Nurses and constructions of motherhood: 'scientific motherhood' and the rise of child welfare services in Tasmania 1918 - 1930

submitted by

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Declaration

I certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person where due reference is not made in the text.

Sheryl Brennan

Abstract

Motherhood is a momentous life-change for women. While commonalities of experience exist between women, each woman's experience is unique. Social constructions define motherhood in particular ways and in doing so tend to deny the range and complexity of individual experience. In recent decades a wide body of feminist and other literature has developed which analyses the way motherhood has been historically constructed and what this means for women. This thesis concentrates upon the ways in which early twentieth century Australians, in common with their counterparts in North America, New Zealand and the United Kingdom, constructed 'scientific motherhood'.

The perspective and method of history are used in this work to explore the construction of scientifi motherhood. In particular, the establishment of the Tasmanian Child Welfare Service is examined, for the origins of this service are closely linked to the requirement that information be disseminated throughout the population about modern 'scientific' mothering. Therefore, this thesis looks at the historical development of this service, at how it grew out of a late 19th century veneration of science as well as concerns regarding population and the position of women in society. It shows the influences lying behind the construction of motherhood as a science and outlines the part played by child health services in bringing this new, as it was perceived at the time, view of rational and efficient mothering to women.

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Notes on Nomenclature

From 1918 to 1956 the present Family and Child Health Service in Tasmania was called the Child Welfare Service. Its voluntary supporting Association was known as the Child Welfare Association.

Between 1956 and 1990 the Service and Association were known respectively as the Child Health Service and the Child Health Association.

After 1990 the Service became known as the Family and Child Health Service while the Association remained the Child Health Association.

This thesis is concerned with the period from 1918 until 1930. In dealing with this period I have followed the nomenclature used in the primary sources, that is Child Welfare Service and Child Welfare Association.

While working in the same practice area in different states and at different times I have been called an infant welfare sister, a maternal and child health nurse, a child health nurse and a family and child health nurse. For simplicity when referring to myself and my position I have used the title child health nurse.

When referring to the present Tasmanian Service I use its correct title, Family and Child Health Service.

Chapter 1: Motherhood constructions: A personal story

This thesis is strongly influenced by the impact socially constructed beliefs about motherhood have had upon me, both as a mother and as a nurse working within maternal and child health agencies during the past twenty years.

In 1977 I gave birth to my first child. During the following year my experience in dealing with health workers as a mother altered the way I practised as a nurse. Prior to this my interactions with clients had been based upon my own preference for being treated as an equal. I disliked being approached by others in an authoritarian manner and was therefore disinclined to approach others in that way. Working alone in the community as a child health nurse had allowed me to develop my own style, one which was deliberately relaxed and informal.

The experience of mothering, however, forced me to look critically at myself as a nurse working with mothers. I saw that, like other health workers I had encountered, my friendly informal manner masked a set of largely unquestioned and fairly inflexible assumptions about women, motherhood and the role of professional 'experts'.

In part, this study is about how motherhood is constructed in specific ways and how health workers often reinforce uncritically those constructions in their dealings with women. The primary aim, however, is to give an account of the historical development of the Tasmanian Child Health Service between 1918 and 1930 with particular reference to the promotion by the service of the construction of scientific motherhood.

While I have developed and refined my views on mothering and nursing over many years, the process of doing so began as a result of one particular experience during my first year as a mother.

Pregnancy and childbirth had been positive experiences for me and I expected motherhood to be the same. My confidence came from a sense of 'being ready'. Emotionally and materially I was organised and I faced mothering a young baby with few qualms. In the previous two years I had worked as a maternal and child health nurse and listened to women telling their stories of mothering with interest and a sense of anticipation. I also had years of experience caring for infants in institutional settings and while I recognised the upheaval and change ahead I felt advantaged and well placed to deal with it.

Therefore when Timothy showed signs of being 'unsettled' I was not initially very concerned. 'Unsettled' is a term commonly used by nurses to describe healthy babies who cry frequently during both day and night and fail to settle into a regular sleep routine within a few months of birth. My lack of serious concern stemmed from my knowledge that babies were often like this for a short time in infancy and I merely thought that the next few weeks might prove rather trying. However Timothy cried persistently for the next 10 months. Not once during that time did he sleep longer than three hours. I know this because as the weeks became months and I became seriously alarmed and exhausted, I charted his sleeping and feeding pattern. Often when he fell asleep I would sit numbly beside him just watching and the restlessness of his sleep gradually convinced me he was in pain.

During the ten months I sought help from a number of different sources. I listened to advice from friends, family, nurses and doctors and if it seemed appropriate I tried it. Twice I admitted myself briefly to the Queen Elizabeth Hospital for Mothers and Babies for rest. At times I felt an enormous sense of failure but I recognised it would be dangerous to allow this to overwhelm me. Instead I actively sought solutions or at least an understanding of his problem. When Timothy was three months old I went back to work part-time. I had not intended to return to work so soon and the primary reason I did so was to put the problem Timothy and I had in perspective. Each working day I was forced to confront the realisation that other mothers had other problems which were often more serious and distressing than my own. While I worked, Timothy was minded by my mother and although I longed for him

to be happy I was also relieved that her experience of caring for him was similar to my own.

Whatever I did or put in place to stop myself being overwhelmed by despair and exhaustion, I still knew that during the night I would be woken approximately hourly by my screaming and distressed baby. I spent many evenings dreading the night, wondering how often he would wake, how I would 'get through' the next day, I thought constantly in terms of 'getting through', and in doing so I now have a sense of having lost a large part of his babyhood.

My feelings of failure were made worse by my perception of myself as being advantaged. I had seen so many women who mothered their children well under great social and financial difficulties. Unlike many of them, I was mature, married to a supportive partner and had a loving and close circle of family and friends, but somewhere right at the back of my mind was the powerful although unexamined belief that mothers, particularly those with my advantages, should be able to soothe their babies. On reflection I am surprised how closely my belief was mirrored by the actions and words of the health professionals I came in contact with. As I struggled not to get caught up in what I realised would be an ultimately unproductive exercise in self blaming, others sometimes overtly blamed me but more often, I felt, covertly disapproved of me.

At various times the following comments were made to me:
From a 19 year old obstetrician's receptionist, 'Tense mothers make tense babies you know' (said helpfully).
General practitioner, as I struggled to explain Timothy's symptoms, 'Your intelligence is getting in the way of your maternal instinct'.
Another general practitioner, 'Nurses and teachers always have trouble being mothers'.
Woman paediatrician on being handed written details of Timothy's crying over the past 24 hours, 'I don't need this, I think he's hungry and I would like you to give him a bottle of unboiled cow's milk every night'. This was despite the fact that his weight gains were normal and he showed no signs of hunger. For a week I gave him the milk and then watched while he vomited. When I phoned and told her that he vomited after every feed, she instructed me to persist.

The decisive moment for me came when Timothy was 10 months old. I had noticed as he had grown bigger that it was becoming increasingly difficult to comfort him. While normally a cuddly

little baby, when he began to scream he went rigid and I was having difficulty holding him. One night I picked him up as he began to scream and laid him on the bed and then sat cross legged beside him and watched him cry. I can clearly remember thinking at that moment that I had to do something myself, that no one else would help him, and so although strongly committed to breast feeding I began to wean him the next day. I had no rational reason for believing that in weaning him I might find a solution, instead I was operating purely on some intuitive level. I took him fairly quickly off two breast feeds and replaced them with water. I told no one because I knew that what I was doing went against every principle of infant feeding. Within a week I noticed his bouts of screaming were a lot fewer and he had begun to sleep for up to four hours. Because of my concern about his nutritional requirements I took him off the other breast feeds more slowly, but by 12 -13 months he was fully weaned, drinking water and fruit juice from a cup and having only one bottle of very diluted milk at night. I hoped that his calcium and protein requirements were being met by the other food sources I began adding into his diet and simply stopped worrying about the fact that he virtually drank no milk. For me everything else paled into insignificance beside the fact that he was a delightful and happy little toddler sleeping usually eight hours at night.

This personal account of one of my mothering experiences is pertinent to this work, because the experience of being a health consumer altered the way I practised as a nurse. Because I was informed and knew the midwives and my doctor well, I had successfully insisted upon the birthing style of my choice. Once I became a mother the advantages of being an insider within the health system suddenly disappeared. I felt helpless and angry. I recognised I was coming up against powerful beliefs about mothers and babies, which my own experience did not match and I quickly realised the importance of holding onto the reality of my experience. I was helped by the fact that others also cared for Timothy and had similar experiences, including a friend who was also a child health nurse. Without my experience being validated in this way it would have been impossible not to have believed that Timothy's crying was somehow my fault. It gave me an insider view of how a mother might perceive herself and be perceived by others when something goes wrong.

Now seventeen years later I believe that all of us who took part in Timothy's story were influenced by very powerful beliefs about the meaning and nature of

motherhood. In the beginning we all shared common views. I believed, along with my family, friends, colleagues and doctors that 'mothers should be able to soothe their babies'. This grew out of the belief that nurturing behaviours come 'naturally' to women and therefore, an unhappy, though apparently healthy baby, indicates that the mother is at fault. The focus becomes trained upon the mother rather than on the baby. I began to realise that when I described Timothy's crying to doctors and nurses, stressing he was in pain, the reason they were unconcerned was because in their view his behaviour would change when I became better at mothering; less anxious, concerned, demanding, strident, analytical, emotional, over protective, intelligent, any or all of these things; less in fact myself. On the other hand, I knew he was in pain and as long as I was the centre of attention his pain was unlikely to be investigated. It was an incredibly frustrating impasse.

Nevertheless, at the time I, as well as my family, friends , colleagues and the doctors I consulted, still believed in the authority of medical practitioners to advise and prescribe treatment and behaviour routines for babies. Only as I became increasingly frustrated and impatient did I begin to doubt that authority. This became a truly schizophrenic experience for me, for I was torn between the depth of my personal knowledge of one baby and my generalised nursing knowledge of many babies. In the voices speaking to me offering facile suggestions based upon false assumptions I repeatedly heard my own voice speaking as a nurse to women only 12 months before. Countless times I had heard mothers say about babies *'they're all different'* and I had also said it, yet at the same time I had accepted unquestioningly generalisations about infant behaviour developed from scientific observation and applied them in my nursing practice to infants. I found it deeply unsettling that while I had been educated to value objective knowledge, I knew that my subjective experience of mothering contradicted that knowledge.

In retrospect I suspect Timothy had an allergy to cow's milk[1], the antigen being passed through breast milk. This was an unrecognised possibility in the 1970s. I

1 Allergic reactions occur when antibodies produced by the body to deal with foreign substances (allergens/antigens) fail to eliminate them. Milk allergy is usually characterised by some of the following symptoms; nausea, vomiting, abdominal cramps or diarrhoea. Rashes and asthma like symptoms any also occur (Minchin 1982:9).

was so imbued with notions of professional scientific mothering that I swallowed without question, my regulation half litre of milk daily while breast-feeding. However, as my second child was undoubtedly allergic to cows milk I may be merely transferring my knowledge from that later experience onto Timothy, and at this distance it hardly matters.

I took back control of my mothering on the strength of what was a calculated risk to Timothy's health by placing him on an almost milk-free diet. Admittedly I saw it as being only a small risk for I was sure I could meet his nutritional requirements through other dietary means, but I knew others would be alarmed at my taking him off all milk products. Soy milk was not yet easily available and I did not consider using it. I knew from observation that his behaviour was somehow linked to his food intake, and having systematically tried eliminating other food, I sensed milk might be the problem. I had tried to make my observations clear to the health workers I talked to, but I knew with absolute certainty that they had never really heard what I was saying. They had heard the words but not the meaning and I despaired of ever being able to make my meaning clear.

Not being heard by health professionals is a disturbing experience. In relation to mothering it is important to note that for three generations motherhood in Australia has been the province of 'experts'. Women care for children but they do so under the guidance of professionals who base their expertise upon knowledge of the behavioural and physical sciences. Midwives, doctors, child health nurses, psychologists and teachers are all experts on parenting, in particular mothering. Scientific findings are generalised and applied to all mothers and babies. People are categorised and those women whose experience falls outside the categories can have the experience either denied or adjusted to fit within a category. In practice, I have seen and been part of this imposition of professional interpretation of personal experience. It can happen so easily. For example, when women raise issues the doctors and nurses tend to try to fit these into overall theoretical frameworks. They may see the issue differently to the client. They may, for example, see it as being much larger, smaller or more complex. Very little is accepted at face value, health workers spend a lot of time looking for hidden meanings and generalised understandings and explanations to explain individual maternal and infant behaviour. Often the different ways

the two parties view the issue is not overtly stated, sometimes to do so would mean disclosing value judgements on the part of the health worker about the client. This can lead to a lack of acknowledgment of women's perceptions and understandings.

