thousand and one other suggestions."[29]

Dr. John W. S. McCullough, a contemporary of Brown's and chief inspector of health for the Ontario Board of Health from 1910 to

1935, edited Chatelaine's monthly "The Baby Clinic" from 1933 to 1939. McCullough also focused on the physical aspects of child care: feeding; immunization; habit training.[30] McCullough's assertive and didactic tone showed little patience with maternal ignorance or laziness, and in his monthly column, he castigated mothers who failed to establish good habits through a rigidly scheduled systematic approach to feeding, rest, toilet training, and habit training.[31]

The work of these theorists must be examined in the context of the broader social concerns of the inter-war years. The high infant mortality rate in both rural and urban areas, and the lack of coordinated child welfare programs for Canadian children was of concern to governmental authorities.[32] In 1920, in response to these concerns and other related problems in child health, the newly organized Federal Department of Health created the Child Welfare Division with Ontario physician Helen MacMurchy as Division Chief.[33] MacMurchy had previously prepared three comprehensive reports for the Ontario government in which she outlined the various causes of infant deaths and summarized attempts being made to reduce the infant death rate.[34] At its May, 1920, meeting, the Dominion Council of Health, a body composed of both provincial and federal representatives, requested the newly formed Child Welfare Division produce original publications on child welfare for use in Canada.[35] MacMurchy and the Child Welfare Division staff set to work at once and provided Canadian mothers with pragmatic advice through The Canadian Mother's Book, a publication which focused on the child's physical care and development. It was an immediate success, and has remained a popular publication unto the present time.[36] Dr. MacMurchy did not initiate any new or innovative child care practices, but rather worked to disseminate practical advice and information that could be utilized

by parents and health professionals in both rural and urban areas.

II

The nature and content of advice available to parents was firmly rooted in the advisor's concept of the infant. Alan Brown reflected the tabula rasa point of view accepted by most child care advisors of the time when he described the newborn as having little more intelligence than a vegetable, with little or no control over bodily motions or facial expressions, unable to hold his head upright, unable to distinguish light and darkness, unable to hear, but equipped with a slight sense of smell and a well developed sense of taste. The newborn, he said, was "not directly conscious of anything."[37] In fact, the infant's mind was regarded as a clean sheet of paper awaiting sensory experience from the world around him.[38] As a consequence, Brown, as well as other advisors of the 1920's, placed a strong emphasis on systematic child training.[39] Beginning immediately after birth, parents were charged with the responsibility of training the child in those basic habits which would produce an obedient, self-reliant, self-controlled, unselfish adult.[40] Parents were warned that if they took the wrong action, their child would be permanently impaired. Parenthood, and especially motherhood, was considered an awesome responsibility.[41]

Other child care advisors of the late 1920's and the 1930's, such as W. E. Blatz, Helen Bott, and Myrtle Meyer Eldred, were influenced by the work of G. Stanley Hall and the Child Study Movement. They saw the child as an active individual who learned through the interplay of innate characteristics and environmental influences. Although concerned for the physical development, these advisors saw the child as also having emotional

and social needs. Parents were urged to study their infants and to guide their development in a manner best suited to their needs and personalities.[42] Whereas Brown urged parents of the 1920's to train their children in good habits, Blatz, who is discussed in greater detail in a subsequent chapter, emphasized the need for parents to guide their children into good habits at an early age in order to prove the basis for their emotional, intellectual, and moral development.[43]

Child care advisors throughout the 1920's and 1930's continued to emphasize the permanent and unalterable influence parents had upon their infants. The writer of the introduction to the "Post Natal Letters" published by the Canadian Council on Child Welfare (1938) stated that

> The care and training of the child for the first few years lays the foundation upon which is built the physical and mental conditions that will govern the life of the child and determine its success in life. [44]

Syndicated columnist Angelo Patri also pointed to the vulnerability of children during their early years. The neglect to train children was wrong on the part of the parent. And, Patri stated, "Any wrong done an infant is a lasting wrong. There is no excuse and no pardon for offenders."[45] A sobering thought indeed for young parents who desired the best for their children. Confronted by such advice and threatened with the ruin of their children if they failed, many parents turned to advisors for help.

III

What advice did health professionals and child care advisors give parents? Did advice change over the time period under study? A review of information available to parents from various sources indicates that advice centered on three general topics: feeding and diet; elimination

and toilet training; habit training.

What to feed, how much to feed, and when to feed were questions that concerned mothers. In the early 1920's, health professionals, child care advisors, and newspaper columnists advocated breast feeding as the best method of feeding infants.[46] Not only was human milk considered more nutritious, but also it was believed to contain special components which provided the infant with protection against childhood diseases.[47] Advisors argued that "Nursing by a mother is safer, easier, wiser, and more successful."[48] They also believed breast feeding was a natural, normal function, and the best way to feed the infant.[49] Health workers claimed, but could not substantiate, that artificially fed babies ran an eight or nine times greater risk of dying in infancy than did babies nursed by mothers.[50] There is, in fact, evidence that the availability of animal milk rather than breast feeding played a major role in reducing infant mortality.[51] British Columbia's health nurses based their appeal for breast feeding on the success of Truby King's New Zealand program, and they attempted to teach British Columbia women the same techniques.[52] By the sixth or seventh month of her pregnancy, for example, the expectant mother was encouraged to begin to prepare her breasts for feeding.[53] Once the child was born, the mother was urged to begin her breast feeding routine, and the public health nurse made regular home visits to insure the mother did so.[54] When mothers failed to establish a breast feeding routine or discontinued breast feeding, the public health nurse insisted they begin again. Nurses Griffin and Garrood followed a procedure called "re-establishing breast feeding by technique of expression."[55] First, they assured

the mother she was capable of breast feeding her infant, then they taught her how to re-establish her milk supply. This was accomplished

> by the simple method of bathing the breasts with hot and cold water alternately, massaging daily, and stripping them after each feeding, and regular three hourly to four hourly feedings; no feed between 10 p. m. and 6 a. m. 56

Mothers were also advised to improve their own diets and thereby increase the quantity and quality of their milk.[57] Advisors were so adamant that mothers breast feed their infants, the Canadian Mothers Book, The Child, and "Post Natal Letters" simply gave no advice on artificial feeding. Helen MacMurchy assumed every mother could and would breast feed her infant until he reached about nine months of age.[58] Yet, health workers were forced to acknowledge that all women could not or would not breast feed their infants.

Infants were to be weaned at about nine months of age, although advisors agreed they should not be weaned during hot summer weather, when they were teething, or when they were unwell.[59] In the best of circumstances, weaning at any time frequently led to colic, rashes, diarrhoea, and sometimes to more serious or even fatal dysentry.[60] Some advisors counselled mothers not to breast feed their infants longer than one year, as they believed the composition of milk changed after that time.[61] Other advisors believed that breast feeding past one year increased an infant's susceptibility to rickets.[62]

There was general agreement among advisors that weaning should be effected over a two to six week period by gradually substituting bottle feeding for breast feeding. Alan Brown, however, believed sudden

and complete weaning to be less detrimental in the long run because the infant accepted the substitute bottle from sheer hunger.[63] In practice, most Canadian mothers adopted the gradual approach as they believed it to be less trying for both infant and mother.

The problems associated with artificial feeding of babies caused the greatest concern to both advisors and parents, and an examination of requests from mothers and responses by advisors indicates their concern was justified.[64] Some infants were fed strange mixtures of cream and water, milk, cornstarch and water, or one part milk to two parts water. As a result, artificially fed babies were more susceptible to colic, diarrhoea, constipation, skin rashes, and colds. Mothers sought advice on popular formulas by writing to newspaper columnists and by consulting their family physicians. Cow's milk, raw, pasturized, or condensed, was the most common substitute for mother's milk, although cow's milk had to be modified or humanized to make it suitable for babies. Although both Holt and Pritchard discussed the preparation of artificial milk, King developed four modified milk formulas based on the use of top milk, fresh milk, sweetened condensed milk, and dried milk.[65] When referring to these formulas, Nurse Garrood pointed out "The mixture for this humanized milk has been worked out scientifically to be exactly the same as mother's milk."[66] In some circumstances, the use of modified milk provided a more nutritious, safer, and more practical method than breast feeding.[67]

Between 1920 and 1939, artificial feeding became more and more acceptable to British Columbia nurses as it became evident many infants thrived on bottle feeding. Health professionals set about teaching mothers

how to make suitable formulas for their infants.[68] Mothers wrote to newspapers and magazine columnists to request formulas and diets based on an infant's age and weight, and advisors provided formulas. In fact, formulas became so standardized that in the March, 1939, issue of Chatelaine, Dr. McCullough outlined diets for infants between one day and one year of age. The outline included changes in the proportions of ingredients and specified supplements to be added to the infant's diet on a bi-weekly or monthly basis.[69]

To convince mothers to use pasteurized milk, to pasteurize raw cow's milk, and to boil water fed infants was a recurring theme in information provided to parents.[70] Many British Columbian households did not have access to pasteurized milk, but used the raw milk from their own or their neighbour's cows.[71] Impure or raw milk was not only the occasional cause of indigestion and diarrhoea, but also the possible cause of diseases such as tuberculosis and tubercular meningitis.[72] Convincing mothers to feed boiled cooled water was almost as difficult as convincing them to boil milk.[73] But there is evidence that at least one pure milk - pure water educational program was effective, for in 1937, Dr. J. M. Hershey, director of the Peace River Health Unit in the north eastern area of the province, reported that in spite of the prevalence of diarrhoea and dysentry among older age groups, the incidence was low among younger children. He stated that "This is attributed to the fact most mothers are boiling the milk and water used in feeding their children."[74]

Scrupulous cleanliness of the infant's utensils, bottles and nipples was another recurring theme of the 1920's and 1930's. In 1919, one

unnamed advisor advocated bottles be boiled for several minutes and nipples be washed or stored in a solution of boric acid.[75] The need for cleanliness did not change over the two decades, but the techniques did. In 1939, Dr. McCullough recommended bottles and nipples be sterilized in boiling water, but he made no mention of boric acid.[76] During the period between 1920 and 1939, British Columbia's public health nurses became less adamant in their demands that all mothers breast feed. Safer milk, purer water, scientifically developed formulas and diets made artificial feeding a suitable and safe substitute for breast feeding.[77]

In the light of today's knowledge, the most startling feature of infant's diets was the amount of sugar used. Before foods other than milk were given to the infant, sugar or some other sweetener was added to modify cow's milk. Nurse Margaret Laine gave the formula for a newborn as one ounce of cow's milk (boiled), one ounce of water (boiled), one teaspoon of sugar, and one teaspoon of cream.[78] The writer of the Family Herald and Weekly Star's "Mother and Baby" column recommended a six week old, eight and one-half pound baby be fed a daily formula consisting of fourteen ounces of whole milk, fourteen ounces of water, and four level tablespoons of sugar. Mrs. Eldred, the writer of "Your Baby and Mine" column told parents to remember sugar was used as a food and not as a flavouring.[79] One voice of warning raised was that of Dr. John W. S. McCullough, who not only warned parents against the excessive use of sugar, but also against the use of sugar as a substitute for essential foods.[80] Was McCullough's warning justified? School records of the 1920's and 1930's indicated a high incidence of tooth decay, caused, perhaps, by the high sugar content of infant's formulas.

What other foods were advocated for an infant's diet? Except for small regular doses of orange or prune juice, milk was the only food young babies received for the first six to nine months.[81] Fruit juices were given as a constipation preventative, rather than as a nutrient. Even though scientists were aware of the need for vitamins in the child's diet, it was not until the late 1920's advisors urged parents to give their infants a daily dose of fruit juice for its vitamin content and nutritive value.[82] Advisors were frequently unaware of the nutritional value of some food supplements for the prevention of some disorders. They failed, for example, to recognize the value of cod-liver oil in the prevention of rickets. Canadian physician and columnist Dr. Royal S. Copeland pointed out that babies born during the summer months had fewer cases of rickets, therefore, infants should be exposed to sunshine and fresh air. He noted that cod-liver oil was a simple cure for rickets,[83] but it was not until the latter part of the 1920's or early 1930's that cod-liver oil became a recommended component of the infant's daily diet.[84] The amount recommended varied from one advisor to another, by the season of the year, the age of the child, and whether the child was breast or bottle fed, but by 1939, cod-liver oil was a firmly established component of the infant's diet.

Because infants could not live on milk indefinitely, solid foods were incorporated into their diets, however, the types of food introduced and the age at which they were introduced changed over the two decades. In 1920, for example, infants received no solid food until they were weaned at nine or ten months of age. They were then given barley, rice, or oatmeal jelly and pureed green vegetables. At eleven months, they were fed oatmeal or cream of wheat cereal that had been cooked for three to four hours, and crisp buttered toast. Baked apples, baked

potatoes, and a tiny bit of raw apple were added at twelve months, and coddled eggs, scraped beef or chicken were added at 15 months of age.[85] By two years of age, the diet of 1920 consisted of half milk and half solid food.[86] Dull fare indeed! Obviously the advisors recognized the dullness of the diet, for Alan Brown suggested the young chilren dine away from their parents until they were able to eat the same food as the adults.

> It is a species of cruelty to expect a hungry child of tender age to sit at a table, see and smell fragrant dishes, and be forced to content himself with restricted fare without complaining.[87]

Children were to be restricted to their own diet. The "Mother and Baby" columnist noted that if children have never been given anything else "they do not tire of their simple diet, anymore than a dog tires of his meat or bones, or the horse of his hay."[88]

Infants of the mid-1920's fared better than their older siblings in that they were fed a greater variety of solid foods at a younger age. At age seven months, they were given a green vegetable daily and spinach three times a week. Peas, carrots, and asparagus were included, but they were cooked for thirty minutes in lightly salted water, thereby destroying both the nutritive value and the flavour. Infants were also fed egg yolks and well cooked whole wheat or farina. Their diet was supplemented with one teaspoon of cod-liver oil and one tablespoon of orange juice or two of tomato juice.[89] Mrs. Eldred described such fare as well-cooked, delicately seasoned, palatable, and attractive. Infants, however, probably did not share Mrs. Eldred's opinion of their food.[90]

By 1939, further changes had been made in the infant's diet. Cooked cereals and zweiback rusks were fed at six months, boiled eggs by the ninth month, clear meat broth by the tenth month, and vegetable soup by

the eleventh month. The diet recommended in 1939 contained considerably less milk and more solids than did the diets recommended in the 1920's. In fact, infants of 1939 were much better fed than their 1920 counterparts.[91]

The introduction of solid food into infants' diets created three recurring problems: reluctance to change from milk to solid foods; chronic constipation; the serious disorder of diarrhoea.[92] Parents sought advice about the easiest and surest way to convince their infants to accept solid foods, but the advice offered varied. The Canadian Mother's Book and the Canadian Mother Craft Society suggested that if infants were taught early to drink from a cup they would not reject solid foods. Furthermore, hunger during the first week of weaning would force babies to accept solid foods.[93] The Family Herald and Weekly Star columnist suggested that mothers feed their infants their solid foods first and then reward them with milk.[94] Mrs. Eldred suggested the parent subtly incorporate new food into the child's diet without drawing attention to it, or creating a fuss about it.[95] The editor of "Post Natal Letter '7'" took a more pragmatic approach to the problem of fussy eaters by stating

> Firmly, but gently, teach your child to eat what is given him as a matter of course and you will prevent malnutrition and under nourishment that often results from bad eating habits. 96

The problem of getting babies to accept foods other than milk was prevalent enough not only to be of concern to mothers but also to health professionals. Alan Brown noted that most underfed children over one year of age that he saw were those who had been breast fed too long or "those who were kept too long on an exclusive milk diet."[97]

Although feeding and diets seems to have been the subject of greatest concern, a second problem was constipation. Child care advisors of

the early 1920's insisted that bowels must be kept open and the infant must have one or more movements each day.[98] F. Truby King admonished mothers, "Don't let 10 o'clock in the morning pass without getting the bowels to move if there has not been a motion in the previous 24 hours."[99] King shared the opinion of other health professionals that open bowels was the key to good health. "If we could keep the motions always normal, we should have few or no delicate children."[100] Infants of the early 1920's were subjected to many different treatments for constipation. Commonly, laxatives such as paragoric suppositors or enemas were used. Foods such as liquid paraffin, fresh cream, olive oil, orange juice, or milk of magnesia were also used.[101] Although Dr. McCullough warned against its excessive use, castor oil was the most frequently recommended laxative.[102] Fortunately for children, by the early 1930's advisors realized that a daily bowel movement was not normal for every child. Mrs. Eldred, for example, advised mothers to pay more attention to their infant's diet than to their bowels.[103] Dr. McCullough pointed out that only five or six defecations a week was quite normal.[104] Concern over constipation progressively diminished throughout the 1930's as infants were fed more solid foods at an earlier age.

Closely allied to the question of defecation was the advice furnished to mothers regarding changes in their infant's stools. Health professionals pointed out that any change in colour, odour, or texture was to be noted as this indicated the state of an infant's health, the source and causes of some illnesses, and the suitability of the infant's diet.[105]

More serious than constipation was the sometimes fatal dysentry (cholera infantum, summer complaint). Breast fed babies were not

susceptible to gastric upsets caused by impure or tainted milk, but all babies were affected by impure water, teething, colds, extremely hot weather, or bacterial infections of the intestinal tract. Health professionals tried to impress on mothers that dysentry was highly infectious and could be easily communicated to other infants, and unless mothers were scrupulously clean the same infant could be re-infected from his mother's hands or from bottles and diapers. Nipples, bottles, and diapers were to be boiled to ensure reinfection did not occur, and an infected infant must be isolated from all other children.[106]

The suggested treatment for dysentry changed radically over the two decades. During the 1920's, health professionals agreed that once an infant had developed dysentry the family physician should be called immediately, but while waiting for the doctor to arrive, the infant should be given one to two teaspoons of castor oil and fed only cooled, boiled water.[107] The rationale for this treatment was that castor oil would clean the bacterial infection or the cause of the dysentry from the intestine. Such treatment sounds as serious as the disorder, and must surely have led to the death of some infants from dehydration. With new medical discoveries and developments during the 1920's and 1930's, the advice to parents changed. In 1938, Dr. McCullough advocated feeding an infant fresh scraped, dried, or powdered apples to stop severe diarrhoea. For two or three days the infant was to be given only cooled boiled water and the apple mixture.[108] McCullough claimed this treatment was an effective method to check diarrhoea.

Perhaps the most interesting aspect of the constipation-diar-

rhoea problem was the great concern expressed by parents in letter after letter to columnists on the problem of constipation. Rare indeed were letters requesting information or advice on the more serious problem of diarrhoea. Was this because constipation was a recurring disorder with which mothers felt they could cope, whereas dysentry was a disorder so serious they must seek the advice of a physician? Did mother feel that once an infant had contracted dysentry there was little she could do and that the infant's life was in the "lap of the gods?" Or did the number of letters concerning constipation simply indicate columnists chose to respond to questions about constipation and did not print queries about the treatment of dysentry? A review of information available to parents throughout the 1920's and 1930's fails to provide an answer to these questions. What is evident, however, is that infant deaths in British Columbia caused by dysentry steadily declined over the two decades. Pure milk, clean water, improved care, and cleanliness in handling the child brought the deaths by dysentry from 5.4 percent of infant deaths in 1923 to 2.3 percent of infant deaths in 1939[109] (Table 3.1).

In the 1920's and 1930's, before the invention of disposable paper diapers and the widespread use of automatic washers and dryers, mothers were anxious to toilet train their infants as soon as possible. For hygienic reasons, health professionals and child care advisors urged parents to begin toilet training as early as possible. As Holt pointed out, not only was regularity important to the child, but also "It also saves the nurse much trouble and labour."[110] Toilet training was initiated by mothers, who observed their children to determine the time of bowel movements, and when they were six weeks to two months old it was time they were put on a chamber pot once or twice a day. If mothers

Table 3.1

INFANT MORTALITY - PROVINCE OF BRITISH COLUMBIA

ANALYSIS OF CAUSES OF DEATH 1923 - 1939

	1923	1924	1925	1926	1927	1928	1929	1930	1931	1932	1933	1934	1935	1936	1937	1938	1939
Premature	28.4	27.5	27.8	32.8	25.8	29.0	28.1	27.9	28.6	26.2	32.1	22.3	26.7	24.5	25.2	29.1	27.5
Conginital Debility	7.8	6.7	8.6	6.6	7.3	6.7	6.4	5.9	6.8	6.1	8.2	4.5	3.9	5.2	3.3	4.1	3.9
Malformation	9.3	9.1	8.8	14.9	8.7	10.7	6.1	9.8	10.6	11.1	10.3	8.9	9.8	10.1	10.0	10.8	13.6
Diahorrea	5.4	6.6	6.9	4.7	4.3	4.0	5.7	6.9	7.2	5.7	4.1	6.6	3.9	5.2	4.4	5.2	2.3
Bronchal Pheumonia	6.7	3.0	6.5	6.5	5.9	4.6	6.3	6.0	7.0	5.2	4.8	8.2	8.5	7.7	6.8	9.2	6.8
Injury at Birth	10.2	4.8	5.6	3.6	3.1	5.5	3.8	5.2	6.0	5.7	8.0	7.5	7.6	6.5	4.6	6.7	8.1
Pneumonia	3.9	5.9	3.5	5.7	6.5	6.5	6.4	6.8	3.7	4.2	5.0	5.4	4.8	4.9	4.0	5.2	5.4
Whooping Cough	3.4	5.9	4.7	4.1	4.3	1.3	1.2	3.6	3.3	2.1	1.5	5.0	1.5	1.9	2.5	3.6	2.3
Influenza	1.9	2.1	1.8	2.7	3.7	2.3	3.7	2.5	1.9	3.8	1.1	3.8	4.3	2.8	4.9	.71	3.3
Convulsions	1.5	1.2	2.5	1.4	1.8	1.1	1.0	.53	1.9	1.7	.91	.5	1.5	1.3	.79	.35	.80
T. B.	1.2	2.3	2.1	2.0	1.3	2.3	1.7	2.7	1.9	1.9	2.1	2.8	3.7	3.6	2.2	3.4	2.1
Measles												1.9	4.3	14.0	3.1		
Other Causes	16.3	27.2	21.3	20.4	24.8	26.0	29.4	22.2	22.4	26.4	21.9	22.3	22.6	22.2	20.8	21.2	20.7
Total Deaths	668	574	569	558	606	524	575	562	517	477	439	426	460	455	630	556	483
Total living Births	10001	10119	10342	10063	10084	10385	10378	10867	10404	10214	9583	9813	10013	10171	11279	12476	12373
Death Rate per 1000 Live Births	66.8	56.7	55.0	58.4	60.9	50.4	58.4	51.7	49.4	46.7	45.8	42.3	45.9	43.9	55.8	44.6	39.0

Decline 66.8 to 39.0 per 1000 live births.

SOURCES: British Columbia Board of Health Report, 1923 - 1939; British Columbia Department of Vital Statistics Report, 1927 - 1939. Where no numbers are available the spaces are left blank.

were good observers and if children had any sense of regularity, their needs could be anticipated by their fretting and grunting, and thereby reduce the number of diapers mothers had to wash. Advisors believed regularity of bowel movements could be established within the first few weeks, but complete bladder control probably could not be achieved until the infants were at least fourteen to twenty-four months of age. By putting infants on a chamber pot when they first awoke and before and after each meal, mothers could help establish the "dry habit." The success of toilet training was watchfulness and patience.[111] Parents were to praise their children for successful results, but they were not to punish them for failures. "Post Natal Letter #2" pointed out "expectancy of success helps greatly. . ."[112] because children want and appreciate the approval of others. Infants who were not completely trained by eighteen to twenty-four months of age were a reflection of their mother's failure to establish good habits.

Another aspect of children's daily schedules was exercise.[113] Just before their morning bath or at diaper changing time, the infants were stripped of their cumbersome clothing and left free to arm-wave, leg-kick, wiggle and squirm. Mothers were admonished to remember that babies tired easily, therefore they should be permitted only ten minutes of unhampered kicking several times a day for the first few months of their lives, but as infants grew older, their play time could be extended.[114] Mothers playtime with their babies was in the morning before bath time and the father's time was in the evening before the babies went to bed, but fathers were remonstrated not to get babies so excited they could not sleep. Above all, babies must learn to play alone and amuse themselves; this was one step along the road to independence.[115] Undoubtedly, many busy mothers had no alternative but to leave babies to their own

amusement!

All babies were to cry for a few minutes each day in order to expand their chests and lung capacities, and to exercise their arms and legs. "They (babies) set the rhythm of the exercise with a couple of lusty howls and then begin with the arms and legs."[116] If the cry was not one of hunger, pain, or illness, the parents were to leave the children alone, as they would soon learn that crying availed nothing and therefore they would cry only for a purpose. Giving in to crying infants would quickly create a behaviour problem.[117] Once children were put to bed, parents were advised to ignore their crys and they would soon learn to go to sleep.[118] But it was not always that simple. Canadian newspaper columnist Gregory Clark detailed the trauma he and his wife endured while withstanding their first baby's cries.[119] Anxious to apply new child rearing methods, Clark and his wife managed to hold out for twelve minutes before they resorted to the traditional, time proven practice of rocking baby and singing lullabies to put him to sleep.[120] How typical were the Clarks? Were many parents able to withstand their infant's cries, or was this one area where scientific child rearing methods gave way to traditional practices?

Although parents made many changes in their child rearing practices, the most startling change was the willingness of mothers to give up their natural desire to cuddle, handle, and pamper their infants. Advisors advocated parents play with their infants as well as show them love and affection, but they opposed overt demonstrations of affection. As an example, mothers and other adults were advised not to kiss their infants, nor to allow infants to be kissed by others. Advisors

warned that disease germs, including tuberculosis, were transmitted in this manner.[121] In 1923, Alan Brown argued that infants should not be handled frequently as their bones and ligaments were soft, and frequent handling could cause spinal curvature and other bone deformities.[122] By 1934, McCullough still believed infants under six months should not be physically played with as such play made infants nervous and irritable, spoiled their sleeping habits, and caused indigestion which resulted in weight loss.[123] Chatelaine columnist Emma Gary Wallace also believed constant handling and playing with the babies used up their strength and retarded their growth. Wallace stated:

> about all the handling a child should have for the first year is that which is necessary to make it physically comfortable - to bathe, feed, change and take it out to air, and to give it as time goes on some opportunity for physical exercise. [124]

If the babies were bottle fed, mothers were advised to hold the bottle and not their babies. Infants of the 1920's and 1930's were certainly not to be indulged, pampered, or petted. As the Family Herald and Weekly Star columnist pointed out, too much petting was just as bad for babies as it was for pets.[125] Many mothers accepted the advice of child care advisors and permitted medical hygiene to supersede natural demonstrations of love and attention. As Newson and Newson point out, only women with courage, and those who ignored all advice in the first place, rejected the advice of the authorities and gave way to their natural desires to cuddle their infant.[126]

V

Although the child care advisors of the 1920's and 1930's focused on physical care, throughout the period there was a growing awareness of the infant's psychological development. Temperance, self-control,

self-discipline, obedience, and sincerity were the attributes to be developed. These attributes would be developed through training the infant in good habits and by eradicating bad habits. As one advisor stated, "it is in the home that the foundation of character and the art of living must be laid."[127] The columnists of the Family Herald and Weekly Star likened the development of a child's character to growing a plant; sometimes it needs to be pruned, sometimes it needs to be supported, but it always had to be trained in the direction the parent wants him to go. Good habits must be taught and bad habits must be eradicated.[128]

Among the bad habits that must be eradicated were thumbsucking, the use of pacifiers, ear pulling, and temper tantrums. Advisor's attitudes toward these habits gradually changed. In the 1920's, thumbsucking was a habit that must be stopped. It was a source of dirt and disease; it could misshape the thumb or the jaw, create thick and soggy lips, receding teeth, and bulging jaws. Parents were advised to bandage their children's hands and to moisten the bandages with a solution of quinine, make them wear a finger stall, or mitts, or pull the sleeves of their nightgowns over their hands and pin the sleeves.[129] The "Mother and Baby" columnist of the Family Herald and Weekly Star wrote "In obstinate cases, it is often necessary to confine the elbow by small cardboard splints to prevent children from bending their arms so as to get their hands to their mouths."[130] By the mid 1930's, however, advisors had modified their views. Mrs. Eldred believed thumbsucking could be cured without attacking the problem directly; she suggested thumbsucking be ignored and infants be offered other amusements to occupy their time.[131] The Canadian Mothercraft Society suggested the mother first check whether the cause of thumbsucking was hunger. If hunger was not the cause, mothers were to place mobiles over their infant's cribs to provide a diversion.

Only as a last desperate resort was the mother to resort to bandages or splints, but under no condition was the mother to scold her child or to withhold love.[132] By 1938, Dr. McCullough demonstrated a modified view and agreed that thumbsucking indicated the baby had not been kept amused and occupied. He advised mothers pay no attention to their children's thumbsucking, as the more attention paid the habit the more the children would persist.[133]

Although the attitude of advisors toward thumbsucking modified considerably, their attitude towards pacifiers did not. Both health professionals and columnists waxed eloquent on this topic. Alan Brown described the pacifier habit as "an inexcusable piece of folly for which the mother or nurse is directly responsible."[134] McCullough described a pacifier as "the last resort of the lazy and ill-trained mother."[134] Pacifiers transmitted diseases such as tuberculosis, diphtheria, and syphillis, irritated the throat glands, and caused enlarged adenoids. McCullough reflected the attitude of all other advisors when he flatly stated that burning was the only suitable fate for pacifiers.[135]

Ear pulling was another habit McCullough deplored. He suggested putting mitts on the babys' hands so they could not reach their ears. For children who made a habit of putting things in their ears, McCullough suggested an even stiffer penalty. "At the first sign of such a habit a vigorous spanking may cut it short."[136]

VI

Health professionals and child care advisors of the inter-war years adopted an extremely authoritative attitude towards parents as

they demanded that parents - especially mothers - adopt the new scientific method. The new scientific method advocated by advisors is best summarized in the introduction prepared by the British Columbia Board of Health to the "Post Natal Letters" (1937) published by the Canadian Council of Child and Family Welfare. The introduction stated:

> Breast feeding is the baby's birthright. Do not deprive him of it. Artificial feeding should be given only on your physician's orders. See that the baby has regular medical supervision. Have your baby protected against smallpox and diphtheria. Regularity on your part will develop regular habits in the baby. A clean baby is likely to be a healthy and happy baby. A baby needs sleep, sunshine and fresh air. The baby's bowel control depends on your efforts. You are moulding the baby's character and habits whether you plan to do so or not: The Baby trusts and depends on you; Do not fail him. 137

Was the new scientific method of child rearing successful? Certainly, advisors were able to support their appeal with statistical data that showed a steadily declining infant mortality rate, the direct result of fewer cases of gastro-enteritis, acute chronic indigestion, and acute infectious diseases (Table 3.2 and 3.3). Although other factors, such as better sanitation, purer milk and water supplies, and better medical care, combined with the scientific method of child rearing to reduce the infant mortality rate, advisors put forth such convincing arguments that most parents adopted, at least to some degree, the very rigid, systematic approach to child rearing [138] (Table 3.3). There were, however, a few health professionals who deplored the regimentation of infants. Dr. Grover F. Rowens, Yale University Medical School, in a syndicated article titled "Modern Babies in Rebellion: Regimentalism Creeping Into Nursery?" stated that he believed many problems were caused by an utter disregard for baby's needs and desires, and by parents and pediatricians who wanted to fit each baby into a schedule. "It would be wise for the physician to worship the baby more and the measuring stick, the scales, the graduate and the clock

Table 3.2

INFANT MORTALITY - PROVINCE OF BRITISH COLUMBIA

1920 - 1939

Year	Total Deaths for B. C.	Total Deaths Under 1 Year	Percentage of Total Deaths	Total Births (Live)	Death Rate Per 1000 Live Births
1920	4888	685	14.0	9308	73.6
1921	4489	617	13.7	10687	57.7
1922	4748	627	13.2	11197	56.0
1923	4997	668	13.4	10001	66.8
1924	5004	574	11.5	10119	56.7
1925	4945	569	11.5	10342	55.0
1926	5474	588	10.7	10063	58.4
1927	5750	606	10.5	10084	60.9
1928	5910	524	8.9	10385	50.4
1929	6347	575	9.1	10378	55.4
1930	6400	562	8.8	10867	51.7
1931	6114	518	8.5	10424	49.7
1932	6150	477	7.8	10214	46.7
1933	6221	439	7.1	9583	45.8
1934	6400	426	6.7	9813	42.3
1935	6857	460	6.7	10013	45.9
1936	7222	465	6.4	10517	43.9
1937	7973	630	7.9	11279	55.8
1938	7450	556	7.5	12476	44.6
1939	7517	483	6.4	12373	39.0

SOURCES: British Columbia Board of Health, Reports, 1919 to 1939; British Columbia Department of Vital Statistics, Reports, 1927 to 1939.

Table 3.3

INFANT MORTALITY - CITY OF VANCOUVER

1914 - 1939

Year	Total Deaths	Death of Children Under 1 Year	Percentage of Total Deaths	Total Live Births	Death Rate per 1000 Live Births	Stillborn
1914	1013	198	19.5	2774	71.3	150
1915	972	142	14.6	2794	50.8	140
1916	1097	166	15.1	2688	61.8	119
1917	1190	154	12.9	2676	57.5	115
1918	1846	185	10.0	2776	66.6	99
1919	1530	153	10.0	2700	56.7	145
1920	1622	186	11.5	3366	55.3	154
1921	1331	164	12.3	3623	45.3	161
1922	1436	176	12.2	3192	55.1	125
1923	1366	153	11.2	3165	48.0	137
1924	1433	133	9.3	3303	40.3	131
1925	1427	130	9.1	3578	36.3	120
1926	1588	153	9.6	3458	44.3	139
1927	1677	142	8.5	3563	39.9	154
1928	1739	141	8.1	3346	42.1	117
1929	2210	146	6.6	4354	35.5	135
1930	2225	148	6.7	4539	32.6	112
1931	2237	140	6.2	4241	33.0	131
1932	2240	139	6.2	3599	38.6	92
1933	2230	108	4.8	3232	33.4	91
1934	2194	80	3.6	3409	23.5	88
1935	2479	99	4.0	3587	27.6	79
1936	2697	119	4.4	3577	33.3	77
1937	2792	125	4.5	3921	31.6	86
1938	2768	134	4.8	4226	31.8	74
1939	2816	117	4.2	4359	26.5	95

SOURCE: Vancouver Board of Health, Reports, 1914 - 1939.

less. . ."[139] Syndicated columnist Angelo Patri expressed the same view in a slightly different way when he suggested that a difficult boy did not need discipline, but rather that, "Maybe he needs a rest from the schedule."[140] Such contradictory advice must have raised uneasy feelings in the minds of young parents anxious to adopt correct child rearing practices.

Advisors stated that modern, responsible mothers did not play with their infants at unscheduled times, cuddle their infants when they cried, rock them when they could not sleep, nor feed them when they were hungry. Parents must not indulge their infants nor allow them to develop bad habits, for the responsibility of moulding infants' habits and personalities rested with their parents. This responsibility must have created tensions within parents as they sought to reconcile their desire to comfort and cuddle their children with the scientific method which condemned such indulgences. Poetess Mona Gould expressed these feelings in a poem entitled "Modern Mother."

> I have tried philosophy
> And applied psychology
> And when John bumps his knee
> I forget - - and kiss it. [141]

In reviewing the advice available to parents, there is evidence that the new scientific method, designed to ensure both good physical care for children and convenience for parents, turned infants into a "little machine." The schedule and not the infant became the more important factor. There is also evidence that by the 1930's, parents were confused by contradictory advice from health professionals and child care advisors.[142] Parenting during the 1920's and 1930's

was both an exacting and demanding task as parents attempted to reconcile their traditional child rearing practices and natural parenting instincts with the scientific approach demanded by advisors.

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2 John Newson and Elizabeth Newson, "Cultural Aspects of Child Rearing in the English-Speaking World," in Rethinking Childhood: Perspectives on Development and Society by Arlene Skolnick, ed., (Berkeley: Little Brown and Co., 1976), p. 343; See also Neil Sutherland, Children in English Canadian Society: Framing the Twentieth Century Consensus (Toronto: University of Toronto Press, 1976) p. 288; Helen Kelly, "Colwood," Public Health Nurses' Bulletin, 1 (Oct., 1924), 1 - 2. (Hereafter PHNB).

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8 "Women's Institutes Holds Convention," Vernon News, Nov. 6, 1919, p. 11.