My experience with doctors, and sometimes nurses, during Timothy's first year made me feel powerless and incompetent. Largely this was a result of being labelled. As I have recounted I was described as 'tense', 'a nurse', 'intelligent' and by default, 'lacking in maternal instinct'. Being judged in such a way made it difficult for me to effectively express my anxiety about Timothy's pain and continual crying. I knew when I tried to communicate this to health workers I merely reinforced the label I had been given. My interpretation was dismissed in favour of the 'expert' interpretation. The 'expert' knows best and knows more' mind-set stems directly from the way medicine and nursing have used the prestige of science to gain professional authority.

Having my experience of motherhood adjusted by professionals to fit prescribed notions of 'normal' mother and baby behaviour, led me to question how women's authority over the practice of motherhood had come to be undermined. I became increasingly curious about why motherhood was defined in particular ways, how did this process occur? what were its origins? what influences lay behind it? what part did nurses, working with mothers and babies, play in reinforcing it? In short, what was the history of motherhood constructions, how were they legitimised by society and internalised by women? The influence of professional experts in child care and the part they played in promoting fashions in parenting, had interested me for some time, and I noticed that parents frequently sought the newest information and were often dismissive of ideas only five years old. I recognised that this made the doctors and psychologists who wrote the bulk of the material aimed at parents very influential in determining parenting, and particularly mothering, behaviours. It was just a brief step, in the light of my personal and nursing practice experiences and interests, to begin to look at how motherhood is constructed.

I decided that for the purposes of this thesis, I would study, from an historical perspective, the foundation years, 1918-1930, of the Tasmanian Child Welfare

Service. During this time the service strongly promoted one construction 'scientific motherhood', remnants of which still influence practice today. This study I felt would enable me to understand more clearly the process involved in the development of motherhood constructions and allow me to explore many of the questions which interested me.

I use the term 'scientific motherhood' to describe a system of child-rearing based upon the principles of efficiency, logic and reason. Rapid scientific advances
reformers and others to believe that scientific principles and methods could be applied to mothering and this would in turn improve child health. Apple (1985) argues that science came to be viewed as the answer to many social problems. In Australia, Reiger (1985) contends that the domestic science, family planning and infant welfare movements developed directly from a belief that the application of science would find answers to society's ills. The goal of the above movements was to modernise the home and family through the education of women. The result, Reiger claims, in terms of child rearing, was that scientific management principles, particularly order, method and regularity were stressed. In addition, Weiner (1994) asserts that scientific motherhood stressed the authority of experts, as does Knapman (1993:115), who claims that the dominant themes of scientific motherhood were an '...emphasis on training, supervision, efficiency and reliance on expert scientific knowledge'. It is this methodical and disciplined style of mothering which child welfare nurses commonly advocated in the early decades of the 20th century which I call scientific motherhood.

The questions coming out of my own mothering experience as well as my nursing practice were clearly concerned with the position of women as mothers in society and the effect of motherhood constructions upon them. Motherhood is still regarded as women's primary career. It matters little if they are in paid work or stay at home, for, on some level, most women I meet view infant and small child care as their especial responsibility, as do the rest of their community, including their partners.

This is borne out in entries I made in my professional journal. Some of the entries are concerned with the problem of crying babies, particularly in relation

to 'six o'clock colic' and consequent family difficulties. In these I often recorded the mothers' exact comments. I believe these comments highlight how women often feel they have failed against some external measure of motherhood (the current dominant construction) and how painful this can be for them.
'Six o'clock colic' is a common lay term given to the occurrence of prolonged crying by young babies in the late afternoon and early evening during the first few weeks of life. The condition is self limiting and most common in breast-fed babies. Frequently the baby screams for a couple of hours at least, around the time of the evening meal. Obviously this is distressing for parents. It is hard to prepare food with a screaming unhappy baby on the hip and perhaps other tired young children under foot. Most men coming home from work try to help, by either cooking the meal, taking the baby or playing with the other children. Some men however are disgruntled and express their disgruntlement. A very few - I heard of three in 1992 - turn, on hearing the uproar and go straight back out. Because I was interested in how women felt while their babies had this condition I recorded many of the comments made by mothers to me:

Some were to do with the unfairness of the situation:

> *why me* or *why can't he cry before 4pm or after 8pm?*

More revealed a sense of failure,

> *why can't I settle her, what am I doing wrong?* or, *What's wrong with my milk?* and *Maybe I'm not meant to breast-feed.*

One woman commenting on her partner's reaction -

> *My husband hates coming home to this,* [I was doing a home visit] *he thinks there must be something wrong with my milk.*

During a home visit Jenny, a mother of three young children, spoke about her husband's response to their situation in the following way:

> *He's tired of the baby crying. It's keeping him awake at night and he has to work ...He's busy at work and really needs a break at night, he does help me a lot, but I feel guilty because I feel I should be able to do it ...he's irritable with Laura* [the toddler] *because the baby's crying, I feel sorry for her, she's really missing out, no-one has time to give her attention.*

These comments show how difficult it can be for both women and men. They highlight how in Australian society the care of babies and small children is still viewed by both women and men as the province of women. Scientific motherhood, the development of which I focus upon in this work, promoted the view that women as mothers require supervision and support and while as a construction it may not be so obviously influential now as in the first half of the century, nevertheless it persists in subtle ways. Certainly when babies behave in ways which lie outside the parameters of what is popularly considered normal, women and their partners often feel that the woman is doing something wrong and requires expert help.

I have chosen to focus upon the way motherhood was constructed as an applied science in order to explore how constructions of motherhood originate, become accepted by society, and are frequently uncritically promoted and reinforced by nurses. Child welfare services throughout Australia were established to promote the scientific management of motherhood and their history is inextricably interwoven with it. This thesis concentrates on the historical development of the Tasmanian Child Welfare Service between 1918 and 1930. This was the foundation period of the Tasmanian service during which nurses and child welfare supporters vigorously promoted the message of modern scientific motherhood. After 1930, while the service continued to expand, there is a sense of 'settling' down and the beginning of a period of consolidation. The study is based in Tasmania not because there was any major difference with the Tasmanian service but mainly because living in the state made the sources easily accessible to me for research and writing this history.

In grouping the historical data several themes were revealed, three of which I chose to concentrate upon in this study. I called them, philanthropy, training of

mothers and babies and the use of propaganda[2]. They reflect, I believe, the way child welfare nursing in Tasmania promoted and reinforced the concept of scientific motherhood. While the themes overlapped at times, they still remained distinct. Together they tell much of the story of the early Tasmanian Child Welfare Service.

Philanthropy was demonstrated by the support given the Child Welfare Service by women's organisations (JPP 1918-19, 28:13)[3]. Women's groups supported and promoted child health nursing because of their commitment to the principle of educating women for motherhood and their concern about the loss of infant life. The rhetoric regarding the advantages of early infant training, which began to appear in the 1920s, implied that mothers had to be trained in order to produce trained babies. Finally, innovative and effective propaganda methods had to be devised to reach the wider community with the message of the benefits of training for motherhood. The early nurses and their volunteer supporters were justifiably proud of their skill in promoting both the service and its concept of skilled scientific mothering. Clearly these themes demonstrate my central contention: scientific motherhood was socially constructed, developed and reinforced by philanthropic and professional groups with the active support of women.

Today, as in the past, child health nurses work intimately with mothers and children for long periods of time. The majority of women in Tasmania will see their child health nurse regularly for years[4], at first weekly, usually progressing to fortnightly and then monthly visits. By the time the child is three years old

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2 Propaganda was a term widely used by health professionals without any pejorative meaning in the early decades of this century to describe the dissemination of health information. For example, in his 1928 report the Tasmanian Public Health Officer refers approvingly, to the lectures, demonstrations and written newspaper articles of child welfare nurses, as propaganda (JPP 1929-30, 3:17).

3 For brevity I have used the abbreviation JPP for the Journals and Printed Papers of the Parliament of Tasmania. The remainder of the reference includes, in sequence, year, paper number and page number.

4 Morris (1992:25) in writing about the Northern Region of Tasmania states that 'A total number of 1756 new babies presented to child health centres in 1991. When compared to the total number of births for the region for the same period there is evidence that a "take-up" rate of new babies visiting child health centres is in the order of 90%+ applies'. This suggests that the role of child health centres and nurses is significant.

mothers may only be coming two or three times a year to see the nurse. On the other hand, they may have another baby and have initiated weekly visits again. It is because of the private and long standing nature of the relationship between child health nurses and mothers that these nurses are potentially powerful reinforcers of motherhood constructions.

Chapter 2: The emergence of scientific motherhood

Tasmanian child welfare nursing services were established in 1918 in common with analogous agencies in the rest of Australia, as part of a concerted campaign by health administrators to reduce the infant mortality rate and improve the health and well being of children. From 1870 the way women cared for their children came increasingly under the combined scrutiny of the medical profession, politicians and philanthropists. This was as a direct result of two noticeable trends in official statistics; a declining birth rate and a high infant mortality rate (Reiger, 1985:28). Australia's slow population growth at this time seriously concerned social planners and politicians, many of whom recognised that reducing the number of babies dying from preventable causes would have social as well as humanitarian implications. McCalman (1984:210) states this concern led to the intervention by professionals into the private life of the family in a way which had not occurred before. In the process, motherhood was redefined from a role women knew instinctively how to fulfil, to one for which they needed preparation in the form of education.

The establishment of child welfare services was a radical health initiative, the outcome, however, was that women were seen as needing professional help in order to become competent mothers. In this thesis I assert that motherhood, by which I mean the nurturing behaviours of women as mothers, is a socially constructed institution. Historically mothering has, in different times and different places, been constructed in vastly different ways (Badinter 1980, Fildes 1986, Aries, 1973). In the early twentieth century under the influence of a multitude of intellectual, social and political factors, a scientific approach towards motherhood was promoted by health professionals and adopted by many mothers. Motherhood was reconstructed along rational, supposedly scientific lines.

Social construction theory is an explanatory theory of human behaviour, which developed out of environmentalism, the belief that the environment is a powerful force in influencing human development (Crowley & Himmelweit, 1992:60). Feminists, and others, generally support the view that gender roles (including mothering) are social constructs (Oakley 1972; Phoenix, Woollett & Lloyd 1991:13). Such a position is in opposition to biological determinism, that is, the belief that our social roles develop as a direct result of our biological programming as females or males.

The idea that mothering behaviours are constructed is well supported in literature. For example, Elisabeth Badinter's (1980) account of French mothering since the middle ages exposes the connection between the political, social and intellectual context in which families and women were situated and the act of mothering. Badinter shows how the social perception of the nature of mothering began to change around about the middle of the 18th century. Her purpose is to show that mothering is a learned behaviour rather than an instinctual one. Boulton's (1983) work examines a variety of twentieth century biological and sociological constructions of motherhood and includes cross-cultural material which shows how motherhood is constituted differently in different cultures. Reiger (1985) outlines how ideologies which address women as wives and mothers reinforce and recreate a social system in which women are primarily defined by these roles. In a further work, Reiger (1991) studies how ideological pressures contribute to the development of constructions of motherhood which women then internalise. Oakley (1974) maintains that biological motherhood is not a natural need for women but culturally constructed as such, the result being a widely held social belief that all women need to be mothers, and all children need their mothers. Rothman (1989) discusses the development of the construction of 'mother as machine' and demonstrates the role played by reproductive technology in the generation of this view of women. E.A. Kaplan's (1992) work on representations of mothers in literature and film offers insights into historical constructions of motherhood before exploring dominant discourses which influence how motherhood is both constructed and represented in the 1980s. Rich (1979) discusses how the institution of motherhood is maintained and controlled in a patriarchal society. In her writing Rich poignantly exposes the confining nature of powerful motherhood constructions:

> I realise that I was effectively alienated from my real body and my real spirit by the institution - not the fact - of motherhood. This institution - the foundation of human society as we know it allowed me only certain views, certain expectations, whether embodied in the booklet in my obstetrician's waiting room, the novels I had read, my mother-in-law's approval, my memories of my own mother, the Sistine Madonna, or she of the Michelangelo *Pieta*, the floating notion that a woman pregnant is a woman calm in her fulfilment or, simply a woman waiting.
> (1979:80)

Motherhood constructions alter in response to historical changes in ideas about mothering, which themselves develop out of a multitude of complex and inter-related influences. Constructions, while unavoidable, nevertheless oppress women. Friere (1968:40) states that wherever one person' objectively exploits' another or hinders their development this is oppression, and at the centre of oppression theory are myths, power and weakness. Exposing the origins of motherhood constructions by demonstrating that they are not absolutes of nature or fate can reduce the power of their impact upon mothers and health professionals (Fiorino 1980:68). Lovell (1980:52) in discussing motherhood myths supports this belief claiming that '... a more effective method of dispelling a myth is to analyse it over and over until the myth loses its power over people's minds and feelings'.

To explore the origins of scientific motherhood and the establishment of child welfare services, it is necessary to take into account the position of Australian women as mothers in the late 19th century, in relation to the social and political concerns of the time.