9 L. Emmett Holt, The Care and Feeding of Children, ninth edition, (London: D. Appleton and Co., 1923); F. Truby King, Feeding and Care of Baby (London: Macmillan, 1913); Eric Pritchard, Infant Education (London: Henry Kingston, 1907); John B. Watson, Psychological Care of Infant and Child (New York: W. W. Norton and Co., 1928).

10 Holt, The Care and Feeding of Children.

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12 Olive M. Garrood, "Sir F. Truby King - A Tribute," PHNB, 2 (Mar., 1938), 10 - 11; "A Lowered Death Rate," Family Herald and Weekly Star, Nov., 22, 1922, p. 29. (Hereafter FHWS).

13 British Columbia Commission on Health Insurance, Report on Maternity Insurance and Public Health Nursing, 1921, p. 519.

14 Garrood, "Sir Truby King," p. 11; "A Lower Death Rate," p. 29

15 King, Feeding and Care of Baby, pp. 9 - 43.

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18. Olive M. Garrood, "Public Health in Kamloops," PHNB, 1 (Apr. 1928), 21 - 23; Margaret E. Kerr, "The Refresher Course For Public Health Nurses," ibid., 1 (May, 1930), 305; Pamphlets included "Guide to the Artificial Feeding of Babies After Nine Months," adapted from a New Zealand Bulletin, distributed by the British Columbia Board of Health, 1932.

19 Pritchard, Infant Education, pp. VI - XIII, 170 - 190.

20 Ibid.

21 Olive M. Garrood, "Teaching Public Health in Kamloops," PHNB, 7 (May 1930), 21 - 33; M. M. Griffin, "Breast Feeding For Infants In Saanich, ibid., 11 (Apr. 1927) 24 - 27; "Education and Public Health," Bulletin of the British Columbia Board of Health, 4 (Sept. 1934), 156, (Hereafter BBCBH); The Canadian Mothers Book, p. 32.

22 Watson, Psychological Care of Infant and Child, p. 3.

23 Ibid.

24 Ibid., pp. 3 - 4.

25 Ibid., p. 12.

26 Ibid., p. 10.

27 Brown, The Normal Child, Title page; Pierre Berton, The Dionne Years (Toronto: McClelland and Stewart, 1977), p. 73.

28 Brown, The Normal Child, "Discipline and Education," pp. 205 - 214, "Habits of Infants and Children," pp. 215 - 220.

29 The Canadian Churchman, Oct. 11, 1923, p. 645.

30 "The Baby Clinic," Chatelaine, Nov. 1934, p. 44; There were 12,270 copies of Chatelaine distributed in British Columbia in 1930 and 23,009 copies distributed in 1939.

31 "The Baby Clinic," Chatelaine, Nov. 1934, p. 44; Ibid., Jan. 1935, p. 24.

32 Handbook of Child Welfare Work in Canada, (Ottawa: King's Printer, 1923), p. 3. In 1919, child welfare work in Canada came under six federal departments: Health; Immigration; Indian Affairs; Soldier Settlement Board; Soldier's Civil Re-establishment; Agriculture.

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35 Handbook of Child Welfare Work, p. 9.

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139 "Modern Babies in Rebellion: Regimentation Creeping into Nursery," The Vancouver Sun, Oct. 7, 1935.

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Chapter 4 The Preschool Child - The Neglected Age

During the inter-war years, British Columbia's health professionals and child care advisors focused their energies and attention on two groups of children - infants and school children. As the public health service developed and expanded throughout the 1920's and 1930's, health workers were charged with the task of reducing the infant mortality rate through the application of new developments in child care and disease prevention and by educating parents to new scientific methods of child rearing.[1] Through the school medical inspection program, initiated in 1910 and expanded during the inter-war years, health care was provided for most of the province's school children.[2] But what of preschool aged children? They had survived the hazards of infancy and they no longer required the intensive care they received during the first two years of life. Their place as babies of the family had probably been usurped by a new sibling and they were no longer the centre of their mother's attention. They were too old for the well-baby clinic and too young for the school medical inspection program. What help was available for parents of preschool aged children?

During the early decades of the twentieth century, American and Eastern Canadian educators focused attention on preschool children through organizations such as the Kindergarten-Nursery Association and the Child Study Association, yet neither of these associations gained a large membership in Western Canada, nor did these institutions develop extensively throughout this province during the 1920's and 1930's.[3] Only a few isolated health or educational programs were organized to meet the needs of preschool children, however, throughout the two decades, British Columbia's public health personnel were quick to acknowledge that the province's preschool aged children constituted a neglected age group. Even though Dr.

H. E. Young, Provincial Health Officer, pointed out in 1926 that "This period of a child's life has always been neglected . . ,"[4] the Board of Health failed to come to grips with the problem. In 1931, Saanich Nurse C. Rose argued that the perschool years were the time to detect and correct physical defects such as defective teeth, infected tonsils, enlarged adenoids, poor eyesight, curvature of the spine, weak lungs, and the time to immunize and vaccinate children against contagious and infectious diseases.[5] Furthermore, Rose pointed out that many health problems which developed in adult life could have been prevented if they had been treated during the preschool years. Nevertheless, as late as 1939, Dr. J. L. M. Anderson, School Medical Inspector for Victoria, confirmed that the preschool child still "suffered from his place between the infant and the school child."[6] This chapter will investigate the sources of advice available to parents of the preschool aged child, examine the nature and content of advice to parents, and identify changes in the focus of the advice throughout the 1920's and 1930's. In short, it will answer the question as to whether preschoolers were the neglected age group.

In 1923, Helen MacMurchy described three kinds of children: infants; little children; big children. Infants became little children when they were weaned, and little children became big children when they went to school.[7] All children, MacMurchy stated, were composed of body, mind, and soul, all three of which needed care and feeding.[8] MacMurchy made no attempt to describe children at various stages of development, but, rather grouped all children from just weaned to school age in one "preschool" group. Because of this view of the preschool child, British Columbia parents had great difficulty locating specific advice to help them rear their preschool children.

During the mid-1920's North American and European researchers such as Arnold Gesell, Susan Isaacs and Jean Piaget focused their research on the preschool age child.[9] But for British Columbian parents, most of the advice originated from three sources: the research and work of W. E. Blatz and his associates at the St. George's School for Child Study, Toronto; two syndicated American columnists, Angelo Patri and Mrs. Myrtle Meyer Eldred; publications issued by health care agencies such as Federal Child Welfare Division, the British Columbia Board of Health, the Canadian Council on Child and Family Welfare. In addition to these sources, occasional articles on the child aged two to six years appeared in newspapers and magazines. However, the advice directed to the parents of the preschool aged child was far less in quantity than that available on the care of infants. Whereas the origins of trends in infant rearing advice are readily identifiable (Holt, King and Watson), the origins of trends for the rearing of the preschool child are less easy to identify. However, one source of influence that can be readily identified is the research and work of W. E. Blatz and his associates.

In January, 1926, the St. George's Child Study Centre opened at the University of Toronto under the direction of W. E. Blatz, a young and enthusiastic Canadian psychologist.[10] Blatz graduated from the University of Toronto in 1917 with a Master's degree in physiology, and in 1924 from the University of Chicago with a Ph.D. in psychology. His area of graduate study focused on psychological changes produced by emotions.[11] At the urging of Dr. Clarence M. Hincks, a founder of the Canadian Committee on Mental Hygiene, and Dr. E. H. Bott, head of the Department of Psychology, University of Toronto, Blatz was appointed as director of the newly organized Child Study Centre.[12] The Centre was designed to provide nursery school education for preschool children and child study training for the

parents.[13] The Centre itself did not directly affect British Columbia parents, but the writings and research of Blatz, his co-worker Helen Bott, and his associates at the child study centre, had Canada-wide coverage. W. E. Blatz and Helen Bott co-authored two books, Parents and the Pre-School Child, (1928), and The Management of Young Children, (1930), both of which received wide publicity in newspapers and magazines and were recommended for use by British Columbia's public health nurses.[14] Blatz believed children's emotional and social growth were as essential to their development as was their physical growth. Blatz's books were designed to teach parents the principles of child study so that through the application of these principles they would not only be more efficient parents, but also they would enjoy the task of parenting.[15] Blatz and Bott clearly outlined the underlying principles and steps for parents to follow in applying the "child study method" in the rearing of their preschool aged children. "First, the need for training in basic physical habits; secondly, the importance of emotional control; thirdly, the significance of the child-parent relationship."[16] Parents were advised to observe and closely study their growing children, for by doing so they would be more aware of their needs and better able to direct their development.[17] Blatz believed that through training and education the potentialities for a happy, fulfilling and effective life could be developed. As he pointed out, "There are three things that every member of your family has to learn if your home is to be a good place to live in. Co-operation, Compromise and Tolerance."[18] Blatz believed his role was one of educating parents to manage their children rather than to give specific advice on specific topics.[19] Frances Lucy Johnson, another St. George's staff member, was a regular monthly contributor to Chatelaine from the magazine's first issue in March, 1928, until January, 1931. Additionally, Chatelaine carried occasional articles by members of the Toronto Child Study Centre staff throughout the 1930's, but Blatz and his co-workers

became even better known to Canadians through their work in the late 1930's with the Dionne quintuplets.[20]

Two syndicated columnists, both American and contemporaries of Blatz, discussed problems of the preschool child as well as those of infants and school aged children. Angelo Patri wrote a daily column which was carried in a large number of Canadian newspapers, including three the writer examined for this study: The Vancouver Sun; the Family Herald and Weekly Star; the Star Weekly. Patri, who may be described as an educator by profession a humanist by philosophy, and a realist by experience, offered sage advice to his readers on a wide range of problems including discipline, inter personal relationships, intellectual development, mental health, and school progress.[21] Patri focused on methods to develop the child's character in order to produce honesty, sincerity, self-control and industry. Patri believed this could be accomplished through a happy adult-child relationship, one in which adults showed love, patience, and confidence towards children.[22] Unlike Blatz, Patri did not see child study as an exact science, rather, he urged both parents and teachers to be sensitive to children and their needs, and to use good sense in dealing with them.[23]

Myrtle Meyer Eldred based her expertise on her personal experience as a mother and a grandmother, but she kept informed of new developments in child psychology and child development and reflected these developments in the advice she gave in her book Your Baby and Mine and her column of the same name.[24] For example, Eldred was cognizant of the work of Arnold Gesell of Yale University, and his influence was reflected in Eldred's description of the age-stage development of preschool children.[25] She described the two year old as being active, bottle weaned, toilet trained,

walking well, running unsteadily, and using a vocabulary composed of names of familiar things and questions about unfamiliar things.[26] In contrast, she described the five year olds as being better coordinated, having a longer attention span and perfect bladder and bowel control, and well on their way to becoming as independent and self-reliant as their mothers would permit.[27] Rather than initiate new trends in childrearing practices, Mrs. Eldred gave pragmatic and specific advice which reflected changing concepts of child nurture and child development.[28] The "Your Baby and Mine" column, which Eldred wrote, was carried in a number of Canadian newspapers including a daily feature in The Vancouver Sun, beginning in 1926, and a weekly feature in the Star Weekly, beginning in 1930. Eldred did not focus all her advice on the preschool aged child, but offered advice on physical care, mental development, habit training, and sex education as it related to infants through to adolescents.

The Child Welfare Division, Federal Department of Health, the Provincial Board of Health, and the Canadian Council on Child and Family Welfare, produced and distributed a limited number of publications which dealt with preschool aged children and their particular needs.[29] These included How To Take Care Of The Children, published by the Child Welfare Division, Diet Folder #3, produced by the Provincial Board of Health, and "The Runabout," prepared by the American Child Health Division but distributed by the Provincial Board of Health. But specific information on preschool children from these sources appears to be almost as scarce as specific programs designed to meet their needs through health care or education.

The concept of the preschool child continued to change throughout the 1930's, and in a 1939 radio broadcast to Victoria parents, Dr. J. L. M. Anderson, Victoria Public School Medical Inspector, described the pre-

school child as being an active, energetic, insatiably curious, exploratory individual anxious to investigate the world around him. But Anderson also recognized each child to be a distinct entity with a unique personality created by the combination of five distinct elements: physical make-up; inherited instincts; learned habits; intellectual ability; emotional make-up.[30] During the 1920's and 1930's, the advisors' view of the preschool child definitely changed from that of just a "little child" to that of a distinct and unique individual, with specific skills, abilities, and needs at each age and stage development.

Although health professionals and child care advisors focused their attentions and energies on infants and school children, enquiries to newspaper and magazine columnists during the early 1920's indicate the concern of parents about the care of their preschool aged child. A review of advice to parents from these two sources shows a small but gradually increasing amount of advice available each year. As the concept of the child changed over the two decades, the nature and content of advice to parents reflected those changes.

II

Throughout the 1920's and 1930's parents continued to be concerned about the physical development of the preschool child, but certainly not to the same degree as during the child's first year of life. Parents were advised to continue the regular routine of feeding, resting, exercising, and eliminating that had been established in infancy, but, during the preschool years, the child was to be given definite instructions in personal hygiene and health care. These lessons formed the basis of the child's future health habits and included training in proper dietary habits, personal cleanliness, and good manners.[31]

In addition there was concern for the dietary problems of pre-school children. Malnutrition was a common problem caused by their reluctance to eat a variety of foods, the lack of access to a variety of foods, or the ignorance of mothers concerning what constituted a well-balanced diet. As late as 1931, Emma Gary Wallace, in an article in Chatelaine, stated, but offered no statistical evidence, that one-third of Canada's children between two and six years of age suffered from malnutrition.[32] She pointed out that preschoolers did not require a special diet in the same sense as infants, but they did require a good diet that provided for adaquate growth. Considerable variation existed among advisors as to what constituted a good diet. In 1923, for example, Helen MacMurchy advocated that a preschooler's diet include a variety of vegetables, meats, raw fruits, coddled eggs, baked custard, milk toast, creamed toast and wafered toast.[33] In the same year the unnamed columnist of the Family Herald and Weekly Star, however, claimed that

> Children should not have meat or vegetables for the evening meal until they are at least six years old. Broths and eggs should be given occasionally. Milk, cereal, bread or crackers in some form, and cooked fruit, are amply sufficient for them. [34]

If parents fed the heavy carbohydrate diet advocated by this advisor, preschool children certainly would be malnourished. They would, in fact, have been better nourished had they eaten the same diet as the adult members of the faimly.

During the early 1920's, milk was considered the nearly perfect food, and children (up to fourteen years) were to drink a quart of milk a day to ensure they ingested the amount of lime necessary for bone development. Although a diet consisting of a pint of milk, carrots, spinach and other vegetables had the potential to provide the necessary amounts of lime, iron and phosphorus needed for building bones and teeth, Dr. H. C. Sherman

and Miss Edith Hawley, of Columbia University, insisted that only by drinking a quart of milk a day could children ensure they were receiving sufficient nutrients.[35] Furthermore, vegetables were to be well-cooked (to a state of mushiness) in lightly salted water, a process that certainly destroyed their nutritive value as well as their flavour. The deficiencies of such a diet were reflected in the child's poor teeth, bone structure, rough skin, and lack of resistance to disease. The recommended quart of milk was needed to supply minerals and vitamins destroyed in the overcooked vegetables. Porridge, such as rolled oats, farina, or cream of wheat, covered with milk was considered the almost perfect food. Although advisors advocated porridge, milk, and a number of other foods as good for children, the problem was to get them to eat those nutritious foods.[36]

Advisors advocated a range of techniques for dealing with fussy eaters. Suggestions included making the meals more attractive, withholding dessert, force feeding children, or simply ignoring them in the hope that hunger would eventually force them to eat. The writer of the Star Weekly's "Kitchen Column" took a firmer stand; if children refused to eat meat, vegetables, and fruit, mother should starve them into submission.[37] Parents must be firm, for bad training or over-indulgence created fussy eaters.[38] Furthermore, mealtimes must be observed with scrupulous regularity, with children seated at their own child sized tables and not with adults.[39] Whether absenting children from the dinner table was designed for the comfort of the children or the adults is never clearly stated, but until children could eat the same food as adults and had developed skills and manners acceptable in adult company, they were to be excluded from the family dinner table.[40]

Although toilet training was an area of major concern in infant

rearing, it received far less attention and advice for the preschool aged child. Advisors assumed that toilet training began early in infancy and must be well established by age two. Advisors warned parents of preschool aged children not to punish for accidents, lest they repeat the accident as an attention getting device.[41]

Language training and language development was, however, a major area of concern. As children learned to talk, parents were admonished to provide a flawless example by using traditional grammar, neither using nor permitting the use of baby talk, avoiding workiness, concentrating on teaching a simple vocabulary, and providing a listening ear for children as they learned to talk.[42] Children were to be trained to hear speech sounds, to see and feel how each sound was formed, and parents were to "correct little slips of the tongue before they became habits of speech."[43] Such stress was placed on children speaking clearly that stuttering may have resulted, a subject that received considerable attention by child care advisors. Stuttering, child care advisors believed, was caused by a fright, shock, illness, or nervous strain, and the stammering children were subjected to various techniques and exercises designed to cure this disorder. Two of these techniques included training children to speak rhythmically, and stopping them to have them think what they are going to say before speaking.[44] These kinds of procedures surely created tension within children and increased their inclination to stutter.

III

Although health professionals and child care advisors were concerned with children's physical development, the main thrust of their advice was towards the development of character and social skills.[45] The preschool years were the time for moral training and for shaping ideals - a respons-

ibility shared equally by both parents.[46] The Family Herald and Weekly Star quoting an unnamed source wrote:

> It has been said that a person who has the care of a child for the first seven years of its life has formed that child's character and disposition for good or ill. And to this we might add that the foundations of good or indifferent health are also laid. 47

Parents were admonished to guide, direct, and discipline the growing and developing child.[48] The stress by advisors on the responsibility of parents for the total development of the child must surely have been frightening to concerned and conscientious parents.