Late 19th century motherhood

Throughout the 19th century in Australia the central position of women within the family as mothers and homemakers had been reified and at times taken on quasi-religious mystical overtones, with mothers being viewed as self-sacrificing angels (Kaplan 1992:28), or compared with saints (Badinter 1980:190; Summers, 1975:168). This did not necessarily mean that women were well treated either in the home or in the work-place. Working-class women

continued, by necessity, to work outside the home[1] while accepting middle-class ideas about the pivotal importance of women within the home (Reiger 1985:130). The type of writing directed towards women about marriage and motherhood at this time is exemplified in the following passage by the Rev. Bernard O'Reilly:

> But she had been trained in a model home, and by the hand of a mother to whom gentleness was the fruit of many an early struggle with self. ...It is God's will and wish that every mother should study self-control, which is only the outward manifestation of that meekness and gentleness of spirit, so lovely in the sight of God and angels.
>
> (O'Reilly 1891:12)

In contrast to this 19th century idealised view of motherhood, Mintz & Kellogg (1988:12) claim that up to the middle of the 18th century mothering had been only one of many functions performed by women. Prior to industrialisation, farming was the dominant occupation of the vast majority of people, both men and women. A century later, however, women's mothering and domestic duties were seen to be pre-eminent, other interests and duties being relegated to sideline status.

Willis (1980:174) maintains that this 19th century emphasis on the domestic and nurturing functions of women was reinforced by societal changes brought about by the industrial revolution, which, she claims, was largely responsible for the division between home and workplace, and for elaborating male and female roles. As mechanisation increased, the number of goods produced within the home was reduced, and cleaning and child care became the major component of women's work. Mintz and Kellogg (1988:63) suggest that the transformation women underwent upon marriage to become 'the family's key nurturing figure' often resulted in personal tension, which sometimes manifested itself as hysteria, a commonly diagnosed neurosis among 19th century women.

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1 Kingston (1975:7) states that in 1890 about one-third of Australian women belonged in the workforce outside the home.

Donzelot (1973:36) also argues that the disruption to traditional agricultural society caused by the industrial revolution was responsible for the emergence of a view of women as possible vehicles for men's salvation, instruments through which the working class might be civilised. According to Donzelot, the peaceful happy home was to be the bait by which men would be hooked into domesticity and recognition of their responsibilities as provider and husband/father. Saunders and Evans (1992:228) support this stating that in Australia women were perceived to be powerful forces in the civilising of men. The home was invested with moral and religious overtones, frequently perceived as a sanctuary and refuge from the competitiveness of the public world (Reiger, 1985:37). Nevertheless, at the close of the 19th century small numbers of women were beginning to enter occupations like law, medicine and business, which were formerly seen as the preserve of men. However, from the 1920s onwards women's groups focused their attention predominantly upon issues related to motherhood and effective child-rearing (Baldock & Cass, 1988:8). In effect, they turned away from what was a successful early movement by women into public life and focused their attention on women's traditional power base, the home and motherhood.

It is important to remember, however, that only economically secure families could afford to have mothers removed from the paid workplace. Poor women inevitably continued to juggle their outside work commitments with their family responsibilities (Saunders & Evans 1992:230). Nevertheless, as the 19th century progressed, the caring role of women was increasingly valued. Their contribution to social betterment was generally regarded as equal to that of men but because of their reproductive role, necessarily different. Grimshaw (1980:46) maintains it was in recognition of this that the trade union movement in Australia fought for a 'family wage' which would enable unskilled working class men, about 30% of the workforce,[2] as well as their middle class counterparts to keep their wives engaged in full time child care and domestic duties. Their efforts resulted in the Harvester Judgement of Justice Higgins in 1907, which awarded Australian unskilled male workers a basic wage sufficient

2 See P G McCarthy 'Labour and the Living Wage 1890-1910', *Australian Journal of Politics and History* Vol 13 (1) April 1967. Also, 'Wages for unskilled Work and Margins for Skill, Australia, 1901-1921', *Australian Economic History Review* Vol 12, (2) Sept 1972.

to maintain themselves, a wife and three hypothetical children[3]. Justice Higgins came to his decision with the aid of budgets compiled by trade unionists' wives (Baldock & Cass 1988:7). The implication of this judgement was clear: women did not need a career in paid work, their career in life was to marry and bear children.

Saunders & Evans (1992:322) claim that despite the diversity of views in the women's movement in the late 19th century, all groups within the movement held the view that women's nature was nurturing and self-sacrificing. Furthermore, they state that the concern of suffragists was not to reject the primary position of women within the home, but rather to lessen the control of men over 'women's bodies and behaviour' (1992:321). Winning the vote was one means of reducing the control of men over women's lives. It seems that many first wave feminists therefore accepted fully the concept of separate spheres for men and women.

Fox and Lake (1990:179) maintains that by the 1870's the language and ideology of 'separate spheres' had become widely accepted throughout Australia and suggests this may have been very much in the interests of women, particularly rural women, who formerly combined long hours of outside farm labour with inside domestic work and child care. Lake also claims that the ideology of 'separate spheres' followed on from the extension of women's civic and legal rights in the 30 years before World War 1, after which it became increasingly unacceptable for men to work their wives as unpaid farm labourers. It appears possible therefore that the concept of separate spheres, freed women from unremitting outside toil while at the same time trapping them for decades within the inside domestic world of the family.

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3 In effect a middle-class radical, Justice Higgins, was attempting to institutionalise middle-class values in the Australian working-class, by providing a wage which allowed the modest comforts necessary in a 'civilised' society. His computation of a reasonable wage included allowance for light, clothing, furniture, books, music, amusements, liquor and tobacco (Rickards 1976:220)

Table 2.1 Participation of women in paid labour in Australia, 1901-86

Year	Percentage of women at work	Percentage of married women at work
1901	30.7	N/A
1911	28.5	6.1
1921	26.7	4.4
1933	27.8	5.4
1947	28.4	8.6
1954	30.5	13.6
1961	33.8	18.7
1966	40.9	28.8
1971	37.1	32.8
1976	43.0	41.2
1981	44.4	42.2
1986	47.6	47.1

(*Source:* Baldock & Cass 1988:27 Abridged table)

To summarise the argument, at the close of the 19th century within Australia, increasing importance was being placed upon the domestic and family responsibilities of women. At the same time a few women were having success in their campaign to win greater civil liberties and were beginning to move into the professions and paid work force. However two decades later, by the 1920s, the activities of women's organisations were focused predominantly on winning recognition for the work women did within the home rather than encouraging them into the paid workforce. As we can see from Table 2.1, after the turn of the century the number of women in paid work fell and remained low until after the second world war. The factors which helped bring about this return to the home are central to an examination of scientific motherhood and early child health services.

The falling birth rate

At the beginning of the new century, women came under unrelenting criticism for using rudimentary forms of contraception. Government and medical authorities, worried about the declining birth rate, claimed that contraception was to blame, and that 'women using it were selfishly defying the laws of God and nature'(Siedlecky & Wyndham 1990:14). The willingness of women to use contraception was caused by a variety of pressures: including the contemporary struggle for women's political rights, the objection of women to repeated child bearing, and the desire of parents for the greater opportunities for each child

that smaller families allowed (Siedlecky & Wyndham 1990:1). Parents also missed the domestic and economic help of their children following the introduction of compulsory primary schooling in the 1880s. In earlier times, the earning power of many children added considerably to the family's income. Now at the turn of the century, large families came to be viewed as an economic drawback (Gilding 1991:27). In the face of these considerations, parents turned to birth control despite strong objections from public male figures - politicians, administrators, clergymen and medical practitioners (Reiger 1985:105).

The widespread criticism of women who used contraception centred around two main issues: the refusal of women to fulfil their natural reproductive obligations and the possibility that the declining birth rate - this decreased from an average of seven children per family in 1881 to an average of four in 1911 - jeopardised Anglo-Saxon sovereignty within Australia (Saunders & Evans 1992:168). Fears of race suicide, common throughout the English-speaking world, became particularly strong in Australia, an immigrant nation of Europeans situated south of heavily populated Asian countries. Because of these racial fears, pro-natalism, the belief that a steadily increasing population is necessary for the survival of the nation, became popular in Australia during the early 1900s (Siedlecky & Wyndham 1990:16). Consequently, politicians called on women to breed for 'race and state' (Gilding 1991:74). The 1903 Royal Commission on the Decline of the Birth-rate and on the Mortality of Infants in New South Wales concluded that the declining birth-rate was due to the use of contraceptives by upper and middle class women and that 'procreation was a sacred duty and women were abdicating their civic responsibility' in choosing to limit their families (Siedlecky & Wyndham 1990:18). Kingston (1975:9) states that far from indicating 'selfishness or laziness on the part of women ' the declining birth rate may have been a result of a greater awareness of the responsibilities involved in motherhood, the costs of housing and education, and developing concepts such as "a standard of living". Despite constant urging, and financial inducements - the baby bonus of 1912[4] and the

4 In 1912 the Fisher Labor government brought in a maternity allowance, quickly dubbed the 'baby bonus'. Five pounds was to be paid to mothers on the birth of a viable child. A viable child was defined as one who lived for at least 12 hours. Later the government extended the allowance to cover women who gave birth to still-born infants. The government hoped that women, knowing

introduction of child endowment in the 1920s - women did not return to having large families. As a result the focus of government and medical attention moved from encouraging women to have more children to attempting to decrease the infant mortality and morbidity levels.

The high infant mortality rate

Throughout Australia, as the birth rate continued falling, concern at the high mortality rate and the loss this meant to the nation, increasingly began to be expressed. In Tasmania the death rate for infants had remained stable for decades, and there is little evidence of great public concern until the beginning of the twentieth century. Charitable organisations and government officials had frequently expressed concern at the plight of destitute and abandoned children, but rarely at the general loss of infant life (Brown 1972:58). At the close of the 19th century the death rate of infants had been maintained at about 10% for decades. The following table for the 40 years between 1870 and 1909 shows the comparative stability of the infant death rate.

Table 2.2 Annual deaths of infants under one year of age per 100 live births for the period 1870-1909 in Tasmania

1870	9.8	1880	11.23	1890	10.6	1900	8
1871	8.5	1881	10.34	1891	9.5	1901	8.9
1872	10.2	1882	10.36	1892	9.9	1902	7.9
1873	8.7	1883	12.39	1893	10.5	1903	11.1
1874	10.36	1884	9.98	1894	9	1904	9.1
1875	13.11	1885	11.3	1895	8.2	1905	8
1876	9.08	1886	10.5	1896	8.9	1906	9.1
1877	11.37	1887	10.1	1897	8.8	1907	8.2
1878	10.71	1888	9.6	1898	11.6	1908	7.6
1879	10.77	1889	10.6	1899	11.6	1909	6.5

(*Source: Statistics of Tasmania* 1909 Paper No. 41)

In the first decade of the twentieth century the infant mortality rate did begin to drop, and averaged 8.4 deaths per 100 live births (JPP 1908, 41:9 & 1910, 16:122). It is interesting to note that while the medical profession in the last decades of the 19th century was clearly aware of many of the pre-disposing factors leading

the money was guaranteed, would spend it on licensed medical care during pregnancy and labour (Kingston, 1975:10).

to infant death, it was not until the beginning of the 20th century, after the failure of the pro-natalist approach of encouraging parents to have more children, that federal and state governments seemed prepared to make a concerted effort to reduce the infant death and sickness levels.

Doctors in the late 19th century knew for example that improved sanitation- that is, personal cleanliness, safe piped water supplies, effective disposal of human and household wastes - particularly in closely settled areas, would save lives (Huon Coward 1988:118). In Tasmania, as towns became larger a marked difference in the mortality rate between country and urban areas developed.

In a report submitted to parliament in 1875, J. L Miller, Chief Medical Officer at Launceston, stated that the death rate over the preceding four to five years had increased by 20% and was now 24.10 per 100 people, a figure much greater than that of the colony as a whole. Miller stated that when he first came to Launceston in 1855, typhoid fever, diphtheria and erysipelas were almost unknown but in 1875 were common. He attributed this to the 'close proximity of urban living combined with inadequate drainage, cleansing and other health measures', and went on to recommend 'underground drainage and strict enforcement of emptying cess-pools, dung-pits and cleansing of cow yards'. Miller did point out however that the introduction of these measures would not bring unmixed benefits, for the contents would be carried into the Tamar river, which as the population increased, would itself become a gigantic sewer (JPP 1875, 67:4).

In 1884 the mortality rate in the colony per thousand living people, was, for country areas 9.99, but for urban areas 24.91. The difference even allowing for the concentration in urban areas of hospital sick, paupers and criminals, was very large. The 'close contiguity of dwellings'[5] was blamed for the high death rate in urban areas (*Statistics of Tasmania* 1885, Paper No. 1).

5 In 1895 in a another report submitted to parliament, the incidence of typhoid fever in 1894 was examined. In that year, Hobart had 91 cases, Longford 15 and Launceston 47. The rate for Longford at 2.75 per 1000 people was higher than that for Launceston at 2.65 per 1000 people. How a small village came to have a higher rate than a sizeable town is explained historically in the report. Longford was one of the earliest areas settled in Tasmania and had had hardly any sewerage work carried out. Therefore, as the writer stated 'the slops of generations have been thrown on the ground about the houses which must be inevitably polluted thereby' (Report of Central Board of Health 1895).