Parents were also responsible for disciplining the preschool child but controversy existed among advisors concerning the best methods to use. The whole issue of discipline depended on what kind of obedience was expected from children and what kind of action parents should use to produce this behaviour. For example, many advisors in the early 1920's demanded instant, unquestioning obedience. "The first law of the home and the cornerstone of character development is respect for law and authority."[49] In 1921, the Family Herald and Weekly Star asserted it was the parent's right and duty to enforce obedience by children, and the children's duty to learn obedience in the home.[50] The same advisor, reflecting the then current view of preschool children, stated that, "theoretic reasoning . . ." with a four year old was a waste of time, as the child's mind had not developed sufficiently to enable them to understand the reasoning process. Furthermore, wrote the columnist, "There is no need to give a tiny child (age four years) reasons for demanding obedience from him, 'Because mother says so' is reason enough for the little one."[51] Chatelaine columnist Dr. J. W. S. McCullough reflected this same attitude as late as 1935. When a mother wrote him that her little girl "will go and bring me things when I ask her, but my friends say that is the way to train a dog but is all

wrong for a child,'" McCullough responded, "I can find no fault with your training, it speaks well of your baby's temper that she is so obedient."[52] But, McCullough appears to have been the exception rather than the rule, for during the 1930's a different attitude emerged. Maud Newcombe, Family Herald and Weekly Star columnist, believed children could be so managed and trained during their early years they would not want to disobey their parents. She stated, "One need not be exacting to the point of unreasonableness to have obedient children."[53] Angelo Patri also believed parents should reason with their children as a means to achieve obedience, for "Reason stays longer, reaches further, wins in the end."[54] Blatz and his associates attempted to teach parents to study their children and to adopt a "flexible attitude" towards dealing with them. Blatz pointed out that instant obedience was not the goal, for, "The accept of the parent's thinking will not be on his ascendency over the child but on the learning process by which the child is coming to rule himself."[55] Self-control and self-reliance would develop as children were guided and directed by their parents.

Did the changing concept of obedience produce a change in the form of discipline used with preschool children? The editor of "The Runabout" stated that discipline was designed, "to teach a child to want to do right and to think before he acts."[56] Most advisors accepted this definition; the controversy centered on how children should be disciplined and who should do the disciplining. There was generally agreement among advisors against harsh or severe discipline; even spanking was generally frowned upon by the advisors. Rather, parents were admonished to spare the rod and to use some alternative form of punishment.[57] Blatz and Bott believed discipline was achieved through setting reasonable, clear and consistent rules for children to observe.[58] If the rules were simple and consistent,

children would readily obey them, but if children failed to obey the rules, it was not punitive discipline but a simplification of the rules that was required.[59] The editor of "The Runabout" went so far as to state that "Situations that call for severe punishment, especially during the first five years, are usually the fault of the parent."[60] Most advisors agreed that well-nourished, healthy children, provided with activities suitable to their interests and level, and functioning in an established routine and well-ordered environment, would create few disciplinary problems.[61] Nevertheless, parents were warned against taking the path of least resistance in disciplining their children, and they were also warned not to seek unnecessary confrontations. Furthermore, advisors warned that discipline must not be evasive or indifferent, for such discipline would fail to give the child constructive guidance.[62] Most child care advisors agreed that discipline must be applied by a loving parent who considered not only the results of their children's deeds but also their motives, For discipline to be effective, advisors stated it must be immediate, inevitable, invariable, and in proportion to the offense.[63] Child care advisors of the inter-war years believed that through careful training and discipline children would develop the desirable attributes of self-reliance, independence, and self-control. Researchers of this period suggested a child be permitted to make choices when alternatives were available, and to learn from the mistakes they would most certainly make. They must also learn to accept responsibility for their decisions. In 1935, Angelo Patri pointed out that "Every child should learn the consequences and be permitted to suffer from the effects of his own erros of judgement."[64]

Children were encouraged to become independent, but assertive aggression or dominance was discouraged. Parents were to discourage and excessive displays of aggression by children and to suppress

attempts to dominate either adults or other children.[65] The preschool child must learn to play amicably and cooperate with others.

IV

Play, indoors or outside, alone or with others, was considered as essential to a child's physical development as food and rest. As Helen MacMurchy pointed out in 1923, "Play is the very life of the child, play in the open air and sun is the making of the child."[66] Play was recognized as a normal part of every child's development, and W. E. Blatz, his associates, and members of the Canadian Council of Child and Family Welfare made parents more aware of the tremendous importance of play both for emotional and social development.[67] They argued that play provided relief from the constraints of a rigidly scheduled routine, that it developed motor control and manipulative skills, it encouraged self-reliance, concentration and the resourceful use of leisure time, it developed latent powers and talents, and it taught co-operation with other children and the care and use of materials.[68] As Harriett Mitchell of the Canadian Council on Child and Family Welfare expressed it: "To the child, play is not amusement, it is his work. Playthings are his tools."[69] Play was a factor too important in the child's life to be left to chance. Parents were urged not only to provide a suitable play environment, but also to carefully select the toys and equipment to "provide planfully for the most desirable stimulators and exercises at each stage of the child's growth..."[70] Increasingly, over the two decades, parents were urged to select toys and play materials suitable to the child's mental and physical development, toys that stimulated sensory development, self-activity and imagination, toys that were durable, washable, simple, workable, and well-designed.[71] Play was serious business for the child. Frances Lucy Johnson pointed out that play, for the child, was a means of gaining facility in the management

of the tools of life.[72]

Another function of play was to provide social training for children whereby they learned to co-operate and associate with other children.[73] The Family Herald and Weekly Star advocated children learn to associate with children of other economic, ethnic, and racial groups - provided, of course, their play was out in the open and under the watchful eye of parents.[74] An examination of the subject of play throughout the late 1920's and 1930's indicates a growing trend by child care advisors towards having children learn designated skills or attitudes by placing them in a carefully prepared environment, equipped with carefully selected toys suited to their ages and stages of development, with companions acceptable to their parents. Spontaneous play became a carefully engineered event! Although advisors recommended the organization of children's play, it is difficult to determine to what extent most parents actually followed their advice. It seems more likely most children outside the preschool setting played as they had always played; when, where, with whom they liked, and with what toys and materials were immediately available to them.

If play was considered an essential element in children's development, then so was work. Mrs. Eldred reflected the traditional work ethic when she pointed out that the "joys of doing these (helpful) things far outweigh the purely 'play' things a child can do."[75] She believed a two year old could help with bed-making, putting the cutlery away, setting the table, wiping the dishes, and straightening clothes. Angelo Patri believed children should do some useful work every day so the habit of work would become firmly established.[76] Blatz and Bott noted that as preschool children frequently wanted to help their parents, they should take advantage of this interest and direct them into simple household tasks.[77]

When children helped about the house, or obeyed their parents, they should be praised, but not overly praised. Rather, they should be intermittently praised, "We can easily overdo our flattery and praise until it acts not as an inspiration to more effort, but an actual throttle on it."[78] As Dr. Anderson pointed out, "Let us remember how sensitive the young child is to any form of suggestion, and not dull the response by excesses of either praise or punishment."[79]

While parents were training their children to develop good work habits, they were to be on guard against them developing undersirable habits. If habits such as thumbsucking, nail biting, nose picking, bed wetting, temper tantrums and masturbation developed, parents must extinguish them immediately.[80] As the writer of "The Runabout" pointed out, "Most bad habits will give way before intelligent home training, a few may require the help of a specialist."[81] What techniques were parents to use to extinguish undesirable habits in their preschoolers? First, they were to look for the cause of the habit -- and then try to remedy it or to replace it with another activity. For example, although thumbsucking and nail biting were undesirable habits, elbow splints or stiff cuffs were not recommended treatments; rather, mothers should begin teaching their preschool children to be well-groomed and to have neat hands and nails.[82] The writer of "The Runabout" suggested parents not use severe punishment to stop nail biting and thumbsucking, "but instead get the child's co-operation in overcoming the habit."[83]

Health professionals and child care advisors suggested that several undesirable habits stemmed from physical causes. Nose picking was one such habit. Children's tonsils and adenoids were to be checked for in-

fection or enlargement, and parents were to ensure that children received proper nourishment, fresh air, exercise, rest, play activities and, finally, provide materials and activities to keep them occupied.[84] The editor of "The Runabout" considered bed-wetting to have a physical cause that could be easily remedied by stopping children's intake of liquids by four in the afternoon and taking children to the toilet before their parents retired for the night.[85] Although Mrs. Eldred agreed that bed-wetting might have a physical cause, she also believed chronic bed-wetting to be a sign of an emotional problem, and the bed-wetter, like the hypochondriac, was using this ploy to get parental attention. "One must look below the surface in such cases to determine what misguided but natural motive is actuating unusual behaviour, other than real illness."[86]

Of all the habits of early childhood which must be prevented or extinguished, masturbation (or self-abuse) was the major one. Blatz and Bott pointed out that masturbation in one form or another was quite common among children and, "it should not be regarded with alarm as a sex perversion."[87] Nevertheless, common or not, parents were warned to investigate first for possible physical causes: tight clothing, lack of cleanliness or need of circumcision. No mechanical device was to be used to prevent masturbation except on the physician's recommendation.[88] The writer of "The Runabout" suggested that when children were put to bed, their hands be put outside the covers (even if he sucked his thumb), they be given a toy to hold, and they be encouraged to go to sleep at once.[89] "Try to keep his mind off himself and keep his thoughts and hands always absorbed in other occupations."[90] Where masturbation was a recurring problem, Blatz and Bott advised mothers to keep a record of episodes, noting the time and circumstances in which it occurred. This information would help mothers to determine the cause and to apply treatment to extinguish the habit. Persistent

masturbation in older (preschool)children required clinical investigation and guidance because it indicated internal conflicts and emotional problems too serious for parents to treat. In these circumstances, parents were urged to seek professional assistance.[91] The writer of "The Runabout" had one further word of caution for parents; "avoid leaving your child with servants with morals you question."[92] They may wittingly or unwittingly introduce the child to unacceptable sexual habits.

Although temper tantrums were not considered acceptable behaviour in preschool children, advisors took a pragmatic view concerning them. Most advisors considered tantrums to be growing pains that most children went through between two and four years of age. If the tantrums were ignored, they would probably go away. Furthermore, advisors argued, it was unlikely children would do themselves any serious harm during a temper tantrum.[93] If the tantrums persisted, Blatz and Bott urged parents to look for underlying causes and, if possible, remove or alleviate the source.[94] Parents were admonished always to provide young children with a consistent model of self-control and to encourage them to follow their parents' example.

Parents were also to provide models of self-control, truthfulness, honesty, sincerity, unselfishness, service, and respect and consideration for others. Advisors believed these qualities were best learned from parents in a home environment.[95] Parents were also to provide good models in their relationships with other adults as well as with their own children. They were to give their children the same respect and consideration they expected from their children.[96] Angelo Patri firmly believed it was through the parents' teaching and modelling that children acquired a desire for personal integrity.[97] Children's lack of truthfulness and their use of exaggeration, or imagination, were of concern to both teachers and advisors.

Parents were urged to teach children to distinguish between the real and the imaginary. Allowances were made for very young children; daydreams were acknowledged as a normal part of children's lives, but advisors insisted that as soon as possible children learn that daydreams were no substitute for real action, and imagination had its place only in a play world.[98] As with all aspects of their children's lives, parents were responsible to ensure that their children developed characteristics, attitudes, and habits that were acceptable to British Columbia society. An awesome task indeed!

VI

The "neglected child" is the best description of the preschool child of the 1920's and 1930's. Preschoolers had survived the rigours of infancy, were mobile, articulate, and no longer in need of the special attention required by infants. Probably they were no longer the youngest member of the family, and their new siblings received the intensive care and attention they had previously received. Although health professionals recognized the desirability of treating physical defects during these early years, there were few scientific programs designed to detect and correct their bad teeth, diseased tonsils, or malnutrition. Lack of early treatment of some defects left permanent effects upon growing children. Preschool children were neglected in that there were very few health or educational programs designed to meet their needs.

Throughout the inter-war years, however, an increasing amount of advice became available about rearing preschool aged children. Whereas the major portion of advice for rearing infants came from health professionals and focused on the scientific methods of child rearing, advice for the rearing of preschool children became eclectic as research

was developed among psychologists, educators, and physicians. Parents were urged to "study" their children and from their study determine how best to meet their needs. Based on children's individual rates of development, special interests, and specific needs, parents provided for the physical, emotional, social, and intellectual growth of children.

Although the traditional values of truthfulness, honesty, sincerity and industry were still held by advisors, the traditional means of achieving those ends changed. No longer could parents rely on traditional child rearing techniques for, by inference of the advisors, those techniques were no longer applicable. In fact, they were believed to be detrimental to preschoolers. Did parents who appeared to have readily accepted the "scientific method" of rearing their infants readily accept the "science of child study"? From the information available, one has difficulty determining the reaction of British Columbian parents to the "science of child study," for there is less information available about preschool aged children than about either infants or school aged children.

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Chapter 5 The School Child: Physical Perfection for Spiritual Welfare

Health professionals and educators of the 1920's and 1930's viewed the school child as the instrument and the school as the agency through which to educate British Columbia parents. Through the child, the parents would be educated to practise better hygiene and nutrition, better home management, and a 'higher' moral standard.[1] Public health nurse Eileen Carruthers described the process as adult education by a second-hand method.[2] Statements made by many of British Columbia's health care professionals and educators implied that they generally regarded parents as incompetent, and thus incapable of providing nourishment proper for the child's body or mind without instructions and advice from advisors, and they were quite willing to give both instructions and advice to parents.[3] An examination of available materials for the inter-war years indicates that health professionals and educators executed a persistent and well-planned program designed to provide health care for the school children, to make parents aware of their parental responsibilities and duties, and to advise parents how to rear their children.

I

By 1920, British Columbia health care programs had moved into a new stage, one which Dr. Young, Provincial Health Officer, described as a period of disease prevention and health education.[4] Public health care expanded through the organization of the provincial public health services and the coordination of existing health services provided by the Victorian Order of Nurses and the Red Cross Outpost Service.[5] But health services for the school child had originated thirteen years earlier when the Vancouver School Board initiated the practice of medical inspections for each student in Vancouver schools.[6] In 1910, the Provincial Board of Health

followed the Vancouver example by passing the "School Health Inspection Act." This act required each school board appoint a physician to examine annually every child in the public school system, members of school staffs, and the state of sanitation and suitability of each school building.[8] Initially, the policy met with opposition from a few educators, health professionals and parents, but two years after its inception Dr. Walter Bapty, Acting Provincial Health Officer, reported that most people concerned had accepted the practice.[9] But Dr. Bapty was overly optimistic, for as late as 1937 a few parents continued to oppose the medical inspection of their school age children, especially of older girls.[10] In spite of some opposition, however, the practice was quickly adopted in urban areas of the province. In 1911, the first year of the medical inspection program, 24,376 children in 145 schools (fifty-four percent of the school population) were inspected. During the post-war period, health care for school children expanded rapidly, and in 1920, 52,407 children in 504 schools (sixty percent of the school population) were examined. By 1939, 107,830 students in 1,119 schools (eighty-nine percent of the school population) were inspected (Table 5.1). An additional 13,274 children (eleven percent of the school population) living in rural and isolated areas of the province were reported as not receiving an annual medical inspection.[11]

Why did health professionals and educators focus so much attention on the school child? In retrospect, one can see that there were five main reasons. First, Henry Esson Young, a physician by profession, was Provincial Secretary and Minister of Education from 1907 to 1915, and Provincial Health Officer from 1916 to 1939; he undoubtedly influenced the order of priorities for the development of the province's health programs. As minister of education, he was able to initiate a health program in the school system, an action he probably could not have effected through any

Table 5.1

SCHOOL MEDICAL HEALTH INSPECTIONS - PROVINCE OF BRITISH COLUMBIA

1911 - 1939

Year	# Medical Inspectors	# Schools Inspected	# H.S. Students Inspected	# Graded City	# Rural Municipal	# Rural and Assisted	Percentage of Defects	Cost Per Pupil
1911		145	Total pupils	inspected	24,376			50¢
1912-13		224	786	22,412	9,804	4,589		
1913-14		302	966	26,606	11,212	7,498		
1914-15		309	1,734	25,523	11,562	8,079		73 1/3¢
1915-16	28	331	1,915	25,254	10,469	7,945		71 1/6¢
1916-17			1,999	22,564	9,012	3,518		60 1/2¢
1917-18		328	2,155	24,019	10,946	7,384		76 1/3¢
1918-19			2,013	29,366	11,869	8,396	90.13	69 1/2¢
1919-20	142	504	2,020	27,278	13,154	9,955	91.52	71¢
1920-21	154	514	3,049	32,392	18,159	11,231	93.98	85¢
1921-22	151	581	3,908	30,218	21,617	13,395	94.01	84¢
1922-23	153	613	4,783	32,181	21,103	14,080	110.35	87¢
1923-24	157	638	5,551	32,475	24,856	14,687	107.56	86¢
1924-25	155	671	7,419	34,036	26,163	15,331	100.81	85¢
1925-26	156	740	7,861	35,653	26,547	16,748	100.65	84¢
1926-27	160	765	9,368	39,882	28,130	17,661	101.97	86¢
1927-28	164	778	11,783	39,387	29,696	18,140	105.47	87¢
1928-29	163	790	12,790	48,898	16,030	18,318	103.31	83¢
1929-30	163	764	15,327	48,860	16,925	18,391	104.24	85.6¢
1930-31	160	823	16,955	48,585	17,705	19,655	101.29	85.3¢
1931-32	151	841	17,785	47,834	16,196	20,728	107.37	84.7¢
1932-33	152	803	18,256	46,046	16,267	20,451	112.15	75¢
1933-34	154	1,055	16,192	44,800	15,075	21,217	111.29	71¢
1934-35	154	1,068	18,732	40,197	17,054	21,205	105.41	71¢
1935-36	156	1,138	20,655	41,235	17,783	21,011	116.75	67¢
1936-37	157	1,116	22,010	38,466	17,956	21,114	112.31	68¢
1937-38	163	1,096	27,219	39,273	19,366	22,182	108.7	64.9¢
1938-39	163	1,119	28,609	38,025	18,542	22,663	100.6	68.1¢

SOURCE: British Columbia Board of Health, Report, 1911 to 1939. Where no numbers are available the spaces are left blank.

other governmental department. Subsequently, as provincial health officer, he was able to co-ordinate public health and school health services into an effective program.[12] But a second and more important reason for focusing on school children was expressed by Dr. F. W. Andrew, a Summerland physician, in a 1916 address to the Okanagan Women's Institute. Andrew reflected the attitude of many health professionals in industrialized countries when he pointed out that the regular systematic inspection of school children was a branch of preventive medicine.[13] For example, through a regular medical inspection, physical defects that were noted early might be corrected before permanent damage resulted.[14] Furthermore, by 1920, recent discoveries in bacteriology indicated that through vaccination, immunization, and quarantine procedures, both infectious and contagious diseases could be controlled. Schools were the obvious point of contact for many victims of communicable diseases, therefore, a third reason for focusing on school children was to locate infected children and diagnose their diseases early so they could be quarantined before their disease spread. Children, of course, were captives in an environment where they were readily accessible for treatment.[15]

Andrew also expressed a fourth reason, one that was supported by a large number of reformers of the era. From the standpoint of eugenics (a popular theory of the time) and the desire to establish a superior race, those individuals constituting 'the race' should be kept under medical observation and educated along 'right lines.'[16] Finally, Andrew argued (other health advisors agreed) that some parents were too ignorant or too apathetic to detect defects in their children, therefore the state was obligated to call attention to their condition and to emphasize the importance of early treatment.[17]

Health professionals were quick to recognize that if the school health program was to succeed, they required the cooperation of classroom teachers and school administrators. In 1908, two years before the initiation of the school medical inspection program in the province, Dr. C. J. Fagan, Provincial Health Officer, argued that the classroom teacher was the best person to impart health knowledge to the school child. Fagan recommended to Dr. H. E. Young, then Minister of Education, that teachers be qualified to "impart instructions in sanitary sciences."[18] In the 1908-09 Annual Report of the Public Schools of British Columbia, Dr. Young urged teachers to assume leadership in educating the school child to better health care and in encouraging school officials to provide sanitary and suitable school facilities.[19] In 1912, Dr. E. C. Hart, Victoria's School Medical Officer, suggested "that at least two lectures as to the needs of school inspection and methods and duties of teachers be made part of normal school training..."[20] But the annual reports of both the Vancouver and the Victoria Normal Schools indicated health education was not included as a regular part of the teachers training program until the mid-1920's.[21] Only with the cooperation of educational administrators and classroom teachers was the medical inspection program able to become as extensive and successful as it was.[22]

By 1911, Vancouver school health workers had established an examination procedure for the medical inspection of school children; this same general procedure was subsequently adopted by school health workers across the province. The school medical officers inspected each child at least once a year for cleanliness, communicable diseases, skin disorders, and pediculosis. Weight and height were measured, hearing and sight tested, tonsils, adenoids, teeth and respiratory system checked, and any physical defects such as flat feet or curvature of the spine were noted.