Thus, the general link between some infectious diseases and poor sanitation was understood. Throughout these years doctors also repeatedly stressed the need for pure cows' milk and safe water supplies, and the need for mothers to breast-feed their babies as a protective measure particularly against diarrhoeal infection. Some indication of how many babies died from what was known as 'summer diarrhoea' is revealed in the following three tables from 1894.

Table 2.3 Causes of death of infants under one year in 1894[6]

Diarrhoea	41
Prematurity	39
Convulsions	59
Epilepsy	1
Bronchitis	32
Pneumonia	14
Enteritis	34
Debility, Atrophy, Inanition	94

Table 2.4 Deaths of infants under one year per calendar month in 1894

Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
56	54	54	35	30	26	22	29	36	34	19	33	438

Table 2.5 Deaths from diarrhoea for all ages per calendar month in 1894

Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
11	14	13	3	1	2	2	2	3	1	2	3	57

(*Source: Statistics of Tasmania* 1895 Paper No. 48)

Enteritis, infection of the intestines, may in some cases, have referred to enteric or typhoid fever. In any case, illness characterised by diarrhoea was the cause of 75 of the 438 infant deaths that year. In addition many of the 94 deaths attributed to debility, atrophy and inanition (malnutrition) could have been caused by gastro-enteritis. However, if we take only those 41 infant deaths directly attributed to diarrhoea, it is obvious that they make up most of the 57 deaths of all ages due to diarrhoea for the year and that they mostly occurred

6 There were 438 infant deaths that year, I have listed only the principal causes of mortality.

during the summer months when the danger of infection from contaminated foodstuffs and water, as well as poor sanitation, was known to be at its highest.

In the early years of the twentieth century increasing interest in the health of babies and school children began to be displayed by health officials in Tasmania. They expressed concern that the Tasmanian infant death rate was very high in comparison with most of the other states. In his report for 1908 J. S. C. Elkington, Chief Health Officer of Tasmania, stated that the infant death rate in Hobart was the second highest for a state capital, in the country. Furthermore, he went on to say,

> ...Launceston occupied an even less favourable position, with an Infantile Mortality Rate from 1901 to 1906 of 132 per 1000 born. The low rate in the country districts dilute these results down to 90 per 1000 born for the same period.
> (JPP 1908, 41:9)

Elkington believed that the cause of the high infant mortality rate could, in the main, be attributed to the quality of mothering babies received. In his report for 1907 he asserted that :

> It is probable that a considerable proportion of the legitimate infant lives appearing in our death-rates are lost through sheer ignorance on the part of mothers of the elementary principles of child-feeding and child-care.
> (JPP 1907, 10:14)

To remedy the situation he recommended demonstrations and instruction for older girls in state primary schools and a system of '... popular education of young wives and mothers in the health protection of the home and the care of infants and children' (JPP 1907, 10:11).

In summary, during the late 19th century, concern was expressed by medical practitioners and health officials about the high infant death rate in Tasmania, particularly in urban areas. They also recognised that this was linked to living conditions. Mothers were advised to breast-feed their babies in order to give them some protection against diarrhoeal diseases[7]. However, after the turn of

7 Breastfeeding was promoted because the reduced incidence of diarrhoea in breastfed infants had been clearly observed. Not known then was that breastmilk contained powerful infection-preventing agents, for example, lactobacillus bifidus, leukocytes and immunoglobulins (Gorrie, McKinney & Murray 1994:653)

the century an even stronger concern about the infant death rate began to be expressed, although the actual rate had shown a small decline. At this time, stronger statements were made by doctors and public health officers about the ignorance of women and their need for instruction in mothering in order to reduce the death rate of babies.

The scientific response

The belief that an improvement in national health and an increase in national population could be brought about through the application of logic and reason, underpinned the influential scientific hygiene movement of the late 19th century. This movement united many prominent doctors, clergy and philanthropists in a crusade against ignorance, particularly in sexual matters. It was responsible for the first text books and pamphlets discussing human reproduction aimed at the general public (Mintz & Kellogg 1988:116). The movement aimed to eliminate suffering and ignorance by taking a scientific and hygienic approach to reproduction and sexual health[8]. It led directly to a more clinical and sterile system of childbirth. The infant welfare movement was profoundly influenced by the earlier scientific hygiene movement's philosophical emphasis on education, hygiene and science.

After 1870, many societies were formed to educate the public about the connection between dirt and disease. One of these was The Australian Health Society, which was active from 1875 and which included discussion of infant mortality within its overall health education aims (Reiger 1985:129) The stated objectives of The Australian Health Society were:

8 The first conference on sex hygiene in Australia was held in Sydney in November 1916, the catalyst for which was the known high rate of venereal disease among Australian troops serving overseas (Huon Coward 1974:174).

1. To create an educated public opinion, with regard to sanitary matters in general, by the aid of the Platform, the Press, and other suitable means.

2. To induce and assist people by personal influence, example and encouragement, to live in accordance with recognised laws whereby health is maintained and disease prevented.

3. To seek the removal of all noxious influences deleterious to the public health, and to influence and facilitate legislation in that direction.

(Australian Health Society 1875)

The Australian Health Society was strongly supported by the medical profession. The major issues it was concerned with were diet, hygiene, management of infectious diseases, provision of fresh air and sunshine, drainage and garbage disposal (Reiger 1985:43). The discovery by Robert Koch in 1876 that a specific bacteria caused a specific disease (Black 1993:14; Tortora, Beddel & Carr 1992:10) reinforced the Society's concern in relation to hygiene. In addition, the Australian medical profession knew quickly of the work of Sir Arthur Newsholme, Medical Officer for Health, Brighton, England, who in 1899 outlined clearly the causes of epidemic or summer diarrhoea. The medical profession and organisations like the Australian Health Society widely publicised his findings. Newsholme had shown that summer diarrhoea was related to poor hygiene and contaminated infant food (Armstrong 1939:641). Now doctors could explain the link between health and hygiene.

Barely five years after Newsholme's discovery Dr. W. Armstrong, the Metropolitan Medical Officer for Health of Sydney, instigated a system whereby newly delivered women were visited by trained health visitors who advised them on breastfeeding and hygiene within the home (Armstrong 1939:644)[9]. In New Zealand, Dr. Truby King established the Karitane Mothercraft hospital in 1907, with the aim of reducing through the education of women the number of babies dying. Figures kept by Truby King for the city show a substantial decline in the number of infant deaths from diarrhoea. In 1907, 25 babies per thousand live births died of diarrhoea in their first year. By 1913 this figure had dropped to 4 deaths and in 1918 there were no infant deaths from diarrhoea in Dunedin

9 Armstrong's figures show a decrease in the infant mortality rate of almost 50% and an increase of 22% in the number of women breastfeeding between 1904 and 1911 in the areas of Sydney where his scheme of health visiting operated.

(Truby King 1923:8). Both Armstrong and Truby King were to inspire the work of others in infant welfare.

Reformers concerned with infant health were committed to a system of child care based upon the philosophy of scientific hygiene. Apple (1987:17) states that scientific knowledge had privileged status. The terms 'science' and 'scientific knowledge' were rarely specifically defined, but were frequently appropriated in order to add prestige and authority. Reiger (1985:213) reveals the enthusiasm felt in the early 20th century for the scientific rational approach. 'The kitchen was to be a laboratory, children's play, a training ground for business, and the marital bedroom the site of family planning'. All aspects of life including the role of women, racial differences, appropriate sexual behaviours, the logic of class, the effects of urban life were in turn subjected to scientific examination (Apple, 1985:17). However, it must be recognised that while the proponents of this approach drew their authority from science, the content of their advice - what they actually had to tell mothers - came less from the laboratory than from theories of scientific time management applied to the factory floor. (Ehrenreich & English 1979:201: Reiger, 1985:69: Gilding 1991:89).

The infant welfare movement was heavily influenced by the scientific hygiene movement which in turn had been influenced by Frederick Winslow Taylor's scientific management theories stressing systemisation and standardisation of work routines in factories (Gillespie 1982:17). Although Taylor intended his system to be applied to factory work practices it came to be applied to other areas including the family (Owen 1987:5). Central to this philosophy was the belief that an ordered, efficient and rational approach to child care would result in a healthier future population. Science was held in such esteem by the end of the 19th century that the term 'scientific' came to be applied wherever possible to new developments seen to be progressive.

It is very easy in retrospect to be critical of the infiltration of parenting by rigidly adhered to, supposedly scientific, concepts. Seventy years ago, however, the scientific approach to parenting was viewed as a progressive reform movement which offered mothers hope in an era when infant deaths were still high. The stated purpose was always the development of healthy children as Vera Scantlebury-Brown the first Director of the Victorian Baby Health Centres

Association makes clear in this statement on the first page of *A Guide to the Care of the Young Child*, text book for child health nursing students which, while constantly revised, was a prescribed text in Victoria from 1929 until the early 1980s.

> The Infant Welfare Movement has been described as one which is concerned with the devising and perfecting of all methods of Mothercraft known to Science, whereby an infant is safeguarded from the danger of the environment and enabled to develop into a fit and healthy individual.
>
> (Scantlebury-Brown, 1947:1)

Clearly Scantlebury-Brown believed that science had the capacity to perfect mothering and thereby improve infant health and well being. Through most of the twentieth century the scientific paradigm has been dominant and only recently questioned. The power and authority of science was logically therefore used in the early decades of this century to give validity to the medical profession's explanations of modern and effective mothering.

In the face of statistical evidence of high infant mortality and the probable role played by ignorance and poor domestic and personal hygiene in maintaining it, it is easy to understand how reformers would find attractive the concept of educating women in hygienic, efficient child care and household management. A major problem with constructions of motherhood, including scientific motherhood, is, as Phoenix, Woollett & Lloyd (1991:18) argue, that they fail to take into account structural differences between women. Working-class women are likely to have less disposable income than middle-class women, yet constructions tend to reflect middle-class lifestyles. Similarly they ignore the traditions and cultural practices of minority groups. In the 1920s what was overlooked, was that a system which emphasised hygiene, good nutrition and order would be inherently difficult for the very poor to adopt, living, as they did, with few financial resources, and often in overcrowded and unsuitable housing. In particular, improved household and personal hygiene depended upon accessible hot water which in turn depended on a piped water system and a reliable and cheap method of heating it. Such facilities were not generally available in working class areas. In 1887 gas water-heating appliances appeared upon the market but it was decades before they came into common use in all poor suburbs (Schedvin & McCarty 1974:87). Nevertheless, the education of

women in infant care and household hygiene, combined with later public health reforms and immunisation, were the strategies chosen by the infant welfare movement to improve the health of babies and children.

The infant welfare movement

Reiger (1985:130) states that the infant welfare movement, sometimes known as the child welfare movement, consisted in the main of professionals from the disciplines of psychology, medicine and education as well as members of various reform orientated voluntary organisations. As time passed, and particularly after the first world war, the movement came to be dominated by professionals. Reiger (1985:130) claims in discussing the type of approach adopted by the movement that

> Women were being confronted by a new group of middle-class childcare professionals who were decrying and undermining their traditional mothering patterns, arguing that mothering should be taught along rational scientific principles.

Gilding (1991:88) contends that there were two main impulses behind infant welfare initiatives: the first was a response to the declining birth rate and high infant mortality rate, and the second was the cluster of concerns around 'rationality, efficiency and social order'. In line with this second concern, the infant welfare reformers recognised that there needed to be a systematic way of reaching all mothers with information, if they were to be effectively educated in the new modern methods of child care. In an attempt to achieve this, by the second decade of the 20th century almost all Australian states had developed child health nursing services.

In retrospect it seems easy to understand why nurses were chosen to spread the new scientific message of healthy child care. Professional nursing in Australia, from its inception in 1868 with the arrival of Lucy Osburn[10] at Sydney Hospital, had based much of its practice, in true Nightingale tradition, on rigorous

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10 Lucy Osburn and her party of nurses arrived in Sydney in 1868 in response to a request from Colonial Secretary, Henry Parks, to Florence Nightingale that four trained nurses be sent to Sydney. After this the Nightingale system of nursing was introduced to the other states. The first nurse in Tasmania, trained on Nightingale lines, was Jeanette Milne who was appointed to the Launceston Hospital in 1886 (Russell, 1990:11).

standards of hygiene, cleanliness and ventilation (White 1993:8). Nurses were imbued with a respect for science. They were trained to be hard working, orderly and efficient. Furthermore, they were also women, who, although probably childless, almost certainly would have had professional and personal experience of child care and domestic work. In addition, they were not expensive to employ and could be relied upon to follow male medical directions. Nurses seemed to have been the natural choice of health reformers to spread the new message of scientific mothering and in Tasmania no other health worker was even suggested. Motherhood was transformed in response to multiple social and intellectual forces into a career for women requiring some knowledge of hygiene, nutrition, biology, child development, psychology and home management. Child health nursing services were used as vehicles to help bring the new scientific knowledge to women.

In the new century, science was harnessed to reinforce the concept of the home as women's domain. However well meaning mothers might be, the prevailing intellectual view of the time was that they tended to be ignorant and therefore potentially capable of harming their infants. In this view, if women were to competently fulfil their traditional responsibilities, they required training and education in scientific child-care and home-making. It is not surprising therefore that so many women's organisations supported such education and training for women, for if women were perceived as ignorant, education would help raise their status.