School medical officers recommended modifications to be made in the school program for any child with defects. They also recommended that parents take defective children to their family physicians or dentists for necessary treatment.[23]

School nurses or the public health nurses assigned to school work considered themselves 'teachers of health' rather than 'angels of mercy.'[24] They assisted the school medical officers with their examination of children. They sent notices of physical defects to parents and instructed them to have defects treated by their family physicians or dentists. As their time and energy permitted, they examined all school children on a regular schedule for cleanliness, communicable diseases, pediculosis, skin infections, sight, and hearing. They kept accurate, cumulative, up-to-date records of the weight, height, growth gain, and defects of all children. In goitre prone areas of the province, they distributed iodine pills on a regular basis.[25]

Home visits were a routine part of all school nurses' duties. Not only did they use home visits as a means to encourage parents to have their childrens' physical defects corrected, but also as an opportunity to instruct parents on home ventilation, selection of suitable clothing, infant care, childrens' sleeping habits, nutrition, and hygiene.[26] In 1912, Vancouver's head school nurse, Elizabeth Breeze, considered home visits the most important feature of her work, but she also pointed out the nurse's visit was not always warmly welcomed.[27] Twenty-five years later, Lyle Creelamn, public health nurse in Revelstoke, still stressed the value of follow-up home visits as the best way to enlist the co-operation of parents in providing treatment for children and educating parents in child care principles.[28]

As each medical inspection was conducted, an exact record was kept of the numbers of defects found (e.g. carious teeth, skin disorders, curvature of the spine) and the score computed against the number of children examined. Of the 52,407 school children inspected in 1920, the school medical officers found 91.52 percent of defects, or less than one defect for each child. In 1923, however, the 72,147 children inspected showed a rate of 110.32 percent of defects, or more than one defect for each child. Probably the expansion of the school medical services to include new areas, and more careful examinations accounted for the increased number of reported defects and justified the further expansion of school health services.[29] By 1939, health workers were still reporting an average of one defect for each child inspected.

School medical personnel reported that the most common defects among school children were poor nutrition, diseased tonsils, enlarged goitres, skin infections, and other health conditions caused by improper hygiene, poverty, and ignorance. For example, a survey conducted in 1920 by Dr. Robert Wightman, Vancouver's School Medical Officer, showed a high rate of malnutrition among the city's school children. Judged against the standards of physical development established by Thos. D. Wood, Professor of Education at Columbia University (1910-1931), 14,282 or seventy-nine percent of Vancouver's school children were recommended for further examination because of possible malnutrition.[30] Of that number, 3,584 (25.1 percent) were found to be more than ten percent below normal physical weight and size as indicated by Wood's standards.[31] Because Wood's standards made no allowance for differences relating to racial origin or body types, the 25.1 percent figure may have been inaccurate, but malnutrition among Vancouver school children, Wightman noted, was manifest in their lack of resistance to infectious and communicable diseases, the frequency of

skin disorders, and their general apathy toward school.[32] But the effects of malnutrition were not limited to the urban areas. The November 4, 1920, issue of the Vernon News carried an article by Ethel Todd, of Columbia Agricultural College, in which she cited Dr. Wood as pointing out that rural children suffered an even higher percentage of defects than did their urban counterparts.[33] Wood asserted that the major causes for poor health among rural children were poor housing, poor sanitation, and parental ignorance of modern scientific methods of child rearing. This opinion was shared by several of British Columbia's public health nurses.[34]

The most serious health problem found among school children was dental defects. In 1923, Dr. Young reported that ninety percent of children inspected suffered from some form of dental defect, and that some of those defects were of an irreparable nature.[35] Young attributed the large number of carious teeth to ignorance, apathy, poverty, lack of available dental facilities, and failure by children to care for their teeth. In an effort to reduce the number of dental defects, school nurses began conducting tooth brush drills with school children.[36]

The need for dental care was so serious that, in 1913, the Vancouver School Board established a free dental clinic for children whose parents could not afford the services of a regular dentist. In 1920, the clinic requested parents who were financially able pay a small fee to cover the cost of materials. The clinic continued to operate throughout the two decades covered by this study.[37]

In several rural areas of the province, the Women's Institute provided either free or subsidized dental care for large numbers of children, and in other areas, the Provincial Board of Health provided subsidized dental

care.[38] During its first year of operation the Peace River Health Unit provided a temporary dental clinic for 1000 of its approximately 1,300 school children.[39] In his 1937 annual report, Dr. Young reported that 5,000 children in the province had received subsidized dental treatment during that year.[40] Health professionals saw dental treatment as the first step in a dental care program. Once the defects were treated, parents were expected to maintain the work and to take their child to a dentist regularly. Dr. R. L. Pallan, Chief Dental Officer for the Vancouver School Board, reported in 1920 that, among other duties, the school nurse checked whether children brushed their teeth, and whether parents maintained the dental work that had been completed at the clinic.[41] Yet, in spite of their efforts to promote better dental care among school children dental defects were of continuing concern to the province's health professionals.

III

Epidemics of infectious and communicable diseases, including the common cold, were of constant concern to health workers and to educators. Outbreaks of smallpox, diphtheria, scarlet fever, whooping cough, measles and mumps could and did reach epidemic proportions in both urban and rural areas. During 1924, for example, there were 2,964 school children (14.6 percent of the Vancouver school population) infected with some type of communicable disease.[42] J. S. Gordon, Inspector of Vancouver schools, reported that for the same school year (1924-25), school time just lost by smallpox cases and their contacts totalled 1,310 school days, or an average of sixty children for each school day.[43] Dr. Young noted that during 1924-25 epidemics of chicken pox, diphtheria, influenza, measles, scarlet fever, smallpox and whooping cough were reported in various areas throughout the province.[44]

Each time an outbreak of smallpox occurred, health workers used it to justify extensive vaccination programs.[45] During smallpox scares in 1921 and 1925, the Vancouver Board of Health attempted to have all school children vaccinated. To effect this process, free vaccination clinics were opened at some of the city's schools and at the Vancouver School Board offices,and city medical workers urged parents to have their children vaccinated by their family physician or at one of the free clinics. Of the 18,590 children enrolled in Vancouver schools in 1921, 10,553 were vaccinated, 1,403 did not comply with the order to be vaccinated, 789 were considered unsusceptible to the disease, and 5,814 were registered conscientious objectors.[46] During the 1925 smallpox epidemic, health workers were armed with the March 19, 1925 "Order in Council" which made obligatory the vaccination of all individuals not registered as conscientious objectors. In spite of the Order and the smallpox scare, only 4,511 school children were vaccinated.[47] Yet, a subsequent outbreak of a virulent type of smallpox in 1932, which resulted in sixteen deaths among fifty-six cases, resulted in 8,000 children being vaccinated within a four day period.[48] Between 1929 and 1939, the number of cases of smallpox in Vancouver steadily declined from seventy-five reported cases in 1929 to no reported cases in 1939.[49] (Table 5.2).

Vaccination was an extremely emotional issue for some members of the Vancouver and Victoria communities. They believed no disease was prevented by loading the body with what they called putrid filth from a sick cow. During the 1925 debate surrounding the issue of obligatory vaccination, the editor of The Vancouver Sun raged, "Vaccination is discredited. It is illogical. It is dirty. It is one of the most damnable injuries one person ever tried to inflict upon another."[50] Health professionals attempted to educate the public to the values of vaccination and to reassure them about

REPORTED CASES AND REPORTED DEATHS FROM
SPECIFIED DISEASES OF CHILDREN UNDER TWENTY YEARS OF AGE

1918 - 1957

	Diphtheria		Smallpox		Tuberculosis	
	Cases	Deaths	Cases	Deaths	Cases	Deaths
1918	143		60		429	
1919	70		22		342	
1920	306		35		721	
1921	369		576		191	
1922	267		137		430	
1923	289		232		261	
1924	682		833		243	
1925	601		1014		257	
1926	375		98		278	
1927	477	20	257		235	167
1928	578	368	368	1	377	180
1929	985	36	738	1	260	161
1930	667	14	157		376	177
1931	286	17	37		586	153
1932	83	3	57	6	876	172
1933	33	5	8	1	1063	162
1934	40	5	7	2	898	167
1935	27	8	13	1	728	165
1936	31	4	3		853	141
1937	26	1			748	45
1938	17	4	2		861	169
1939	9		14		1209	148
1940	10	1			1610	153
1941	23	2			1351	135
1942	60	1			1345	124
1943	28	5			1408	99
1944	17	1			1991	129
1945	36	8			2051	136
1946	63	5			2536	96
1947	34	5			2544	122
1948	35	3			2178	99
1949	12	3			2202	49
1950	63				1828	47
1951	5				1662	48
1952	11				1411	25
1953	8				1494	13
1954	7				1434	8
1955	8				1414	1
1956	1				1331	1
1957	5				1355	

SOURCES: British Columbia Board of Health, Report, 1918-1957; British Columbia Department of Vital Statistics, Report, 1927-1957. The Reports of the Board of Health and the Reports of Department of Vital Statistics cover only approximately the same time periods, not exactly same time period. Blank spaces indicate no recorded deaths in the above reports.

the controlled conditions under which vaccine was produced and tested, but letters to the editor of The Vancouver Sun clearly indicate that not all members of the public were convenced.[51]

Vaccination appears to have met with considerably less opposition in other areas of the province. Dr. Young reported in 1921 that eighty percent of the province's school children had been vaccinated during the previous six months.[52] In the face of opposition in Vancouver and Victoria in 1925, Dr. Young reported that sixty percent of the province's unvaccinated school children had been vaccinated during the year.[53] In spite of the articulate opposition of the anti-vaccinationists, vaccination became an acceptable and standard practice throughout the province.

Health workers in rural areas used various tactics to effect vaccination of children. In the Peace River area, children were immunized and vaccinated by public health personnel during their regular school medical inspections. If children were absent from school on health inspection day, health workers found the most efficient method was to visit the children's homes and vaccinate them.[54] In this way, health workers were certain to treat all children. Dr. White noted in his first report of the Metropolitan Board of Health in 1937 that all school children within the health unit area (Burnaby, Richmond, North Vancouver, Vancouver, West Vancouver) were checked for their vaccination requirements. Children not vaccinated were excluded from the school system until they were treated unless their parents were registered conscientious objectors. White reported that vaccination and immunization clincis were held weekly in each school and at each public health unit.[55] This procedure was effective, for by 1939, White reported that eighty-four percent of Richmond school children were vaccinated and sixty-eight percent immunized.[56]

How effective was vaccination? Between 1920 and 1926, the number of reported cases of smallpox dropped from 576 to 98 cases.[57] Although the number of reported cases increased sharply to 738 cases in 1928-29, the cumulative effect of vaccination was demonstrated by the rapid and steady decline to no reported cases in 1940.[58] In spite of an outbreak of smallpox in 1932, only fifty-seven cases and sixteen deaths were reported. Six of those deaths were children.[59] (Table 5.2).

Diphtheria was another recurring contagious disease that responded to immunization. The development in 1923 of a diphtheria toxoid provided health workers with another tool in their fight to reduce the diphtheria incidence.[60] In 1926 Vancouver's Medical Officer recommended an extensive toxoid immunization program. But the immunization program did not bring an immediate decrease in the number of cases of diphtheria, rather, the number of reported cases increased from seventy-four cases in 1926, to one hundred seventy-eight cases in 1929 before dropping sharply to sixty-two cases in 1930.[61] Between 1929 and 1934, 30,000 Vancouver children were immunized, and by 1938 there were no reported cases of diphtheria among Vancouver's school children.[62] (Table 5.2).

The toxoid immunization program against diphtheria also met with opposition, but not so vigorous as that directed against smallpox vaccination. As late as 1938, Dr. J. W. MacIntosh, Vancouver's Medical Officer, stated in a report carried in the Vancouver Province that "Young children do not feel the slightest effects of toxoid immunization under the age of 12."[63] Three Vancouver physicians took Dr. MacIntosh to task and publicly declared in a letter to the editor that any poison introduced into the body through the use of toxoid certainly had detrimental effects on a child's body and led to increased cases of heart disorders among

children under ten years of age.[64] They did not substantiate their claim with research or statistical evidence.

Was toxoid immunization effective? The diphtheria rate dropped from a high of 985 reported cases in 1928 to eighty-three in 1931[65] (Table 5.2). Dr. Young reported a startling fifty percent reduction in the diphtheria mortality rate between 1930 and 1933.[66] In 1939, only nine cases were reported for the entire province, eight less than for the previous year.[67] Health professionals believed their program of immunization, vaccination, quarantine procedures and sanitation to be effective, and the decrease in the number of cases of communicable diseases appeared to substantiate their beliefs. Another opinion, however, was expressed by George Rosen, Professor of Public Health Education at Columbia University. Rosen argued that from about 1870 onward a number of infectious diseases including smallpox, diphtheria and tuberculosis, began to wane both in virility and frequency.[68] If this is true, the total effect of immunization cannot be accurately evaluated, but what can be clearly demonstrated is that there were fewer cases and fewer deaths caused by these diseases.[69]

IV

Smallpox and diphtheria, both highly visible diseases, were preventable through vaccination and immunization at the cost of a few cents a person, but tuberculosis was a less visible and far more insidious disease. Dr. Robert Koch, a German physician, discovered the tubercule baccile in 1882, and the subsequent research established the highly infectious nature of the disease.[70] Nevertheless, health workers had great difficulty convincing some members of the British Columbia medical profession and the general public that tuberculosis was both contagious and preventable. The reluctance of physicians to commit tuberculosis victims to the sanatorium for

treatment during the incipient period of the disease was based on the physicians' refusal to accept the highly contagious nature of the disease, and economic considerations for patients, their families, and the state. The cost of maintaining patients in long term care, or the loss of family breadwinners made physicians pause before committing patients to treatment. At the 1914 meeting of the British Columbia Medical Officers, Dr. J. J. Thompson of North Vancouver argued that the eradication of tuberculosis could be accomplished only by curing those with the disease and by preventing the spread of infection through systematic inspections but he did not recommend all cases be isolated for treatment.[71] In 1916, Dr. H. E. Young, reflecting the view of the time, argued that only advanced cases of pulmonary tuberculosis were sources of infection and only those cases should be institutionalized. He believed that incipient cases could continue their work uninterrupted and receive treatment at a locally operated dispensary similar to the one established in Vancouver in 1914.[72] Through this method, patients would receive necessary treatment and their families would not lose their breadwinner or family members. By 1918, Young modified his opinion for he recognized tuberculosis as a highly infectious disease, especially among children.[73] In his 1918 report, Young announced that plans were underway to appoint a full-time travelling health officer to supervise and advise local health officers in locating both active and incipient tuberculosis.[74]

In an address to the 1918 meeting of Medical Health Officers, Dr. C. H. Vrooman, Medical Superintendent of Tranquille Sanatorium, outlined in detail the highly contagious nature of tuberculosis and the need for early detection in order to contain the disease.[75] Basing his address on the work of researchers such as American physician M. P. Revenal, a pioneer in sanatorium treatment, Dr. H. M. Briggs, State Commissioner of Health for

New York, and his own experience at Tranquille, Vrooman alerted his listeners to the magnitude of the tuberculosis problem. He stated that about fifteen percent of the province's children contracted tuberculosis during their first year, about fifty percent during their first five years, and about eighty percent during the first fourteen years.[76] Vrooman reported that the mortality rate for children under two years of age was high, but dropped for those aged two to fifteen. After fifteen, the rate rose sharply until age forty, and then again declined.[77] He noted that the requirement that all milk cows be tested for tuberculosis and that no milk be sold from infected cows kept the numbers of tuberculosis cases originating from that source very low.[78] He recommended that the Provincial Board of Health launch a well organized anti-tuberculosis program designed to locate and assign for treatment all active cases, and he also recommended an extensive educational program for both physicians and the general public. In 1923, the Division of Tuberculosis Control was formed with Dr. A. S. Lamb as travelling diagnostician. Lamb was directed to seek out and commit for treatment active cases, check their contacts, do follow-up work on ex-patients, and educate members of the medical profession and the general public to the causes, treatment, and prevention of tuberculosis.[79] In 1928, the program was extended to a provincial wide-district based tuberculosis prevention and education program. By 1936, there were permanent clinics in Vancouver, Victoria and Tranquille, and three travelling clinics covering the remainder of the province. In 1939, a fourth travelling clinic was added.[80]

Prior to Lamb's appointment in 1923, the family physicians either treated tuberculosis cases at home or referred them to Tranquille for treatment. As Lamb travelled about the province, local physicians, health workers and school nurses began to refer suspected tuberculosis cases to

him. Lamb examined each case, and requested X-rays be taken of doubtful cases. The X-ray was used to provide definitive evidence for the presence or absence of tuberculosis.[81]

In 1935, the tuberculin testing was adopted as a way of detecting active cases among school children. Each child with a positive reaction to the test was X-rayed and a trace made to determine from whom the child might have contracted the disease.[72] This procedure made testing for tuberculosis both more efficient and more effective. In 1936, tuberculin tests were administered to 6,054 school children living in Vancouver, Victoria, Kamloops, Kelowna, Steveston and Prince Rupert but only 52 cases were found.[83]

Even with the convenience of tuberculin testing, procedures varied from district to district. Health workers and school administrators in the Peace River area required routine tuberculin testing include not only suspected active cases and their contacts, but also as many preschool and school aged children as logistically possible.[84] The Fraser Valley Health Unit tested only suspected cases and their contacts.[85] Beginning in 1935, each child entering the Vancouver school system and each Vancouver high school student was given a tuberculin test and, when deemed necessary, a follow-up X-ray.[86] In 1937, each teacher in the Vancouver school system was given a chest X-ray. The same policy was adopted in areas covered by the Metropolitan Health Unit formed in 1937.[87] By 1939, Dr. White reported the annual tuberculin testing program had located no advanced cases of tuberculosis in the Metropolitan Health Unit area, and only four minimally advanced cases.[88] Beginning in 1938, the Vancouver Metropolitan Health Unit administered a tuberculin test to all children entering the Greater Vancouver school system for the first time, all high school students, and

all teaching staffs. The intensive tuberculosis preventional and educational program helped reduce the tuberculosis mortality rate and the number of advanced cases among both adults and children.[89] (Table 5.2). Dr. A. S. Lamb noted in his 1925 report that as he travelled about the province an increasing number of school aged children were referred to him by school doctors or nurses, although he found many of the children were non-tubercular. This procedure, however, provided an opportunity to locate potential cases and to recommend treatment before tuberculosis developed.[90] Between 1924 and 1928, the tuberculosis mortality rate among the province's general population declined from 95.1 for 100,000 population to 74.0.[91] By 1939, the tuberculosis mortality rate had dropped to 49.2 for 100,000 population.[92] Yet the tuberculosis mortality rate for children did not drop significantly until 1948, but, as Dr. Hatfield pointed out, the high incidence of tuberculosis among Indian children accounted for the high rate among the province's children.[93] (Table 5.2).