In summary, during the decades around the turn of the century, concern grew within Australia, regarding the falling birth rate and the high infant mortality rate. As little could be done about the first, the focus of action fell upon the second. The position and role of women in society was central to these debates. The women's suffrage movement won for women considerable civil liberties including the right to enter professions from which they had previously been debarred. However, at the same time, the concept of separate spheres for men and women - the distinction between paid work and home work - continued to grow. Women's organisations campaigning to receive recognition for the contribution they made to society as mothers and homemakers, saw that by placing greater emphasis upon training and education among girls and women for these traditional roles, the status of women in general could be raised. After

the first world war these influences led to an increasing value being placed, by society, upon the personal and domestic roles of women, at the expense of their public role.

Chapter 3: The beginnings of the child welfare service in Tasmania

In January 1918 Laura Richardson commenced work in Hobart as the first child health nurse in Tasmania (JPP 1918-19, 28:13). Soon after her appointment a centrally located child welfare centre was established at 138 Macquarie Street, Hobart. Laura Richardson visited mothers at home each weekday morning and two afternoons a week. The remaining three afternoons she was available for consultation by mothers at the centre. During her first six months employment she visited 560 women at home, and 483 women brought their babies to the centre for advice (JPP 1918-19, 28:13).

One month after the first child welfare centre opened in Hobart Myrtle Searle, a young nurse from Victoria, was appointed by the Public Health Department to the position of child welfare nurse at Launceston (JPP 1918-19, 28:14). In March 1918 Miss Searle was interviewed by a journalist from *The Examiner* who commented with some surprise:

> It was rather a mental effort to realise that Nurse Searle has been occupied in active nursing for a period of eight years. In appearance she is little more than a girl, and one is surprised to hear she was in charge of the Alexandra Midwifery Hospital, Victoria for three years.... it was easily gleaned that she is an enthusiast in her profession of caring for babies.
>
> (*The Examiner* 16 March 1918).

Myrtle Searle proved both tactful and astute however in impressing upon the journalist that her assistance was really for the benefit of the baby and no mother need take her advice if she did not wish to. Like Laura Richardson in Hobart she was, within weeks, inundated with women seeking advice. *The Examiner* carried the following report barely six weeks after her appointment,

> The nurse's report of the Launceston baby health centre is as follows for the week ended March 23. Visits to mothers at home 26; visits paid by mothers with babies to the clinic 17; expectant mothers advised 7; babies seen by doctor 16.
>
> (27 March 1918).

For a very new service this appears to have been a busy week. Demand for the service was so great that in Hobart more suitable premises were quickly needed and in 1919 the Hobart centre was moved to 38 Murray Street, another central location. While the nurse's salary was paid by the Public Health Department, the expense of leasing and maintaining premises was entirely borne by the voluntary Child Welfare Association (JPP 1918-19, 26:13). A second nurse, Jessie Peterson, was appointed in 1919 to the Hobart centre because the number of women attending had rapidly grown. And in Launceston in 1919 Myrtle Searle carried out 963 visits to homes and mentioned, gratefully in her annual report, the bicycle provided for her by the government (JPP 1919-20, 23:35). In 1928 the central clinic in Hobart moved for the third time when the Hobart City Council built a new clinic behind the Town Hall and then leased it back to the Association for an annual fee of 117 pounds (Spargo 1977:9).

The immediate popularity of child welfare nursing is surprising, for it was only the year before that the possibility of such a service in Tasmania had been raised[1]. In 1917 C.L Park, Chief Health and Quarantine Officer to the Tasmanian Government, had recommended that a nurse be employed to visit mothers and instruct them in infant feeding in their homes. Park was driven to suggest this by his belief that incorrect infant feeding leading to diarrhoea was responsible for many infant deaths. In his view such deaths could be avoided if information regarding the importance of breastfeeding, and of hygienic food preparation and storage, could be made available to women (JPP 1917, 32:9). Park's conviction thatdiarrhoea was a major cause of infant deaths was supported by the evidence of the time. In 1910 in Tasmania when the infant mortality rate peaked at 101.9 deaths per 1000 live births and 569 babies died, 168 (29.5%) of these infants died of diarrhoea alone (JPP 1930, 8:16)

Park's recommendation that a nurse be employed to teach infant feeding to women in their homes began to arouse interest after May 1917 when a columnist for *The Mercury* commented on a report in the Melbourne paper *The Argus,* about the founding of baby clinics in New South Wales. The purpose of these baby clinics, according to *The Argus,* was to 'lecture mothers

1 J.S.C. Elkington an earlier Chief Health Officer of Tasmania had made the suggestion in 1908 that 'one carefully selected trained nurse' might be employed in each city residential area, to advise mothers (JPP 1908, 41:10). Nothing appears to have come of this suggestion, but the idea was around prior to Park raising it in 1916.

on the feeding of their babies sick or well .... any room that will hold say 20 women and their babies, a doctor and a nurse is suitable. The furniture can be simple'. *The Mercury* columnist made the point that these clinics were starting in Melbourne (*The Mercury* 19 May 1917).

In succeeding weeks baby clinics were constantly mentioned in *The Mercury*. Barely a month later a Committee was formed from the Women's Health Association and other women's organisations to raise public interest in the question of 'saving the babies' (*The Mercury* 30 June 1917). This committee became the Child Welfare Association and began to recruit members as a separate organisation. The first meeting of the new organisation was reported in *The Mercury* on Saturday 28 July 1917.

In August the fledgling Child Welfare Association debated whether, if a nurse was appointed, women would resent her visiting them in their homes? The conclusion reached was that if the visits were handled sensitively there should be no difficulty (*The Mercury* 11 August 1917). At the beginning of 1918, barely seven months after the first article in the press had appeared regarding the service, Laura Richardson was appointed.

When the Child Welfare Association was first formed its primary objectives were to provide facilities to help women pre and post-natally and to reduce the infant death rate (Spargo, 1977:2). The Association applied for some federal government funding and while waiting for this, rented and furnished the first clinic in Macquarie Street. The state government provided the nurses' salaries (Kelly, 1977:153), although at busy times the Child Welfare Association sometimes employed an extra nurse (JPP, 1925-26 4:18). Early nurses depended upon Association volunteers, who not only effectively raised large sums of money and produced clothing and other goods for distribution to poor families, but also assisted the nurse with her clinic work on a roster system. In both Launceston and Hobart members of the Association campaigned relentlessly for reforms, in particular, the provision of pure[2] milk. By using very effective publicity measures, including large scale exhibitions of child welfare work, these women reached the public with the child welfare message in a way that individual nurses could not.

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2 By pure milk, reformers meant, fresh, pasteurised, full cream milk, undiluted with water. It was not uncommon for milk vendors to sell milk diluted with water at the turn of the century.

The Child Welfare Association provided large quantities of material goods for distribution among the poor. In the winter of 1919 the position of the poor in Launceston was particularly difficult. Unemployment was high as a result of a long running maritime strike and drastic restrictions upon shipping and trade, had been put in place in an effort to halt the spread of the pandemic pneumonic influenza (*The Examiner* 12 March 1919). In July of that year Myrtle Searle wrote in her report to the Health Department that the Child Welfare Association had donated 500 infant garments for distribution. In addition, a 'clothe the baby' appeal conducted on May 16th by the Association had raised forty pounds to buy material which four different women's groups had sewn into garments for babies. Food was also given to people in distress (JPP, 1919-20, 35:23). One year later Myrtle Searle mentioned in her report 'that garments to the number of 1152 have been distributed by the Association since its inception' (JPP, 1920-21, 65:32).

The distribution of clothing appears to have been a feature of the early efforts of the Child Welfare Association. Over a period of several years, nurses mention this aspect of the Association's work in their reports. But perhaps of more lasting benefit in the fight against infant illness, was the campaign mounted by child welfare nurses and members of the Association for a pure milk supply for infants, to be given free or at minimal cost, for people in 'necessitous circumstances'. Laura Richardson stressed the urgency of the need in her first report to the Health Department:

> During the months of February and March a good deal of summer diarrhoea and gastro-enteritis was treated at the clinic. Several cases were sent to the hospital for treatment. There is a very urgent need for a supply of pure milk for artificially fed infants in Hobart. There is a great deal of ignorance re feeding, prevention of thrush, diarrhoea &c.., amongst many of the untrained midwives and mothers.
> (1918-19, 28:22)

Eighteen months later she had obviously achieved her objective, for in her June 1919 report she stated that a pure milk supply for Hobart had 'become an accomplished fact' (Richardson & Peterson, 1919, 35:22-23). Orders for the milk were left at the child welfare centre, which was presumably a great inducement for mothers to attend the centre. Milk from a dairy in Kingston, where the cows were tuberculin tested, was collected and analysed daily for bacteria under the supervision of the Government Inspector. The milk was then placed in bottles sterilised by boiling and stored in specially constructed

coolboxes while awaiting collection by women (Spargo, 1977: 3). In Hobart in 1921, 532 pints of milk were sold at 6d per pint. If mothers were unable to pay no charge was made (JPP, 1921-22, 46:29). This appears to have been just the beginning of the demand for pure milk, for in Launceston in 1926, 4526 pints were distributed to mothers attending the clinic (JPP, 1927-28, 5:23).

One of the most ambitious undertakings of the Child Welfare Association was the establishment of the Mothercraft Home in Hobart. In 1925, with the assistance of government grants, land was purchased and in August the Home was opened (Spargo 1977:3). The need for a Home where mothers and babies could stay for some time and registered nurses train for child welfare nursing had been mentioned by nurses almost since the inception of the service. In 1922 Clara Bonnily, a Hobart nurse, expressed the need for 'the establishment of a hospital or home for the teaching of mothercraft, where mothers could be in residence for a few weeks with their babies'. She believed that such a centre would help mothers understand the simple measures needed to continue breastfeeding (JPP 1921-22, 46:28).

Once opened health workers appeared highly satisfied with the service the Mothercraft Home offered describing it as 'a valuable asset' (JPP 1926-27, 2:12) and 'doing splendid work' (JPP 1927-28, 5:22; 5:15). However the ongoing upkeep of the Home, combined with the maintenance of the growing number of child welfare centres, proved a financial drain on the Child Welfare Association. Eventually in 1947, control of the Mothercraft Home was passed to the State Government (Spargo 1977:3).

Clearly, throughout the 1920s, health workers and philanthropists had reason to be concerned about the state of health of children. Infant mortality and morbidity figures failed to reflect the sheer extent of chronic ill health which has existed among children for much of this century. Morbidity figures revealed the extent of infectious and other notifiable diseases, but there were many other less acute, but nevertheless potentially serious, health conditions experienced by children.

In 1906 The Tasmanian government instigated the medical examination of 1200 children attending state schools in Hobart, as well as 51 children living in Campbell Town, and 35 boys resident at the New Town Boys home. All the children were aged between eight and fifteen years. The results were

alarming. High rates of vision and hearing impairments were discovered, as well as a number of children with severe posture problems. Many of the children, from all classes in society, were found to be unwashed and wearing, in the words of the inspectors, 'frowsy' underclothing. The inspectors maintained the standards of hygiene they applied veered towards laxness, and that they had allowed for a considerable amount of normal childhood dirt. The number of decayed teeth among the children was very high and most children stated they never cleaned their teeth. Those who did clean their teeth generally used a corner of a towel to do so, and soot or salt as toothpaste. Few children were found to be malnourished although the inspectors stated many were 'frail and anaemic' in appearance (JPP 1906, 23:18).

The following Victorian example also reveals the extent of less than optimum health among children during the period covered by this study. In 1928 Dr. Springthorpe, President for the Society of Women and Children, Victoria, gave an address in which he made the following statement regarding the health of the 2000 children attending kindergarten each year in Victoria:

> About one third of these are found to be malnourished-probably more from want of knowledge than from want of funds and over 80 percent have bad teeth. And when this neglected army enters School some quarter to one-third are found to be suffering from some form or other of minor physical defects, and, even then, only about one-fifth of their number have been examined.
>
> (Springthorpe 1928:1)

In the face of obvious wide-spread poverty, ill health and lack of government funded welfare services, it is hardly surprising that charitable women's organisations took up the cause of child welfare with enthusiasm and commitment. Yet despite much evidence of the connection between ill health and poverty and the expectation of charitable organisations that the child welfare message would be directed towards the industrial poor, this was not the intention of the emerging services. In discussing the emergence of professionals in infant welfare, kindergartens, education and psychological guidance throughout Australia, Reiger states:

> It is quite clear that these reforming strategies were not directed at working-class families. Although some began that way in the hands of philanthropists, once they were in the hands of professional experts, they became part of a broader series of interconnected programmes aimed at family life in general.
>
> (1985:174)

From their beginnings the Tasmanian services were intended to be free and available to all families. By 1929 child welfare centres existed in Hobart, Moonah, North Hobart, Glenorchy, Launceston, Invermay, Longford and Newstead (JPP 1929-30, 3:24-25). In other words centres were established in middle and working class, rural and urban areas. While assistance was undoubtedly given in the form of material goods to poor families, the underlying philosophy of the child welfare movement was always educative rather than charitable.

Olive Green, the nurse in charge of the Launceston centre in 1926 emphasised this in her report that year to the Department. 'The mistaken ideas that the clinic is for sick or poor babies only, and that it is a sort of agency for humanised milk, must be wiped out. Our aim is to "Help the mothers and save the babies"' (JPP, 1926, 5:23).

The role of the supporting women's organisations was always greater than the dispensing of charity. In advocating training in mothering skills they perceived themselves as working politically for mothers and children. Their overt aim was to reduce the maternal and infant suffering caused by poverty and ignorance. But they also hoped to raise the status of mothering and homemaking by presenting motherhood as a career requiring skill and training. On the other hand, health officials were concerned primarily with achieving an improvement in infant and child health and they believed this could best be achieved by the education of women in breast-feeding and hygienic infant and home care. In addition, while recognising that the infant mortality and morbidity figures were highest in poor areas, the numbers were still high enough in middle-class areas for health officials to believe that women from all social classes required education in motherhood (JPP 1907, 14:10). Control over the early development of child welfare nursing was largely exercised by public health officials, yet it is unlikely that the rapid extension of the service could have taken place without the strong support, described here, of women's organisations.

That the early nurses believed in the value of their work is reflected over and over again in their writings. Myrtle Searle in her 1919 report referred to 'the growth and possibilities of the work and declared that 'the results achieved have completely justified the establishment of the clinic' (JPP 1919-20, 35:23). Clara Bonnily in her 1924 report claimed 'The work progresses steadily, and

its usefulness is becoming more apparent' (JPP 1925-26, 4:19). Olive Green, stated frequently that the aim of child health work was to 'Help the Mothers and Save the Babies' In addition in referring to the health education activities of the service in her reports, she frequently included the aphorism, 'It is better to put up a fence at the top of a precipice than to maintain an ambulance at the bottom' (JPP 1926, 1929, 1940, 1942).

Perhaps it is Olive Green who best sums up the value nurses placed upon their work 'Our aim and object is to keep **our** babies healthy, and to do this we must have the mothers' co-operation (my emphasis). There is a curious sense of ownership in Miss Green's statement, babies are obviously national assets, mothers simply their carers. Such an interpretation would allow these nurses to see their work as being not only valuable in terms of reducing personal suffering but also of great benefit to society (JPP 1927-28, 5:23).

That the loss of infant life in Tasmania was a serious problem is shown in the following table, which outlines the amount the infant mortality rate had fallen in Tasmania, over a 20 year period, in relation to other states and New Zealand.

Table 3.1 Australasia: Percentage decrease in infant mortality rate in 20 years, 1896-1900 to 1917-21

	per cent
New South Wales	43.5
Victoria	40.2
Queensland	42.0
South Australia	46.1
Western Australia	59.0
Tasmania	34.1
New Zealand	39.9

(*Source:* JPP 1922-23, 46:15)

Health officials appear to have had no idea why the fall was less in Tasmania. The answer they constantly articulated was that mothers needed more education (JPP 1921-22, 65:17). They regarded the struggle to reduce the infant mortality rate as a battle. E.S. Morris, Chief Health Officer of Tasmania, in discussing the role of nurses in combating the high death rate, maintained, the goal must be '...to eliminate for all time the prestige - unfortunately still existent - of the woman "who has had 10 herself, but buried seven of them" ' (JPP 1921-22, 65:17).

The following year in writing on the same subject, Morris stated that 'the clinic may be regarded as an excellent base, but the actual warfare must be conducted in the front line trenches, i.e, the homes against the conditions which produce the casualties (JPP 1922-23, 46:15). The goal of child welfare services was to reduce infant mortality and the ignorance of women was perceived to be the enemy (JPP 1922-23, 46:17). Nurses took seriously their task of educating women in scientific mothering.

Table 3.2 Number of babies attending child welfare centres in Hobart and Launceston[3]

	1920	1922	1924	1926	1928	1930	1940
Hobart & Suburbs							
No. of babies born	1382	1360	1249	1206	1023	* NA	1210
No. of individual babies attending CWC	NA	NA	926	957**	1459	NA	3157
No. of newborn babies visited by nurses	1144	1468	1242	1086	920	NA	1090
Overall CWC attendances	8659	11545	NA	11697	12717	NA	23078
Launceston & Suburbs							
No. of babies born	760	623	610	555	592	598	668
No. of individual babies attending CWC	NA	NA	NA	334	797	465	922
No. of newborn babies visited by nurses	***	NA	NA	603	649	802	1383
Overall CWC attendances	4081	NA	NA	5393	6742	9600	19462

* No Hobart child welfare figures available for 1930

** Of these 957 babies, 745 were from the city and suburbs 212 from the country (JPP 1927-28, 5: 22)

*** While no breakdown of overall attendances exist for this year, the nurse reported 'that 70% of mothers visited subsequently attended the centre' and 'from 11 mothers at the beginning, the visits to the clinic have now reached to the total of between 90-100 a week' (JPP 1920-21, 65:32).

3 There are some discrepancies with the table. The difference between the number of babies born and the number of individual babies attending centres in 1928 may be explained either by the fact that at this time children sometimes attended the centres until they were two years of age, or by the possibility that children were being brought to the centres from surrounding country areas, as was explicitly stated in the 1927-28 nurses' report. Revealed also is that the number of babies visited is frequently higher than the number of babies born in the area. The most likely explanation for this is that nurses visited babies in neighbouring localities. The figures refer only to the first visit made to the baby.

That Tasmanian women valued and used the fledgling service is clear from the above table compiled from the nurses reports to the Public Health Department and the Queen Victoria Baby Health Centre Association.

In summary therefore most women visited by nurses later attended centres and some maintained contact with centres during their child's second year. Children were brought to the centres from country areas without having first been visited by the nurse, and nurses also visited women who lay outside their official designated area. By 1928, although exact figures cannot be obtained, the majority of women who had access to child welfare centres were attending them.

Later on better statistics were kept by the Public Health Department, and although beyond the time of this study, the figures below for 1946 give a more accurate reflection of the extension of child health work throughout Tasmania.

Table 3.3 Tasmania: Summary of Work Performed by Child Welfare Sisters during the year ending 31st December, 1946

No. babies born	No. of newborn babies visited by nurses	Individual babies attending centres	Total attendances at centres by babies
6847	5453	13795	99609

(Source: Abridged version of Table C Department of Public Health 1947 Report No. 55:6)

The population of Tasmania is highly decentralised, many women would have been beyond the reach of even extensive child health services in 1946. Therefore this table indicates that after 28 years of operation, a high proportion of women who were able to, were choosing to use the service.

This type of statistical evidence only indicates the number of women in Tasmania who might have encountered the message of scientific motherhood through contact with the child welfare service. It cannot show to what extent, if at all, the message was influential in altering mothering behaviours. All that can be claimed from it is that the child welfare service was widely supported by Tasmanian women.

In conclusion, child welfare nursing services were established in Tasmania in response to a multitude of pressures. Public health officials concerned that

babies were dying through lack of knowledge on the part of their mothers, combined to initiate the service with powerful women's organisations, who wished to raise the status of women as mothers and homemakers. The press supported and gave extensive coverage to the child welfare movement. The first nurses appear to have been well liked and women readily availed themselves of their help and advice. A radically new style of health service had been devised, one which was free, available to all, yet voluntary, and based on health education principles. It was also one which supported dominant prescribed views on mothering and the role of women within Australian society.

The message promoted by the service was that of modern and efficient mothering. This was viewed by supporters of child welfare as holding part of the answer to high infant sickness and death rates. The ignorance of women was openly blamed for many of the deaths. As will be shown in the following chapter, traditional mothering lore was denigrated by reformers, who instead promulgated with fervour the message of scientific motherhood.

Chapter 4: Training mothers and babies

' Trained' as an adjective applied to babies first appeared in the writings of child-care reformers after the first world war (*The Examiner* 25 May 1918, Truby King 1930:52). Prior to this, while regularity was viewed as desirable some flexibility of babies' timetables was allowed (Jack 1922:95). As the 1920s progressed, the importance of training to the scientific approach to motherhood became more marked. The overt message of the early Child Welfare Service was that the nation would benefit from training girls and women in modern scientific mothercraft. In the view of reformers, a well organised and therefore, probably a well rested woman, was more likely to care for her baby successfully. A journalist in *The Mercury* made the following point, 'women need teaching the best means of caring for themselves and their babies, and a great deal of existing evil will cure itself' and she continued 'the reason for the unqualified success of the movement lies in the fact that it is essentially woman's work, and touches a long-felt want in mothers, who while lacking nothing in love, lack a good deal in knowledge and experience'(16 October 1923).

Women had to be taught to help themselves. In the rhetoric of early child welfare supporters there was no recognition of the skills women already had in mothering. To win adherents to their cause the new experts in child care denigrated the knowledge of earlier generations of mothers and grandmothers.

While women were to be educated in scientific mothering it was not envisaged by child welfare supporters that they would then become independent of expert supervision. Instead, increased control over women during pregnancy and the early mothering years was often explicitly stated as desirable. A 1923 *Medical Journal of Australia* editorial, shows just how taken for granted this control over women was:

> Suffice it is for the present to state that much suffering and death can be prevented by the proper care of women during pregnancy, by skilled attention during birth and the puerperal period and by the well-planned control of mothers during the nursing period.
> (*Medical Journal of Australia* 1923:268)

The writer also urges that every means be used to bring young mothers under the skilled care of medical practitioners and nurses 'who will induce them to nurse their babies at the breast for at least six months'. In conclusion, he suggests that women should be paid for breastfeeding or in his words 'premiums should be offered for mothers who obey Nature' (MJA 1923:269). Some health officials and medical practitioners believed mothers could not be trusted to always understand, or remember instructions. The solution they suggested was an intensive, extensive and ongoing educational campaign among girls and women (JPP 1921-22, 65:17).

Social control was an accepted aspect of the early child welfare service, regarded as necessary by health officials in the interests of improving infant and child health. However, it is important not to overlook both the active acceptance of this control by women, as well as the resistance and negotiation between nurses and mothers which occurred within the centre setting.

Child welfare services were not imposed upon women, rather women actively sought their establishment. In Reiger's (1985) view the contribution of women to the demand for a technical, rational approach to child-bearing, child-rearing and home management, demonstrated that women were not passive victims of expert advice but rather discerning recipients of services. In Tasmania, a number of women's organisations supported the establishment of child welfare services. The three most dominant organisations were the Women's Non-Party League, formed in 1920, Child Welfare Association formed in 1917, and State Council for Mother and Child formed in 1937. Other influential groups were the Women's Christian Temperance Union, Bush Nursing Association, Country Women's Association and Australian Women's National League (Waters, 1983:26).

Support for child welfare services came from a combination of doctors, health bureaucrats and philanthropists, as well as many middle-class women's organisations, but it also came, perhaps more directly, from the women who brought their babies to the centres in ever increasing numbers. It becomes

increasingly difficult and perhaps patronising to believe that all those thousands of women were unthinking victims of a medical take-over of child care rather than selective consumers of a service they perceived as being generally beneficial. Knapman (1993:112) claims that the centres have had an enduring popularity with Australian women, and in the past women campaigned vigorously for their establishment, and although attendance was voluntary, they often travelled many hours to reach them. Furthermore, Knapman (1993:113) argues health officials were well aware both that women did not always tell the truth and that many 'clinic sisters' broke the rules. In other words, while a scientific approach to motherhood may have been broadly accepted within the community, in some situations, individual mothers and possibly many nurses applied its main tenets fairly loosely.

Nevertheless, the scientific management of motherhood was perceived to be an improvement over existing practices, and so it was in many ways. But the change entailed some losses - including the partial loss of women's independence and traditional mothering lore. With the new management came increased professional control of parenting and an attitude of 'the expert knows best'.

Training mother and baby

The early child welfare nurses actively set about teaching mothers individually through consultations and in groups through lectures and demonstrations. Laura Richardson in her first six months work in Hobart, gave numerous demonstrations on how to prepare food for babies, make and apply poultices, and improvise steam tents and mothers came from country as well as urban areas to attend them (JPP 1918-19, 28:13). Within two years of the establishment of the service, child welfare nurses had extended their teaching activities to school girls and pregnant women. The training of young girls in mothercraft was seen as an essential way of spreading the new message. In 1921, Clara Bonnily, the nurse in charge of the Hobart centre, reported that:

> ... a class of 15 girls from Albuera Street State School has received a course of instruction in mothercraft. This consisted of five weekly lessons of one hour each and a written examination on the sixth week. The girls showed an intelligent interest in the subject.
>
> (JPP 1921-22, 46:28)

Miss Bonnily in the same report stated that two groups of girl guides, had also received instruction. The syllabus for school girls and girl guides was the same:

> 1st Lesson.- Bathing, clothing and gentle handling of the baby, with practical demonstrations.
> 2nd Lesson.- Ventilation, fresh air, making of baby's bed, and sleep, with demonstrations and diagrams.
> 3rd Lesson.- Feeding baby up to nine months of age- (a) natural feeding, (b) artificial feeding.
> 4th Lesson.- How to give baby's bottle. Feeding from nine months to two years. Clothing from nine months to two years.
> 5th Lesson.- General care of teeth, nose, ears, and napkins. Ailments; when to send for the doctor.
> 6.- Examination.
>
> (JPP 1921-22, 46:28)

In 1924, five primary schools in Hobart had nurses teaching mothercraft to their students. In addition, material was being supplied by the Child Welfare Association so that the girls could learn to make baby clothing of Truby King's design in their sewing classes (JPP 1925-26, 4:18). Nurses talked to schoolgirls, girl guides, women's groups and pregnant women as well as their clientele in an effort to spread the message of the importance of training for motherhood.