V

Another feature of the school medical program was the introduction of special drills, exercises, and treatment for children who suffered from physical defects. In 1923, a special exercise program designed to correct deformities caused by poor posture, poor seating, and poor footwear was introduced. Although Dr. White reported on the success of these classes in both his 1924 and 1930 reports, he did not disclose either the number of participants or the number of successes achieved through exercises.[94] By 1932, the program was redesigned to provide exercises to correct spine deformities, chest deformities, paralysis of the extremities, and flat feet. The appropriate remedial exercises were prescribed by the school physician and supervised by the school nurse. Parents were invited to be present for the first treatment, and they were expected to carry on the

same exercises at home.[95] Although Elizabeth Breeze reported encouraging results from special exercises, in her 1937 report she did not indicate the number of children participating nor the number completing.[96] Such classes were not limited to the Vancouver school system, but were also held in other areas of the province.[97] Although these exercises probably alleviated physical defects to some degree, some children appeared to regard exercise time as a pleasant way to escape the classroom routine.

Endemic goitre was another health problem among children living in goitre prone belts of the province such as the Peace River, Okanagan, Lillooet, Prince George, Vanderhoof, and Lower Mainland areas.[98] Dr. H. B. Maxwell instituted the regular administration of iodine to Ladysmith school children as a goitre preventive measure.[99] Vancouver commenced a similar program the same year; with the parent's permission and payment of ten cents a year, each child received one iodine pill a week.[100] Following the 1932 report of 5400 cases of goitre among British Columbia's school children, the Provincial Board of Health urged iodine be regularly administered, either in liquid or chocolate-coated pill form, to those school children living in the goitre belts of the province.[101] No record exists concerning the number of pills issued, but Dr. White noted in his 1937 report that 7,349 ten mg. iodine tables were distributed weekly to Vancouver school children.[102] Was the treatment effective? Dr. A. M. Menzies, Provincial Epidemiologist, stated in 1933 that some school medical inspectors reported excellent results in reducing the number of cases in their areas.[103] Between 1930 and 1936, the percentage of cases of endemic goitre among Vancouver school children decreased from 3.9 to 1.1 percent.[104] The distribution of iodine pills continued until the 1940's, when iodine became a standard additive to table salt.

VI

Although health professionals during the 1920's and 1930's focused considerable time and energy on improving the physical health of school children, they also worked to improve their knowledge of hygiene and health care. As Mrs. C. H. Lucas, Nurse Superintendent for the Saanich Health Centre pointed out in Public Health Education in the Schools (1926), a booklet distributed by the British Columbia Board of Health, teaching health education was a patriotic duty.[105] Health education, she argued, would prepare school children, the citizens of the future, to demand proper health care for themselves and their communities.[106] Because few students began high school in the 1920's and fewer completed high school, Mrs. Lucas contended that the seventh or eighth grade children should have a good working knowledge of the fundamentals of good health habits and disease prevention.[107]

As early as 1894, anatomy, physiology, and hygiene were included among the twenty subjects a teacher candidate must pass to receive a second-class teaching certificate. Until the Vancouver Normal School opened in 1901, preparatory classes for a teaching certificate were offered at some high schools.[108] A review of high school entrance requirements and high school examinations indicates that lessons focused on anatomy and physiology and not on health care.[109] But from its inception in 1901, the Vancouver Normal School included lessons in physiology and hygiene in its nature study courses.[110] In 1908-09, then Minister of Education Dr. H. E. Young requested teachers to post a set of health rules in their classrooms for the children to see, to teach a series of short lessons on each of the health rules, and to encourage children to observe health rules.[111] In the same year the Council for Public Instruction provided free copies of Stowell's Essentials in Health for use in high school

classrooms.[112] In 1913-14, How To Be Healthy was also recommended and supplied as a reference book for use with senior high school students.[113] Although health education was being accomplished directly through classes, the appointment of school nurses and public health nurses brought a direct approach to health education. As these nurses made their regular visits to the schools they gave little health talks to children after every visit, directed classroom dramas, conducted toothbrush and handkerchief drills, organized essay contests, organized school fairs, health pageants and poster contests, all designed to educate children in proper nutrition, personal hygiene, and body care.[114] In 1925-26, health education became a prescribed course in public schools.[115] To equip teachers to instruct health education classes, the 1925 provincial summer school offered a course titled "Hygiene and Child Health" taught by Vancouver's Head School Nurse, Elizabeth Breeze.[116] Not until 1927-28 did health education classes become a regular feature of the normal school training program.[117]

The 1925-26 health program focused on each student establishing basic health habits, on developing a positive attitude toward personal hygiene and health care, and on developing a sense of responsibility for the health care of others. Nutrition, cleanliness of self and surroundings, and control of infectious and contagious diseases were recurring themes throughout the first eight grades. Pupils in grades one to six were taught the need for proper rest, sleep, fresh air, and exercise. Children from grades six to eight were expected to apply their knowledge of health principles and health care to remedy conditions in their homes and communities.[118] With the curriculum revision of 1928-29, the health program was redesigned not only to instruct children in health care and personal safety, but also:

To lead parents and other adults through the health education

> programme for children to better habits and attitudes, so that the school may become an effective agency for the social aspects of health education in the family, school and community. 119

Ideally, curriculum editors believed improvement of individual children and adults would promote national health improvement and race betterment.[120]

Although the curriculum guide for 1928-29 continued to stress nutrition, hygiene, rest, exercise, and disease prevention, it also included accident prevention and safety education. Traffic safety received special attention, probably because of the increase in the number of automobiles. In addition, classroom teachers of grades one to five were expected to conduct a daily health inspection of their classes, and to focus their health lessons on those habits neglected by their children. The 1928-29 curriculum guide of health education for grade one outlined in graphic detail the proper way to unfold, blow into, and refold a handkerchief, and the most efficient way to teach children to use a toothbrush.[121] By 1929, the classroom teacher and not the school nurse taught health education classes, conducted handkerchief and toothbrush drills, and made the daily cleanliness inspections.

Following the major revision of the public school curriculum in 1935, health education took on a new focus. At that time, a mental health component was added to the existing physical health component.[122] Health education was no longer concerned only with children's physical health and safety, but also with their mental, moral, emotional, and social state. To the health workers and educators, the development of a healthy personality was as important as the development of a healthy body.[123] Ten years before, teachers were teaching children the basic rules for good physical health; by 1936, they were exhorted to teach the rules for good mental health.[124] Included in the instruction was the concept of personal adjust-

ment, which meant children conformed to the highest social standards, modified by behaviour to meet new situations, cooperated with others, respected the rights of others, and disciplined themselves at all times. Health educators firmly believed mental health care could be taught in the classroom just as physical health had been taught during the previous decade.

The classroom was not the only place children received health education. During the 1920's and early 1930's, Little Mother's League classes constituted a regular part of the school health program for girls between ten and fourteen years of age.[125] The twelve week course, taught by public health, VON, Red Cross, or school nurses, trained adolescent and preadolescent girls how to feed, clothe, bathe, and train a baby. As Nurse Lucas pointed out:

> The general care of the baby itself was included, not only his physical care as we ordinarily understand it, but instruction as to how to avoid the formation of bad habits, and particularly concerning the necessity of protecting the baby from communicable diseases.[126]

Upon completing classes and passing a written examination, each girl was issued a badge and certificate from the Provincial Board of Health.[127] During the late 1920's and 1930's as Junior Red Cross branches became more numerous in classrooms, and domestic science classes were redesigned to include a child care component, responsibility for health education shifted from nurses to classroom teachers. Consequently during the late 1920's and the 1930's Little Mother's League classes were discontinued.[128]

The Junior Red Cross movement commenced in 1914 as a means for children to participate in the war-time humanitarian work of the Red Cross Society.[129] At the October 1919, Cannes Conference of International Red Cross Societies, the conference resolved to retain the Junior Red Cross as

a children's peacetime organization devoted to the promotion of good health and humanitarian ideals, good citizenship, and international friendship.[130] The Junior Red Cross program was endorsed for school children by the British Columbia Department of Education in 1922.[131] This made it possible for the classroom teacher to use school time and school facilities in which to operate the program.

Junior Red Cross clubs were classroom based groups operating under the direction of classroom teachers. For a ten cent membership fee, each child received a Junior Red Cross membership badge, a membership care on which was printed ten health rules, and a copy of the Junior Red Cross magazine. The health rules taught the child the need for a nutritious diet, fresh air, sleep, exercise, posture, elimination, cleanliness of teeth, body, hands and fingernails, and the way to prevent the spread of diseases through coughing, sneezing, and spitting. Club activities encouraged members to develop a wholesome interest in personal physical development by following specific health rules and hygienic practices. The Junior Red Cross Magazine, colourful posters, playlets and classroom dramas reinforced the club's health teachings.[132] Although the clubs operated under the direction of classroom teachers, the public health nurse often addressed them on health topics and awarded achievement badges.[133]

Was the Junior Red Cross an effective organization? The essential element to the success or the failure of the organization was the classroom teacher. When the teacher was interested, voluntary participation by children seemed to engender an 'esprit de corps'. Jean Browne, the National secretary of the Junior Red Cross, believed the clubs stimulated children to practice better health habits.[134] A public health nurse working in the Fraser Valley noted that:

> With all the schools now affiliated with the Junior Red Cross and the new (health) curriculum stressing Health, the children are now rapidly becoming health-conscious and looking back, one can see marked improvement in the personal hygiene.[135]

The Junior Red Cross grew and flourished between 1922 and 1939. There were 112 branches with 2280 members by 1928. The organization increased to 202 branches with 4656 members in 1935.[136] By 1939-40, the provincial membership reached 30,999 students representing 25.7 percent of the province's school population, and forty-four of those branches operated in high schools.[137]

VII

One other area where child care advisors believed school children needed education was in social hygiene. Social hygiene, or race hygiene, referred to those "Social-health problems which directly or indirectly have grown out of sex instinct."[138] Although children were considered a legitimate instrument to educate parents to better physical health, they certainly were not considered a suitable messenger to enlighten parents about social or racial hygiene. In fact, controversy centered about who should teach sex education, or whether children should be given sex education at all.[139] J. H. Putman and G. M. Weir recognized the need for sex education in the schools, but acknowledged "that the present state of public opinion makes it impossible to study this subject in the public schools."[140] The membership of the Canadian Social Hygiene Council (and many other members of the community) believed sex education to be the sole responsibility of parents, which the school should merely supplement by the teaching of nature study and 'kindred subjects' in the classroom.[141] Parents who felt unequal to the task could seek information through pamphlets or books, or encourage the organization of "programmes

of enlightenment..." through organizations such as the Parent-Teacher Association.[142] Laura Jamieson, Judge of the Juvenile Court of Burnaby and a member of the Canadian Social Hygiene Council, suggested that for their own edification parents read those authors "who place sex on a high plane - Maude Royden, Edward Carpenter, and the greatest of all, Havelock Ellis."[143] To help parents achieve this 'higher plane,' the British Columbia Board of Health re-issued five leaflets prepared by the National League for Health, Maternity and Child Welfare, London, England, entitled, "Some Thoughts for Wives and Mothers and Some Teachings to be given to Children by Parents who find it difficult to put their Thoughts into words."[144] This material was intended to teach children to 'think rightly' about their wonderful bodies. The five leaflets included in the package were, "God Saw That It Was Good," "The Gift of Life," "The Temple of Life (boys)," "The Temple of Life (girls)," and "The Meaning of Love." These pamphlets certainly informed children about the birds and the bees, but contained little information about human sexuality.[145] Unfortunately, the annual Reports of the Board of Health do not indicate how many copies of these pamphlets were distributed nor to whom they were distributed.

In the literature examined, no reference was made or recommendations given for use of the eight volume "Self and Sex Series." Published in Philadelphia but distributed in Canada through the official publisher for the Methodist Church in Canada, the "Self and Sex Series" was probably the most popular set of sex manuals for sale in Canada between 1900 and 1915. Canadian historian Michael Bliss described the series as "A compendium of orthodox sexual knowledge and precept in late-Victorian and Edwardian Canada." Rather than place sex on a 'higher plane' as suggested by Judge

Jamieson, this series stated that sexuality created difficulties for all ages from childhood to old age.[146]

If the school was to teach sex, who should do the teaching? In 1926, Mrs. Lucas stated that sex education must be taught by some specially trained person, but certainly not by classroom teachers.[147] Dr. Harold White took a very pragmatic approach to health care and sex education; he and the school nurses taught the subject. Although Dr. White does not mention his annual talk on hygiene and sex to each group of high school boys until his 1926 Report, former Kitsilano High School students Ruth Sutton and Frank Hardwick remember Dr. White's talk to the boys and Nurse M. Campbell's talk to the girls in 1923 and 1924. The talks, they recall, centered on personal hygiene and physical development; any reference to sex or human sexuality was couched in extremely oblique terms indeed.[148] White established a pattern that continued long after his retirement in 1942.

Health professionals and child care advisors certainly believed that pre-adolescent students should be taught about human reproduction, sexual development, parenthood, and the sanctity of family life. Furthermore, in 1927 Laura Jamieson argued that adolescence was the time instruction was to be given "regarding the darker side of sex, in order that young people may be safeguarded from sexual disease."[149] Throughout the two decades, advisors attempted to impress upon youth the permanently debilitating effect of venereal diseases upon both victims and their offspring.[150] But the major problem with sex education in schools during the 1920's and 1930's was that discussions about human reproduction, venereal disease, and birth control were wrapped in such vague and oblique terms that children probably learned more on the streets or behind barns than they ever did

in sex education classes.

VIII

During the immediate pre-First World War and post-war years, the school assumed more and more responsibility for the moral and ethical education of the school child. Some British Columbia advisors maintained that only the school could provide moral education for the child who did not attend church or Sunday school, or whose parents were derelict in their parental duty. In a 1918 address to the first annual meeting of the Vancouver Child Welfare Association, Wm. Burns, Principal of the Vancouver Normal School, contended that the ultimate end of education (and the duty of the school) was character formation and the development of correct habits.[151] A year later, Victoria physician Dr. Ernest Hall told the second annual convention that the school must assume those responsibilities which the home neglects to fulfill.[152] Not all British Columbians shared that view, for at the same conference Mrs. J. Muir, President of the Parent-Teachers Federation of British Columbia, noted and deplored the tendency for the school to assume the duties of parents for the child's physical, mental and spiritual well-being without consulting parents.[153] The Canadian Churchman, official organ for the Church of England in Canada, declared that it was the duty of the church to inculcate standards of personal honesty and honour in children, and to support the family by being certain "never to cast reflections on a child's parents, his beliefs, or his moral sense."[154] Nevertheless, some educators and other citizens believed the school should be involved in developing the child's moral character. The movement to teach moral and ethical values in the school gained momentum throughout the 1920's.[155] In the December, 1929, issue of The B. C. Teacher, John Ewing, of the Vancouver Normal School, stated that he believed morals should be taught, and that the child's moral

character could be developed by both direct and indirect teaching in the classroom.[156] Mr. T. R. Hall, Inspector of Schools for the Kelowna District, told the October, 1930, convention of the Okanagan Valley teachers that "Modern education was more than the three R's. The teacher had a very important part to play in the teaching of ethics and morals."[157] In 1935, Charles C. Watson, teacher at Point Grey Junior High School, stated in an article in The B. C. Teacher that (unnamed) authorities agreed that a strong moral character could be built within the schools' specialized and controlled environment.[158] Watson discussed in detail the aims and methods used to achieve character development.