Essentially the trained mother was one who applied fairly simple rules of hygiene and order to her household. Cleanliness in all things was regarded as essential, and fresh air within the home, particularly the bedrooms, considered a vital requirement for good health. The provision of wholesome food was an important maternal responsibility and a simple, plain but nutritious, diet was advocated for all the family. In general, housekeeping was to be done in a planned and considered way. Breastfeeding, or 'natural feeding', as it was often politely termed in the 1920s, was the duty of all mothers if at all possible, and was expected to be carried out in a punctual and regular fashion (Truby King 1930:117). Clearly housework and mothering were viewed by the writers of child care manuals as women's primary role. The main purpose of all these skills was to produce responsible future citizens. Moral overtones were evident in much of the literature written about baby training. Truby King emphasised the importance of the first year of an infant's life with regard to training in the following way:

> Half the irritability and lack of moral control which spoil adult life originate in the first year of existence. The seeds of feebleness and instability sown in infancy bear bitter fruit afterwards. For the ordinary family ill-health and instability mean unemployableness; unemployableness means morbid thought and feeling; and morbid thought and feeling mean loafing, vice and crime.
>
> (Truby King 1930: 104)

Clearly in Truby King's view the responsibility for social stability lay with mothers. Following his success in lowering the infant mortality rate in New Zealand, Truby King had become a very influential figure, whose views were widely respected in Britain, Australia, South Africa and New Zealand with regard to infant rearing practices. He was a leading proponent of the concept of training infants according to scientific principles

Truby King first came to Tasmania in 1919 (Spargo 1977:2) and there after made several visits prior to his death in 1938 (Deem & Fitzgibbon 1945:12, Green 1931:9). As early as July 1921, Myrtle Searle, in her half yearly report, mentions the 'gratifying absorption by mothers of the Truby-King System' (JPP 1920-21, 65:32). Many of the early nurses, including Myrtle Searle, travelled to the Karitane Mothercraft Home in Dunedin for six months training, or refresher courses in child welfare nursing (JPP 1929-30, 3:24). In Tasmania the views and writings of Truby King were accorded considerable respect. Nurses recommended clothing for babies cut to Truby King designs (JPP 1925-26, 4:18) and Karitane Emulsion (a source of fat) obtained from New Zealand was used to modify cows milk for infant consumption throughout the 1920s (JPP 1926-27, 2:18). How widespread the influence of The Plunket Society founded by Truby King, was, can be gauged by the fact that Karitane Emulsion could be obtained in the United States of America, South Africa, Great Britain, Australia, Canada and New Zealand
(King, 1932: 109).

If, in Truby King's view, the mother's influence and care during the first year of infant life was likely to have an influence on the future character development of the child, then that view was likely to be taken seriously. The importance he placed upon training is seen in this extract from *Feeding and Care of Baby* written for mothers:

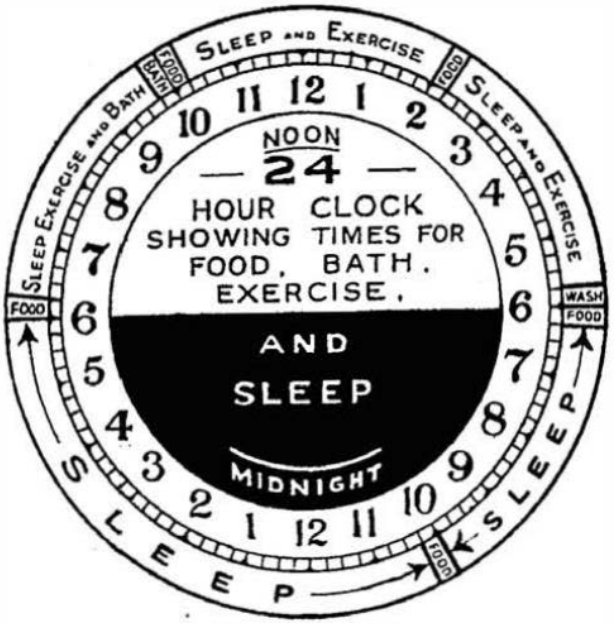
> One cannot begin 'too young' to train a baby. We often hear the remark made by some dear old grandma or loving mother, "Oh ! he will grow out of it,' or, 'Wait until he grows a little older and under-stands what you say to him.' If you do wait you are lost ! Begin when a baby is born to make him understand that you mean what you say; you are the one to be obeyed: it is for your child's good.
>
> (1930:98)

It was assumed by writers that a child brought up to be regular and punctual in all things would later be likely to be a responsible, orderly citizen and member of the workforce.

How actually were babies to be trained? Imbued with the scientific approach, child-care experts devised principles to cover most aspects of infant care. In relation to feeding, babies could be trained to do without night feeds from birth and to take their milk feeds by the clock, preferably no more than five feeds in 24 hours (Arbuthnot Lane n.d: 203; Frankenburg 1922:15). Toilet training also interested reformers who recommended that babies be trained to use the pot from the age of one month and to be absolutely regular in their bowel movements. Babies sleep patterns could also be made amenable to training, well taught babies would sleep well and not be irritable. They would go to bed happily and wake up 12 hours later, well rested. In addition, they could be taught to chew properly in infancy and to be independent by not being cosseted (Truby King 1930:52). In any case rocking, patting, and swinging babies were bad habits which could cause vomiting and giddiness (Truby King 1930:103).

The following clock detailing a baby's schedule was found in both an early booklet written for mothers by Truby King and a Tasmanian Public Health Department publication. It is easily seen that all aspects of baby care were regulated by the clock.

Table 4.1 Infant care by 24 hour clock



(Truby King 1930: Department of Public Health, *Happy Motherhood* 1947).

Babies could also be taught to live virtually most of the time in the open air from the age of one week with no ill effect. Frankenburg (1922:60) in enlarging upon the benefits of open air living (even in the north of England in winter) quotes Truby King's statement that babies at the Karitane Hospital:

> ...live out of doors all day and a broad stream of pure cold outside air flows through the sleeping rooms all night ... tiny, delicate babies, after a week or more of gradual habituation, sleep well, grow and flourish in rooms where the temperature may sometimes fall almost to freezing point.

A comparison between the style and content of this statement and that of Charles Hunter who forty years earlier had written a pamphlet directed to mothers, entitled *'What Kills Our Babies'* demonstrates the authoritative nature of the exponents of scientific motherhood. Hunter's style is encapsulated in the following extracts:

> Let no one frighten you that your milk is bad; it must be bad indeed to be surpassed by such cows' milk as we get in the city, or by any other food... Babies cannot live by milk alone, no more than "man can live by bread alone." A mother's love, and petting, and joy in her child goes far to carry it safe through the dangers of the first year.
> (1878-9)

Admittedly Hunter's tone appears sentimental and perhaps patronising to the modern reader's ear, but his style is typical of late 19th century writing directed towards mothers; it is relaxed, anecdotal and imprecise. It allows for the differences in babies and households, in a way that later writings under the influence, supposedly, of science, did not.

It must be said that supporters of child welfare did not suggest that babies be left to cry for long periods of time uncomforted, or that toddlers be scolded harshly for misbehaviour. Instead a sort of benign kindness towards children permeated much of their writing. In general they appear convinced that well trained babies would not have problems and they would learn quickly and with minimal discomfort to fit in with their mothers routines. Mothers were advised to be kind but firm and never indulgent, for this could lead to the baby being spoiled with the possibility of long term character defects.

Other publications supported the message of regularity and discipline . A Tasmanian pamphlet entitled 'The Dangers of Overstimulation' (no date or publisher), which was widely distributed by child welfare nurses also highlights the rational scientific approach to mothering:

> Too often the newly-born babe, especially if it is the first baby, and probably the first grandchild, is treated as a new toy or plaything...Instead of sleeping the clock around at first, and only being awakened for feed and bath times, it is often picked up out of its cot for some admiring relation to nurse ... A baby can be easily overstimulated and nervously upset by being talked to far too much.

Such mistaken attention could lead to unwanted results:

> ...restless and disturbed nights and nervous habits such as stuttering and bed-wetting are often the outcome of such overstimulation.

The trained baby was one who slept all night from birth, fed four hourly during the day, played happily alone, rarely cried and then only with good reason (good reason did not include boredom or loneliness). The trained baby also obliged its mother by using the pot in the first few months of life. In other words, a trained baby was one who learned early that power rested with others rather than itself.

How did this emphasis on training affect families and particularly mothers? Did some women feel a degree of frustration at being given instructions

regarding the care of their baby, that their economic circumstances made impossible for them to follow? Clean spacious, well ventilated homes, where children had their own bed and preferably their own room were necessary backdrops to training a child into an orderly routine of sleeping, exercising and eating. The middle-class experts were presuming that education was the means through which their clientele could live a similar middle-class life-style to their own. Their advice would have been impossible to follow for those of their clients who lived in overcrowded, often insanitary housing and precariously near the breadline.

The question must also be asked whether training women for motherhood so overtly in the 1920s did not more honestly reflect the reasons women were valued, than our present system of educating women for the workforce and then pretending they will not spend years at home caring for children? Oakley (1993:198) points out most women on giving birth, cease working for a time and then return to part-time work. Often it is years before some women return to full-time work. Caring for small children remains in the 1990s, as it was in the 1920s, primarily a female responsibility. The rhetoric of equal opportunity claims that women are valued for more then their nurturing and domestic functions now, but the reality is that both women and men still view the mother as the primary carer of young children.

Between 1918-1930, the period of this study, the Tasmanian Child Welfare Service promoted and reinforced the tenets of scientific motherhood. In doing so it reflected the knowledge base as well as the dominant attitudes and understandings of early twentieth century Australian society. The service displayed a high level of organisation and innovation in the way it approached the problem of how to disseminate the new thinking on motherhood throughout the community.

Spreading the message - the use of propaganda

The high public profile of the early child welfare nurses obviously helped the spread of information about child welfare work. The supporters of the child welfare movement were skilled propagandists and often well known within the Tasmanian community, but the success of the movement depended to a large extent upon the nurses, the workers who actually met and talked with

mothers. It was presumably a considerable help therefore, that the first child welfare nurses appear to have been highly respected.

Nursing reforms in Australia after 1868, when Lucy Osburn had arrived to take charge of Sydney Infirmary with a group of other Nightingale nurses, had raised the status of nursing to that of a respectable and worthwhile career for women, one of the very few open to them (Russell 1990:15, Kingston 1975:82). Child welfare nurses, while removed from institutional settings, were accorded considerable community respect and their opinions were sought on a wide range of health and related social issues. Within the first three to four years of the establishment of the Child Welfare Service, nurses spoke publicly on a wide range of subjects, including the need for a supply of pure milk for infants (JPP 1918-19, 28:22; 1919-20, 35:23); tighter controls on untrained but registered midwives (JPP 1919-20, 35:23); the desirability of illegitimate infants remaining with their mothers for some time after birth, instead of being removed from their care immediately (JPP 1920-21, 65:32); the need to continuously promote breastfeeding in the interests of infant health (JPP 1929-30, 3:24); the necessity of situating centres so that they were accessible for mothers (JPP 1927-28, 5:23); and the poor state of housing in Launceston and the need for some system of state owned cottages (Searle, *The Examiner* 19 September 1919).

It is also possible that providing a free health service raised the nurses' status in the community. This was a time when medical care was a luxury many people could not afford. From their centres the child welfare nurses often arranged free medical care for their clients (JPP 1919-20, 35:22). They also gave detailed instructions and support to women nursing their sick children at home.

The high public profile of nurses like Myrtle Searle, who had been appointed to the Launceston centre in 1918, meant that their pronouncements on matters relating to health were listened to with respect. Myrtle Searle appears particularly well known, perhaps partly due to her activities during the pneumonic influenza pandemic of 1919, which killed approximately 20 million people world wide (*The Australian* 2 October 1994). Miss Searle was placed in charge of a home nursing service for Launceston residents unable to afford private nurses. She was free to do this because child welfare centres, along with most other places where people normally met, including theatres,

churches and schools were closed in an effort to reduce cross infection (*The Examiner* 18 August 1919).