Although momentum increased among some educators during the 1920's and 1930's to have schools assume more responsibility for moral training, other educators declined to accept this responsibility. Miss M. Harwood, a Summerland teacher, speaking to a 1931 meeting of the Women's Institute, deplored the attempt to pass the major task of character building on to the schools and other institutions. Institutions, Miss Harwood declared, could never replace good parenthood.[159] Another type of concern was voiced by Premier T. D. Pattullo in an April, 1935, address to the British Columbia Teachers' convention. Pattullo claimed there was a "considerable tendency upon the part of parents to expect the schools to do many of the things that should be done at home..."[160] And he deplored the fact parents were unwilling to accept their parental responsibility.

As schools assumed more responsibility for the child's moral development throughout the 1930's, opposition from parents and the church appears to have declined. In a 1933 address to a Prince Rupert Parent Teachers meeting, Rev. Dr. W. D. Grant Hollingworth pointed out there were two institutions which dealt with the child - the home and the school. The

home and the church were responsible for "inculcating into the mind of the child those high ideals of Christian living which can and should motivate all behaviour..."[161] But, Dr. Hollingworth conceded, as children spent more living time in school than in church, it was "In the school they really learn to live by living."[162] Reflecting the philosophy of American educator John Dewey, Hollingworth stated that it was the duty of the school to give the child "what it needs to know in order to develop into a well-rounded, happy, efficient citizen."[163]

By 1938, educators had assumed some responsibility for the moral education of British Columbia school children. The curriculum guide for junior high schools in 1936 stated that the ultimate goal of education was character, and the school and the curriculum should be organized to achieve this end.[164] Moral education ensured development of a good moral character, and a good moral character manifest itself in 'right living' based on the application of high moral principles, right attitudes, proper values, and highest ideals. The concept of 'right living' did not develop during the 1930's. In 1923, Helen MacMurchy, Director of the Child Welfare Division, defined 'right living' as:

> To love truth and follow the right, to do justly and love mercy, to listen to conscience, to be unselfish, kind and affectionate, to fear God and honour the king, to respect and reverence and remember high standards, noble thoughts, and great traditions of home and service and sacrifice - these are learned at Mother's knee and from Father's way and world.[165]

In 1925, The Canadian Churchman placed a Christian emphasis on its definition of 'right living.' In addition to the positive qualities listed by MacMurchy, the editor emphasized acceptance of failures, the need to bear ills with cheerfulness, to replace doubt with hope, to accept sorrows silently, to trust, to pray, and to keep in mind that right living was pleasing in God's sight.[166] The writers of the Programme of Studies (1936) did not give the Christian emphasis to 'right living' stated by

MacMurchy or by The Canadian Churchman, nevertheless they believed "right attitudes and ideals furnish the motive for right action and the centre around which the habits of life are integrated."[167]

Instilling right attitudes and ideals in school children through textbooks, story books, and organizations for children and youths was not initiated during the inter-war years. Historian Ruth Elson, in her book Guardians of Tradition details the process by which political, economic, social, cultural, and moral concepts were presented to nineteenth-century American children through their school books, a process Elson maintains both created and solidified American traditions.[168] British Columbia educators and child care advisors followed the same approach. The children were bombarded with stories, poems, and activities which focused on right living, bravery, honour, and service.[169] Even the graded basal readers were filled with stories and poems of valour, patriotism, truth, and kindness, lauding the Nation and the Empire.[170] Youth organizations such as Girl Guides, Boy Scouts, and the Canadian Girls in Training embodied right living in their creed and programs.[171] Health professionals and child care advisors believed the world would become a better place if children of the 1920's and 1930's were educated to take care of their bodies, develop their minds, and to form a good upright moral character.[172] As Dr. Young pointed out in 1920 and again in 1935, "Physical perfection must and does go hand in hand with spiritual welfare."[173]

IX

Were health professionals and educators successful in improving the school child's health and in educating his parents (Table 5.3)? In 1937, while gathering information for the Royal Commission on Dominion Provincial Relations, the British Columbia Board of Health used the opportunity to

Table 5.3

CHILD MORTALITY - PROVINCE OF BRITISH COLUMBIA

AGES BIRTH TO 19 YEARS. 1923 - 1939

Year	Under 1 Year	1 Year	2 Years	3 Years	4 Years	5-9 Years	10-19 Years	Total Deaths of Children	Total Deaths	Percentage of Deaths
1923	668	110	68	36	28	136	245	1291	4997	25.83
1924	547	104	61	50	46	137	247	1220	5004	24.38
1925	569	110	62	39	39	117	215	1151	4945	23.27
1926	688	106	50	42	47	119	238	1290	5474	23.56
1927	561	129	91	59	45	136	321	1342	5750	23.33
1928	524	83	70	40	39	163	293	1212	5910	20.50
1929	575	118	52	44	48	157	311	1305	6397	20.40
1930	562	83	44	48	30	146	279	1192	6400	18.62
1931	514	89	37	44	37	125	280	1126	6114	18.41
1932	477	67	44	27	32	127	254	1030	6150	16.74
1933	439	70	38	35	89	261	--	--	6221	--
1934	562	83	44	48	40	146	279	1202	6400	18.78
1935	460	82	48	33	31	98	242	994	6857	14.49
1936	465	71	30	38	26	110	258	998	7222	13.81
1937	630	136	62	32	32	148	280	1320	7973	16.55
1938	556	61	56	38	27	112	253	1108	7450	14.80
1939	483	47	41	27	22	92	256	968	7517	12.87

SOURCE: British Columbia Board of Health, Report, 1919-1939; British Columbia Department of Vital Statistics, Report, 1927-1939.

send questionnaires relating to the school health program to every board of school trustees in the province. Dr. Young reported "We asked them to give us their opinion of the work in general and the results obtained."[174] Young then incorporated responses into his own annual report of medical inspections in schools. The trustees unanimously agreed that the province's school children were generally healthier than before the provision of health services as evidenced by fewer epidemics of contagious diseases and less absenteeism. Physical defects were corrected earlier and infections treated before they spread. Trustees also believed school children were more health conscious than their predecessors had been. One board stated "the betterment of health conditions in the school is reflected in the general well-being of the community."[175] The trustees believed children were healthier now than formerly; one board stated that "Mothers are educated in the better care of children."[176] Young concluded that responses to his questionnaire indicated "that the public are entirely satisfied with these results which will bring about, of course, further extension of the work."[177] As late as 1937, he continued to see schools as the agency through which to educate parents.

> We have centered our public-health teaching-work on the populace, using the schools as a basis. It is the best approach to the home, and the counsel given the parents is illustrated by the children of the family as examples of what can be done when the rules and regulations of the improvement of the daily life of the pupil is shown.[178]

By 1939, health and health education focused not only on the physical care of the individual child, but also on building wholesome attitudes and a social conscience that advisors believed would lead to the betterment of life in both home and community.

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Chapter 6 Advising the Parents: A Preventive Measure

I

> The child is the asset of the State, and all conditions should be arranged as far as possible to get the best results from that child. It (child welfare) is a business transaction, and results are what we are looking for in all business transactions. We do not want inferior products turned out that may or may not answer the purpose, but as perfect a thing as can be produced - something to be proud of; something with stability and quality, that can be used for the purpose of development and advancement and for protection, if need be, of the State to which it belongs.[1]

This statement by Dr. Isabel Arthur of Nelson in an address to the 1917 meeting of the British Columbia health officers expressed the attitude that many social reformers in industrialized countries have expressed for the past century. These reformers, motivated by political, economic, and humanitarian considerations, and armed with developments in both social and health sciences, devoted considerable time and energy to improving the care and rearing of children. Research in medical science and studies in child development provided health professionals and child care advisors with better techniques for health care, more effective methods of disease prevention, and a greater understanding of the developmental processes and specific needs of the child. Armed with this knowledge, a concerted effort was made to produce a child who was an asset to the state. British Columbia social reformers during the post-First World War period worked to provide an appropriate environment in which the child could grow and develop.

Advisors used two approaches to accomplish their goals. First, they initiated health care and child care programs and coordinated the efforts of existing social agencies into more effective services. Second, they disseminated health care and child rearing information to parents. In an effort to provide appropriate health care services in the immediate post-First World War period, the British Columbia Board of Health, assisted

by the British Columbia Division of the Red Cross and the Women's Institute, organized and expanded public health services throughout the province. Although the province's public health service provided diverse types of care and treatment designed to reach all age groups and all segments of British Columbia society, specific programs such as well baby clinics and school medical inspection programs were directed towards children. Additionally, programs of numerous small philanthropic agencies were reorganized and coordinated into larger and more effective associations such as the British Columbia Child Welfare Association, because such associations were able to provide help and care to a wider segment of the province's children than they had been able to offer individually. Simultaneously, at the community level, women's organizations, service clubs, and community associations coordinated their efforts to provide needed and effective local health and child care programs. In short, in response to their vision of British Columbia as a growing and thriving province and the child as its future citizen, British Columbia's political leaders, health professionals, and other concerned citizens worked to provide health and child care services they believed essential to produce strong citizens for the future.

But the provision of health care and child care services was only part of the process; advisors also directed their energies towards disseminating child care and child rearing advice to British Columbia's parents. Advisors believed the key to producing a healthy, happy, productive citizen lay in convincing parents to abandon traditional child rearing practices and to adopt the new systematic, highly regimented, scientific approach to child care. Science, they argued, had provided greater efficiency and effectiveness in both industry and the school system, and medical science had effected the control and prevention of some diseases,

therefore, the scientific method should also be utilized to improve child care and child rearing practices.[2] Parents were assured that if they adopted the new scientific methods of feeding, caring, and training their child, they would prevent or at least reduce the major causes of infant and child mortality. Health professionals were so diligent in their efforts and so convincing with their message that, by 1939, most advisors and many parents no longer assumed a child's survival rested in the providence of God, but rather depended on secular science. Advisors claimed the steadily declining infant and child mortality rates were proof of the effectiveness of the new health care and child rearing techniques. Between 1920 and 1939, the mortality rate in British Columbia for infants under one year of age declined from 73.6 to 39.0 per thousand live births; from 14.0 percent of 6.4 percent of total deaths. Furthermore, the mortality rate for children under twenty years of age declined just as dramatically from 25.8 percent of total deaths in 1923 to 12.8 in 1939. To strengthen their argument for the effectiveness of the scientific approach, public health workers pointed to the steady decline in the number of reported cases of infectious and communicable diseases such as diphtheria and smallpox, and school officials pointed to the increased percentages of pupil attendance in the province's schools as the direct result of less illness among school children. Although advisors attributed the decline in both mortality and morbidity rates to parents adopting new approaches to child care, credit must also be given to improved sanitation, purer milk, cleaner water, immunization, vaccination, and the availability of health services.

Advisors devoted considerable time and energy to improving the physical health of the child, for they believed there was a close relationship between a healthy body, a good mind, and an upright moral character,

therefore, by extrapolation, improving the health of the province's children would improve British Columbia society in general. If diseases such as smallpox, diphtheria, and typhoid could be prevented or at least controlled through education and the application of scientific principles, then social diseases such as poverty, indolence, apathy, and sexual immorality could also be prevented or at least controlled by the same methods.[3] Health education, through the public school system, health care programs, the distribution of printed materails, and the use of mass public media was deemed to be the most effective way to "arouse the apathetic and enlighten the ignorant and prejudiced."[4] With the expanding body of knowledge available through medical research and the child study movement, with the growing number of helping professionals ready to assist children and advise parents, and with the increasing reliance on education as the panacea for society's problems, the school system increasingly assumed more and more responsibility for health education, moral training, and character education. Training in these areas, which had once been the prime responsibility of the home and the church, became a prescribed area in the public school curriculum. Additionally, character training and moral education in the school was supplemented by programs of associations such as the Junior Red Cross, Canadian Girls in Training, and the Boy Scouts.

The tendency of public health services to focus on providing health care for the child, coupled with the proliferation of studies in child growth and development by the Child Study Movement in both the United States and Eastern Canada during the inter-war years brought a rapid increase in the number of helping professionals associated with child health and child care services.[5] Amateur child care advisors, such as religious specialists and untrained but concerned social workers, were replaced

by child psychologists and trained social workers who provided specialized care for the child. Paramount among these professionals was the medical advisor, a position achieved because, for the first time in history, medical science could provide the kind of care that greatly enhanced the child's chances for survival. The aura of the medical expert, either by inference or by image, was utilized by both health professionals and commercial outlets to advise parents on such diverse topics as selecting proper food, clothing, soap, and laxatives. Furthermore, reports of many health professionals of the 1920's and 1930's indicate that they were fully convinced they were more knowledgeable about children and child rearing than were parents. Because they believed they possessed superior knowledge, many advisors approached parents in an authoritarian and dictatorial manner, insisting parents adopt the child care and child rearing practices and methods advisors considered to be correct. Parents were made increasingly aware that many advisors believed the family was no longer capable of providing for the total development of the child without advice and assistance from helping professionals. As early as 1919, Mrs. J. Muir, president of the British Columbia Parent-Teacher Federation, deplored the tendency of schools and other child care agencies to assume duties and responsibilities which had once been those of the parents.[6] Yet, in spite of the concerns of people like Mrs. Muir, advisors increasingly assumed more responsibility for the care and training of the province's children.

II

Advisors considered the task of disseminating child care and child rearing information to parents to be of paramount importance, and to accomplish this process they utilized all the methods and media available to them. As health care and child care services grew and expanded, more

outlets became available through which to distribute advice to parents. With on-going medical research and the Child Study Movement providing more data, more child care and child rearing advice was available for dissemination to parents.

Well baby clinics provided an excellent opportunity for health workers to work with large numbers of mothers and infants. During 1920, for example, the Vancouver Division of Child Hygiene held 133 clinics to which 2,194 infant visits were made. As each visit by an infant was counted, no method is available to determine the actual number of infants involved. The same year, division nurses made 2,847 home calls. Unfortunately, the division report fails to indicate the percentage of infants born in Vancouver in 1920 who attended a clinic. The division report for the following year indicates that 18.6 percent of infants born in Vancouver in 1921 attended one of the division's clinics. By 1939, fifty-four percent of babies born in Vancouver attended a well baby clinic operated by the Division of Child Hygiene. In addition to the 20,906 visits made by mothers and infants to well baby clinics, division nurses made 8,733 home calls. Reports by health workers in other areas of the province also indicate a steadily increasing attendance by infants at well baby clinics. Yet, in spite of the success of the well baby clinics and the practice by some mothers to take their infants to a pediatrician or family physician, there were still mothers who did not receive adequate infant care information.

But well baby clinics were not the only point of contact with parents. Health workers used occasions such as school medical work, vaccination, immunization and tuberculosis clinics, and home nursing classes as opportunities to advise parents on better health care and child rearing tech-

niques. Undoubtedly, parents living in some isolated areas of the province lacked the services and advice of health professionals, yet by 1939, through the combined efforts of the British Columbia Public Health Service, private agencies such as the Red Cross and the Victorian Order of Nurses, and church organizations, most residents of the province, both rural and urban, had access to advice from health workers or general medical practitioners. But only in the large urban areas such as Vancouver or Victoria were the services of child care specialists such as child psychologists and mental hygienists available through the school system.

Parents unable or unwilling to seek help or advice from health professionals had access to a large supply of free printed materials. Governmental boards and departments, voluntary agencies, and commercial firms printed and distributed thousands of pamphlets, booklets and child care manuals throughout the province through health workers, women's groups, and booths at fall fairs and exhibitions. Newspapers and magazines aimed at both rural and urban readers carried regular child care information columns and feature articles written or edited by health professionals and child care specialists. These same publications advertised free pamphlets and bulletins available to parents from agencies such as the British Columbia Board of Health, the Canadian Council on Child Welfare, and the Child Welfare Division of the Dominion Department of Health. Furthermore, newspaper and magazines reviewed and recommended several child care manuals and books prepared and written by Canadian health professionals and child care specialists. Indeed, every parent in the province could obtain a large number of informational pamphlets and bulletins directly from health care workers, through commercial outlets, or by writing for materials from various boards or agencies.

British Columbia's health care workers quickly recognized the educational potential of radio and film as a means to disseminate information to parents. As early as 1922, health workers prepared and broadcast talks on their local radio stations on a variety of health topics. Although advisors continued to use radio throughout the inter-war years, the mountainous terrain and the distances involved prevented radio braodcasts from reaching all areas of the province. The use of films as a media of health education was initiated before the use of radio, but the need for electricity to run projectors limited the distribution of films to schools, community centers, and local movie theatres. Although radio broadcasts and films were not available in every area of the province, sufficient sources of child care and child rearing advice existed to provide information to any parent who requested either advice or assistance. By 1939, facilities and services existed to enable every British Columbia parent to be well informed.

III

How had life changed for children of 1939 as compared to their 1920 counterparts? Although the mother of 1939 did not attend a prenatal clinic or class, she probably visited her physician at least once or twice before her delivery date, and, in all likelihood, the birth occurred in a hospital or nursing home. No statistics are available for the number of births in hospitals in 1920, but by 1927, sixty percent of births registered in British Columbia occurred in either a hospital or nursing home, and by 1939, eighty-two percent occurred in a medical institution. A delivery within a hospital setting was treated as a medical case and, as a result of better medical care, mothers were less likely to develop puerperal septicaemia or other birth complications, and infants were more likely to survive their first year of life. Because of better care, between 1920 and 1939 the

maternal mortality rate for British Columbia dropped from 6.8 to 3.5 per thousand live births. During the same period the infant mortality rate declined from 73.6 to 39.0 per thousand live births.

Following her return from hospital, the mother of 1939 who was living within a health unit area was more likely than her predecessor of 1920 to be visited by a public health nurse or a member of the Victorian Order of Nurses. The visiting nurse instructed the mother in the proper feeding and care of her infant. As she had in 1920, the nurse insisted the infant be placed on an extremely rigid schedule of feeding, sleeping, exercising, and toileting. The nurse also encouraged the mother to take her infant to a bi-weekly or a monthly well baby clinic which monitored the infant's weight and general health, and administered immunization shots.

As was the mother of 1920, the mother of 1939 was encouraged to breast feed her infant. If she could not or would not breast feed, health professionals recommended a carefully balanced diet consisting of pasturized whole or canned milk, water, and sugar, supplemented with citrus fruit juice and cod-liver oil. Unfortunately, the diet advisors believed to be a proper substitute for mother's milk included a high sugar content that not only taught infants to regard sweets as food, but also created dental problems during their growing years. On the positive side, advisors recognized that rickets was preventable, and they urged the mother to expose her child to fresh air and sunlight and to feed cod-liver oil on a regular basis. For the infant born in 1939, better sanitation, pure water, pasturized milk, and scrupulous cleanliness and care in preparing formulas reduced by fifty percent the chance of the child dying from gastro enteritis or dysentry.

Advisors justified changes in infant feeding procedures and diet ingredients on the basis of a scientifically determined formula, and their claims for the success of new feeding methods were supported by the reduction in both infant mortality and morbidity rates. But there was no scientific justification for placing the infant on the highly regimented sleeping, eating, and exercising schedule which discouraged the mother from handling and cuddling her infant. In attempting to ensure the infant's survival, advisors failed to recognize the emotional and psychological needs of both mother and infant to express and receive love through physical contact.

Because vaccination and immunization programs were increasingly extended during the 1920's and the 1930's, children born in 1939 were less likely to contact smallpox or diphtheria than their 1920 counterpart. Even though sulfa drugs were available for the treatment of bacterial infactions, no effective drugs existed to combat virus infections, and by 1939 infants were still vulnerable to respiratory diseases, including tuberculosis. Although infants born in 1939 were still susceptible to some diseases, no doubt exists they had a greater chance of surviving to adulthood than had infants born twenty years earlier.

The greatest change in child rearing advice over the two decades related to the preschool child. In 1920, most advisors made little distinction between two year olds and five year olds in terms of physical, intelectual, and social development. The work of researchers such as Arnold Gesell and W. E. Blatz, however, made advisors more cognizant of the specific and sequential ages and stages of child development. During the late 1920's and the 1930's, the Child Study Movement in both Canada and the

United States worked to disseminate a growing pool of information on child development to the parent, and the movement's leaders popularized the idea that parents not only apply the new scientific principles to child rearing, but also study their own children so they would know best how to guide, teach, and train them during their preschool years.

Although many advisors claimed to apply the scientific approach to child study and child care, as late as 1939 they were not fully aware of the abilities and the capabilities of preschool children. They expected them, for example, to speak clearly and distinctly from the time they learned to talk, even though they were physically incapable of doing so. In all probability, the pressure exerted by adults on the preschool child to enunciate clearly and distinctly produced stuttering in many young children. Additionally, advisors agreed that play was a natural and desirable learning activity, but from two years of age onward advisors insisted children be trained to work at the same time they learned to play. As soon as they were able, preschool children were expected to be working members of the family and to assume responsibility for a portion of the household chores.

Undoubtedly, the scientific approach to child rearing brought many positive changes in the lives of preschool children of the 1920's and the 1930's, but all changes were not for their benefit. Until the 1920's, for example, most preschool children ate essentially the same food as their parents, but the scientifically determined diet recommended by advisors during the inter-war years was high in carbohydrates, low in proteins, and included pureed vegetables that had lost both flavour and nutrition through over cooking. Preschool children of 1939 who shared their parent's diet of meat, vegetables, cheese and eggs, were probably better nourished than children who were fed the diet prescribed by advisors.

While the preschool child tended to be a member of a neglected age group, from 1910 on the British Columbia school child received considerable attention from health professionals and child care advisors over the whole of the inter-war years. By 1939, for example, eighty-nine percent of the province's school children came in touch with the school medical program immediately before or soon after entering the British Columbia school system. An annual medical inspection by the school medical officer and regular examinations by a school nurse ensured the systematic monitoring of the school child's health. In addition, health professionals and educators taught children habits of personal hygiene, rules of safety and accident prevention, and principles of community health with the expectation that the child would carry this information home to their parents. Not only did advisors of the 1920's and the 1930's provide health care and health education for the school child, but also some advisors advocated the school assume responsibility for the child's moral training and character education. As a consequence, the British Columbia school child of the 1930's was taught from a prescribed Course of Study designed to inculcate those values, attitudes, and high ideals advisors deemed to be correct, proper, acceptable, and to reflect the British point of view.

Supplementing the school program were club activities for both boys and girls. These activities included such associations as the Little Mother's League classes for girls aged ten to fourteen years. No records exist reporting how many girls were involved, but during the 1920's, Little Mother's League classes were held across the province. In these classes, girls were taught procedures touted by nurses as the scientific approach to feeding, bathing, and training an infant - a message nurses hoped the girls would take home to their mothers and would apply when they had their own children. During the 1930's, membership in the Little Mother's League

classes declined, and the Junior Red Cross, an association for both boys and girls, rapidly expanded. The Junior Red Cross stressed, among other goals, the development of habits of personal hygiene and health care, both individually and within one's own home. First endorsed by the British Columbia Department of Education in 1922, by 1940 30,999 school children, or approximately thirty-two percent of the province's school children were involved in Junior Red Cross activities.

The parent of 1920 had few resources from which to seek child care and child rearing advice. The parent of 1939 could turn to child care specialists, helping professionals, and a vast amount of printed material. Yet, with the increase in child care and child rearing information, most advisors implied that many parents failed to provide properly for their child's physical, intellectual, moral, and ethical development. If parents doubted their own capabilities, the criticism of health professionals and advisors certainly was not reassuring. Furthermore, attempts by advisors to use the school child as a means to educate parents did little to enhance the parents' feelings about their parenting ability, and probably served to create tension between parent and child. Because advisors were critical of parents, they were ready and willing to advise parents on all aspects of child rearing and child care.

This study has focused on the nature and content of child care and child rearing advice available to British Columbia parents during the inter-war years, but the reader will notice that several questions remain for further study. Despite the availability of advice, what proportion of parents of the 1920's and the 1930's actually sought and heeded the advice? To which sources did parents turn for advice and which advisors did they find most acceptable? Were parents more likely to seek advice on the care

and rearing from one group of advisors in preference to that of another?

A second area for research involves an investigation of factors that led to the steady decline in infant and child morbidity and mortality rates during the inter-war years. Was this decline the result of parents adopting the scientific approach to child care and child rearing, or was it simply the effect of better sanitation, pure milk, clean water, and better methods to prevent and control infectious and contagious diseases? No doubt exists that the child born in 1939 had the potential for a healthier, happier, more productive life than had those of previous generations. The question is, how much of this potential can be attributed to changes in child rearing practices?

IV

What does this study contribute to the historiography of childhood in Canada?[7] It is the first study to investigate child rearing in British Columbia. By focusing on the content of child care and child rearing advice disseminated to parents rather than on the development of health care programs and child care agencies, this study provides a new perspective on the history of Canadian childhood. Not only does it demonstrate advisors' changing concepts of both the nature of the child and the state of childhood, but also it shows that advisors believed child rearing meant more than feeding and caring for the child. Child rearing involved instilling in children the attitudes, values, and mores of the society in which they lived, a process American historian Lawrence Cremin describes as education.[8] But child rearing during the 1920's and the 1930's was an educational process involving both child and parent, and the latter was supported in the child rearing through child care services and child rearing information provided by public health workers, child care advisors,

educators, and social workers. These same educational agents urged the parent to abandon traditional child rearing techniques for the new scientific approach to child care. Although this study does not investigate how many parents adopted the highly rigid, systematic approach to feeding, caring, and training the child, it does demonstrate that advisors were persistent and consistent in their attempts to change child rearing practices and to improve the life potential of the child.

What were the advisors' motives for demanding parents change their child rearing techniques? Radical revisionist historian Michael Katz contends that, during the nineteenth and early twentieth centuries, education was used as a means to effect social control of the working class and to instill in them the attitudes, values, and ideals acceptable to the middle class.[9] Even though child rearing was an educational process designed to produce a healthy, happy, productive citizen, an examination of advice disseminated by health professionals and child care advisors during the inter-war years does not indicate that it was aimed at any one class of British Columbia society. Advisors believed it was essential all parents adopt the new approach to child rearing, for all children were susceptible to illness and disease, and these problems could be prevented, or at least ameliorated, if the parent followed the advisor's advice. Individuals such as Alan Brown and W. E. Blatz did not direct their advice specifically towards the poor, and the province's public health nurses worked to reduce the infant and maternal mortality rate of all classes of British Columbia society. Although The Canadian Mother's Book was written in a simplistic, almost condescending manner, the editor, Helen MacMurchy directed her practical advice to all Canadian mothers in both rural and urban areas of the province. Rather, this study supports the view of moderate revisionists that the advisors' motives were based on humanitarian and

compassionate considerations.[10] The advisor's stated purpose was to lower the infant and maternal mortality rates, and they diligently worked to that end during the 1920's and 1930's.

In his examination of the development of health care services and child care agencies in English Canada, social historian Neil Sutherland contends that by 1920 social reformers had formed a consensus of how the generation of young, growing Canadians should be reared. This study supports Sutherland's contention. Whether through the provision of care for children or through advice to parents, advisors never wavered in their efforts to provide better child care in both the home and the community, and to lower the child and maternal mortality rates. Sutherland also suggests that reformers believed the way to reform society was by establishing better public health care programs, a more efficient educational system, and better child and family services, and advisors saw these changes as the methods to improve life for children. But, this study makes abundantly clear, advisors believed the way to change society was to change child rearing practices, and the way to change child rearing practices was by educating parents to the new scientific approach to child care and child rearing. As important as health care and child care agencies were, advisors viewed them as an avenue through which to teach parents. This study also supports the notion that while reformers and advisors expected the scientific approach in child care to provide a better life for children, better care did not always result. In some cases, pseudo-science rather than real science provided the rationale for changes in child rearing techniques, and the method advisors considered as scientific was not always best for children. Infants' lives, for example, were determined by the clock and not by their individual needs.

Educational historian Alison Prentice contends that the traditional educational system created stereotypical roles for women.[11] This study bears out Prentice's findings. Although child rearing advice was generally addressed to 'parents,' the mother was viewed as homemaker, child rearer, and implementor of advice being disseminated. But father fared no better than mother as he was portrayed in the equally stereotypical role of bread winner, ultimate authority in the family, and supporter of mother. Although encouraged to show interest in his child's welfare, advisors did not encourage the father to become involved in the child rearing process; that was the mother's role. So narrow was the advisors' perception of the parents' role and child rearing ability, they frequently overlooked the competent and capable manner in which many British Columbia parents reared their child. Throughout the inter-war years, advisors continued to view both mother and father in the same stereotypical roles. As a consequence, even though research in child care and studies in child development changed the advisors' concept of the child and the nature of childhood, their view of the parent remained relatively constant.

In summary, this study places child rearing during the inter-war years within the broad spectrum of education. Not only was child rearing the deliberate and systematic education of the child to the attitudes, values and mores of British Columbia society, but also it was the deliberate and systematic education of parents to a new scientifically based approach. This study clearly demonstrates that advisors of the 1920's and the 1930's believed their responsibility was to ensure a better life for the province's children by providing child care services and by educating parents to new techniques. By these methods, advisors believed they provided the potential for a healthier child of the present, and a healthier, happier, more productive citizen of the future than was possible before 1920. An examin-

ation of advice to parents identifies many of the sources of child rearing advice the media used to disseminate information and demonstrates changes in advice as concepts of the child's needs and the nature of childhood underwent continuous change. Finally, this study provides a perspective of advisors' perceptions of the role and the duty of parents, and indicates why advisors believed parents required their advice and guidance.

The practice of advising the parent in child care and child rearing techniques was not, of course, limited to the inter-war years. Today, parents have access to a vast body of advice from pediatricians, health workers, child psychologists, nutritionists, early childhood educators, family counsellors, and social workers. Health workers continue to distribute free copies of the 1979 edition of The Canadian Mother and Child (formerly The Canadian Mother's Book) as well as a wide range of materials on topics such as thumb sucking, bed wetting, and shyness. Through newspaper columns, feature magazine articles, and radio and television programs, parents have access to information on all aspects of child growth and development from the time of conception through to adolescence. Interestingly, many concerns of advisors of the inter-war years are reiterated by advisors today. Television advertisements prepared by the British Columbia Ministry of Health urge expectant mothers to seek prenatal care early in their pregnancies. Mothers are encouraged to breast feed their infants for the first six months, and to give them no solid foods during that time. Furthermore, advisors suggest mothers make their babys' food at home and supplement their diet with vitamin D. Parents are admonished to ensure their infants are immunized against polio, measles, diphtheria, and other diseases as many parents are negligent in this responsibility, and public health workers fear outbreaks of contagious and infectious diseases once considered eradicated. Nutrition is still of great concern, and parents are

urged to make certain their children eat a well balanced diet and do not exist on junk food. The availability of modern drugs and commercially prepared milk diets means gastro-enteritis and respiratory infections are no longer the scourge they once were, but advisors are now concerned that milk and water may be contaminated with chemical agents more insidious and dangerous than those of sixty years ago. The high incidence of teen age pregnancies and the onset of puberty at a younger age has led some parents and advisors to advocate family life education classes be included as a required course in the public school program. Family counsellors also recommend both male and female high school students be given training in child care and child rearing. In spite of the optimism of advisors of the 1920's and 1930's, the scientific approach to child rearing has not solved all the problems associated with child care and child rearing. Indeed, advice to the parent has changed significantly less in the past sixty years than a cursory examination would lead one to expect.

Footnotes

1 Isabel Arthur, "Child Welfare," British Columbia Board of Health, Report, 1918, p. G139.

2 Steven L. Schlossman, "Philanthropy and the Gospel of Child Development," in Proceedings of the Rockefeller Archive Center, June 8, 1979, Gerald Benjamin, ed., pp. 15 - 16, 22. Schlossman discusses the development and role of the Child Study Parent Education Movement in the United States. One of the goals of the Movement was the immediate application of scientific research information to the child rearing process.

3 Sol Cohen, "The Mental Hygienist Movement, The Commonwealth Fund, and Public Education, 1920 - 1933," ibid., pp. 33 - 46. Cohen points to the confidence American advisors placed on science and the school system to detect, correct, and prevent mental illness.

4 C. A. Lucas, Public Health Education in the Schools, British Columbia Board of Health, 1926, p. 3.

5 Christopher Lasch, Haven in a Heartless World: The Family Beseiged (New York: Basic Books, 1978), pp. 12 - 24. Lasch gives the period 1900 to 1930 as the time of the development of the helping professionals.

6 J. Muir, "Parental Responsibility," Report of the Child Welfare Association of British Columbia, 1919, p. 41.

7 For a discussion of the historiography of childhood, family life, and education, see Neil Sutherland, "Introduction Towards a History of English Canadian Youngsters," in Education and Social Change by Michael Katz and Paul Mattingly (New York: New York University Press, 1975), pp. xi - xxxi; see also Marvin Lazerson, "Revisionism and American Educational History," Harvard Educational Review, 43 (May, 1973), 269 - 283.

8 Lawrence A. Cremin, American Education: The Colonial Experience, 1607 - 1783 (New York: Harper and Row, 1970), p. XII.

9 Michael Katz, Class, Bureaucracy and Schools, (New York: Praeger Publications, 1971), pp. xv - xxiv.

10 Neil Sutherland, Children in English Canadian Society: Framing the Twentieth Century Consensus (Toronto: University of Toronto Press, 1976), pp. 228 - 241.

11 Alison Prentice, "The Feminization of Teaching," in The Neglected Majority, by Susan Trofimenkoff and Alison Prentice, (Toronto: McClelland and Steward, 1977), pp. 49 - 65.

Note on Sources

In disseminating child care and child rearing advice to parents during the inter-war years, health professionals and child care advisors provided a wide variety of information through government departments, private and voluntary agencies, popular press, and commercial outlets. A complete bibliography is contained in the footnotes of this study, and a selected bibliography is provided at the end of the study. In searching out the materials for the study, the British Columbia Board of Health Reports (1900-1957) contained a wealth of detailed information treating the development of public health services, the organization of well-baby clinics and dental clinics, and the effects of disease prevention and disease control programs. The Reports also contained some annual reports of the individual health units where specific local health care programs are detailed and the contributions of voluntary organizations noted. The legislative library contains copies of pamphlets and other printed materials distributed through the Board of Health to British Columbia parents. The public schools Reports (1894-1941) provided information on the development of health training for both teachers-in-training and children in the public school system. The Programme of Studies for the public school system (1920-1939) outlined the focus and the content of the health curriculum used throughout the two decades. The province's Statutes supplied information on regulations governing sanitation, pure water, safe food, and the immunization, reporting, and treating of contagious and infectious diseases.

At the federal level, the Child Welfare Division of the Department of Health Reports (1920-1932) provided information on the division's work in developing and supplying information to parents. Also available were copies of The Canadian Mother's Book (1923), the "Little Blue Book Series," and The Enquiry into Maternal Mortality in Canada, July 1, 1925 to July 1, 1926

(1927), produced by the Child Welfare Division.

The Vancouver Board of Health Reports (1910-1937) and the Vancouver Metropolitan Health Unit Reports (1937-1939) furnished information on health care and child care in both Vancouver and the Greater Vancouver area.

The major source of child care-child rearing information to parents was contained in regular columns or frequent articles in Vancouver's largest daily newspaper, The Vancouver Province (1919-1939), the daily Vancouver Sun (1919-1939), the weekly Vernon News (1919-1939), the weekly national magazine the Star Weekly, a weekly farm magazine The Family Herald and Weekly Star (1919-1939), and the woman's monthly magazine Chatelaine (1928-1939). Seven to ten issues of each publication were examined for each year covered by this study. The Canadian Churchman, official organ of the Church of England in the Dominion of Canada (1919-1933), provided another valuable source of information. The Church of England's Yearbook (1919-1939), available in the archives of the Anglican Church in Canada at the Vancouver School of Theology, provided information on the types of materials recommended and distributed to parishioners of a major Protestant church.

The British Columbia Division of the Canadian Red Cross Reports (1919-1939), located at Red Cross Headquarters, Vancouver, provided information on the role of the Red Cross in training public health workers, establishing clinics, and sponsoring specific programs such as the Junior Red Cross.

Periodicals that were extremely useful included the Public Health Nurses which not only reported work activities of nurses, but also frequently included their child care-child rearing messages to parents. The B. C. Teacher,

official organ of the British Columbia Teachers' Federation, which carried articles by educational administrators and classroom teachers who commented on the role of the teacher and the school system in providing health education and moral training of the province's school children, and the Canadian Public Health Journal (1919-1939), which gave background information on the development of child welfare and health care programs across Canada.

The Papers and Proceedings of the Canadian Council on Child and Family Welfare, 1923, 1925, and 1927, detailed the coordinated activities and efforts of various health care and child care organizations throughout Canada. The Proceedings of the British Columbia Conference on Child Welfare (1918 and 1919) supplied information on developments in child care in British Columbia.

The Metropolitan Life Insurance Company provided copies of pamphlets and bulletins distributed to their policy holders by public health workers.

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