Because the number of available hospital beds was inadequate to deal with the vast numbers of seriously ill people in Launceston, there was no alternative for people but to stay at home and manage as best they could. In an effort to reduce the potential death rate, the Albert Hall was transformed into a relief depot to provide food, fire-wood, blankets and nursing to the sick (*The Examiner* 23 August 1919). Unfortunately in many families every member became ill at about the same time and therefore no one was available to do any nursing. When this happened, the system for contacting the nurses was simple but effective. A card was placed in a front window requesting help, passers-by and neighbours were relied upon to pass on the request to the nurses at the Albert Hall (Brown 1991:23).

The nurses, if possible, visited the sick twice a day. *The Examiner* (25 August 1919) reported that, on the previous day, Myrtle Searle and three other women had visited 240 sick people and that the average number of sick in each house was four. Private cars with drivers had been volunteered by citizens so the nurses could get from house to house quickly. When the epidemic waned, Myrtle Searle had entered hundreds and hundreds of poor households during a few brief weeks and attempted to nurse, often whole families, in overcrowded and insanitary conditions.

Table 4.2 Myrtle Searle (centre) on the steps of the Albert Hall with helpers (*The Weekly Courier* 18 September 1919)

Following that experience she gave a long interview to *The Examiner* about the state of Launceston housing, entitled "From Behind the Veil...Nurse Searle's Experience". In the interview she described some houses as 'hovels' and said they were 'absolutely unfit for human habitation'. She told the journalist about people living in 'small wooden huts of places, low-roofed, with the timbers rotting from dampness, and floors falling into decay, and in many cases full of holes'. In particular she stressed that although well meaning citizens might believe it was possible for the residents to reduce the squalor of their surroundings by paying greater attention to cleanliness, this was actually impossible. The state of housing in some areas of Launceston was so bad that nothing could be done to improve it. She gave an example of a cottage, one which consisted of five rooms and housed three families, a total of 16 people, and she touched on how people existing in such conditions might feel, and how they might avoid seeking help in the event of illness because of embarrassment about their living situation. Finally she recommended that some system of government owned cottages be provided (*The Examiner* 19 September 1919).

That particular interview appeared in Friday's edition of the *Examiner*. On the following Monday the editorial distanced itself from Myrtle Searle's stance.

While agreeing there was no excuse for grasping landlords, the writer said that many of the problems of tenants were brought about by their 'dirty and shiftless habits...pressure can be brought to bear on land-lords to keep houses in repair, but how is it to be brought to bear upon occupants' to 'recognise the uses of soap, water and scrubbing brush'. The answer suggested by the editorial was that many of the evils of slum housing could be reduced if girls were educated in cleanliness and good housekeeping (*The Examiner* 22 September 1919). In other words the state of slum housing was attributed to the ignorance of women regarding hygiene and housekeeping. This was a clear rejection of Myrtle Searle's statement that many of the houses of the poor could not be made habitable.

In this instance Myrtles Searle's views were discounted by the editor of *The Examiner* for they clearly threatened powerful vested interests, but in general the nurses were constantly in demand to speak, not only about their work but also about social issues which impinged upon it, and their views were listened to and often acted upon.

As the service became firmly established during the 1920s, there is less evidence[1] in the press that nurses spoke out about social issues. They still spoke publicly, but their comments were reserved purely for clinical issues relating to infant care. It is difficult to understand why these first few child welfare nurses were so outspoken. Did they perhaps see themselves as pioneers of a new, freer, more socially aware form of nursing? Did not having a role model for how nurses should behave once removed from institutional settings, have an influence on them? Or was it part of a deliberate policy by child welfare supporters to raise the public profile of the nurses within the community and thereby attract women to the service as consumers. If this was so it would explain why, once the service was accepted, the public comments of nurses on social issues ceased. They would no onger have been required and may have actually been discouraged.

Certainly the supporters of the child welfare movement were skilled propagandists of their cause. And from the very beginning the service as well

[1] I have systematically searched *The Examiner* and *The Mercury* for 1917, 1918 and 1919. *The Examiner* for 1920, 1922 and 1923, and randomly searched both newspapers for 1927, 1928 and 1929. After 1919 there is much less reportage of nurses activities, although the activities of the Child Welfare Association, particularly in relation to fund raising, still receive a fair amount of attention.

as its nurses had a high public profile. Articles regarding both the Child Welfare Association and the Child Welfare Service constantly appeared in the press stressing the value of the work, while at the same time presenting little one and two line messages about correct parenting. The first interview in *The Examiner* with Myrtle Searle was primarily a vehicle for reassuring women about her role. 'Many mothers have been grateful for the treatment given their babies' eyes - a trouble which arises through neglect at birth and if not attended to may lead to disease'. The journalist urged mothers to attend the clinic nurse 'so that she will be enabled to keep in close touch with them and their babies'. A description of clinic routine and the use of baby weight cards was also outlined. In addition, the writer stressed the value of the work in reducing the number of infant deaths in the first year of life (*The Examiner* 16 March 1918).

In May *The Examiner* ran an article detailing the size and attractions of a Child Welfare Exhibition organised by the Child Welfare Association at the Albert Hall in Launceston. The exhibition lasted one week and included lectures on nutrition as well as a wide range of other topics relevant to baby and child care. The Child Welfare Centre was moved to the Albert Hall for the week so the public could view the centre in operation. Various cooking demonstrations were given by domestic science experts. The Federal Director of Quarantine attended as did other medical officials. The balcony was reserved as a creche with a trained nurse in charge. Afternoon tea and supper was provided for the public by various women's organisations. The Free Kindergarten was also moved to the hall for the week and the public were able to watch children taking part in their usual kindergarten activities. (*The Examiner* 25 May, 1918). According to *The Examiner* the main objective of the Child Welfare Exhibition was to demonstrate that, 'correct methods of training a baby from birth are possible, to all parents, willing to learn' (25 May 1918). C.L Park, Chief Health Officer of Tasmania referred to the exhibition as 'highly successful' [and]'doing much to bring the work before the general public' (JPP 1918-19, 28:13).

Child welfare nurses reached out to all the women in the areas they worked in. They tried to reach as many pregnant women as possible and then after babies were born they visited them at home. They taught school-girls and girl guides - the next generation of mothers - as well as spoke to women's groups. The nurses wrote weekly articles for newspapers in Hobart and Launceston

and spoke on local radio stations, after these were established in the mid 1920s. They maintained a large and apparently growing correspondence with country women and encouraged women to the centres by the provision of pure milk at minimal cost (JPP 1927-28, 5:23, 1929-30,3:17).

In line with common practice in the early decades of this century child welfare nurses sometimes used testimonials to prove the value of their work. Olive Greene included extracts from letters sent to her by mothers in one of her reports to the Public Health Department in order to emphasise the needs of country mothers. In one letter a mother explained her confusion in the following way:

> I was very pleased to get your letter. It helped me such a lot, and I am hoping to come to Launceston within a week or two. Baby has been better, but still sometimes after I feed her she cries as though she is still hungry. She is good at night. I am trying to follow your instructions, but so many people tell me different things they make my head turn. One says she is starving, another it will turn her brain if I let her cry; another to use the charm, and so on. But I am doing my best. Thank you so much for your help.
> (JPP, 1927-28, 5:23)

The result of the propaganda methods used by child welfare nurses and their supporters can be seen in the child welfare figures for 1924. The number of home visits carried out by nurses from the three centres in Hobart totalled 6650, while attendances by parents at the centres numbered 11,498. Steadily the numbers of people having contact with child welfare centres rose as more centres were established and the nurses tried more varied methods to reach mothers.

The Maternal and Child Health Report for 1947, included the following statement, which, while outside the period I have focused on, gives a very clear indication of the results of the nurses' efforts after a generation of child welfare work.

> ...an increase in the attendances at clinic throughout the state of over 9000 compared with the previous year can be regarded as highly satisfactory.
> Fifty-one clinics, one pre-natal centre and four mobile units were functioning, the respective figures for the previous year being forty-two clinics (including one pre-natal) and two mobile units.
> (JPP 1947, 55:6)

By this time the Child Welfare Service had obviously become widely accepted by Tasmanian women. Could Laura Richardson and Myrtle Searle, walking the streets of Hobart and Launceston in 1918 looking for mothers to attract to their centres, have envisaged they were laying the foundations of such a vigorous community health institution?

The early child welfare nurses and their supporters were skilled promoters of the message of training for motherhood, willing to use any forms of propaganda available to them. Women wanted the service and supported it. The statistics on attendance at the centres presented in chapter three confirm this. There is no direct evidence from the mothers who used the service as to whether they incorporated the message of scientific motherhood into their lives. However, as the literature all focused on scientific motherhood it can be inferred that Tasmanian mothers were influenced by it. Whether the message of scientific motherhood was actually successful in achieving the desired result, a reduction in infant mortality and improved child health, is examined in the next section.

Saving the babies 1918 - 1930

The imperative behind the establishment of child health services throughout Australia was the combination of a falling birth rate and a high infant mortality rate. This led politicians and other influential citizens to become concerned about the size and quality of Australia's population. As women were unwilling to bear more children, policy makers focused, for both humanitarian and national considerations, on the need to reduce the infant death rate. Therefore throughout Australia in the second and third decades of the twentieth century, child welfare services were established under the influence of the infant welfare movement. Their purpose was to improve personal and domestic health through education and thereby contribute to the reduction of the high rate of illness and death among babies.

Dr Springthorpe, President for the Society of Women and Children, Victoria, expressed his opinion that child welfare work was a matter 'which affected the very life of the nation' and went onto say:

> All over the world birth-rates are falling, particularly amongst the people who could most profitably hand on the gift of life; and since it is impossible to force people to have children, the finger of common-sense points to the very plain necessity of preserving the life of every child we have. In countries like our own the question of conserving child-life is one of burning interest, and there is growing realisation of this truth....The cheapest and most satisfactory immigrant is the native born.
>
> (*The Mercury* 2 January 1924)

Even as the service was being established in Tasmania some of its supporters warned that the results from the interventions of child welfare nurses in family life would not be immediate, but stressed they would be certain. C. L. Park, Chief Health Officer for Tasmania, stated that 'Any actual effect on infant mortality rates will, of necessity, take some time to appear...This being the case, good results are only a matter of time and perseverance' (JPP 1918-19, 28:13). The expectation was that, although it might take some time, there would be a reduction in the death rate of babies clearly and directly attributable to the new service.

In 1928, ten years after the establishment of centres in Hobart and Launceston, 2256 individual babies attended centres in the two cities. These children often attended until they were two, so this figure represents children enrolling over a period of two years. The combined number of births for the cities in 1928 was 1615. Four child welfare centres had been established in each city, as well as the Mothercraft Home in Hobart, all of which were administered and maintained by the voluntary Child Welfare Association (JPP 1929-30, 3:17). It appears fairly certain from these figures that most mothers in areas with child welfare centres were in contact with child welfare nurses and receiving advice about the best and safest ways of caring for their babies known at the time.

The service was a success in terms of attracting large numbers of women, partly because it employed committed and innovative nurses, and partly because it was given immense support from the press and public figures. Two questions need to be asked however. First, did the service contribute to a decline in infant illness and death up to 1930? To do so was the reason, after all, for its establishment. Secondly, was its real success in fact, of a different type to that which had been envisaged in 1918?

At first glance the decline in the infant mortality rate between 1918 and 1930 does not appear very impressive.

Table 4.3 Tasmanian Infantile Mortality Rate (Deaths per 1000 Births) 1920-1929

Year	1920	1921	1922	1923	1924	1925	1926	1927	1928	1929
	65.2	78.4	55.7	57.6	55.0	55.0	46.5	53.0	63.9	53.1

(*Source:* Department of Public Health Report, 1929-30, 8:15. Abridged table)

Because of the fluctuation in the rate throughout the decade health officials sometimes saw cause for rejoicing, only to be dismayed by an increase in the following year. E. J Tudor, the Chief Health Officer of Tasmania, in 1927, commented on the 1926 figure in the following way:

> Statistics reveal a substantial decline in the infantile death rate. As a matter of fact the rate for the year, viz., 46.5, is the lowest on record. This is probably due, not so much to climatic change or sanitary improvement, as to "the awakening of the public conscience on the subject," which expressed itself in wider knowledge and greater care of child life. These figures must give all of those interested in this work reason for congratulation.
> (JPP 1927-28, 5:15)

Sadly, the following year the rate was up again. Other health officials were more cautious. E. S.. Morris, Chief Health Officer of Tasmania, in 1922, expressed his concern that the Tasmanian infant mortality rate was the worst in Australia. It seems however that this was partly due to an epidemic of a particularly virulent form of gastro-enteritis in 1921 from which babies often died within 48 hours (Morris, 1921-22, 46:14). He added in his report:

> It is somewhat disconcerting to realise that in those centres where an effort has been made to stem the tide by the provision of child welfare clinics, the rates should be higher than the average for the state. In Hobart the rate is 79 and in Launceston 122. Had the country districts not shown a smaller rate, Tasmania could be legitimately regarded as an infant's danger zone.
> (JPP 1921-22, 46:14)

Although the Child Welfare Service had been in existence for 10 years the overall infant mortality rate had barely declined at all. However when the figure is broken down to principal causes of death after 1921, it can be seen that there is a substantial decline in the number of infants dying of diarrhoeal disease.

Table 4.4 Number of infants dying of diarrhoeal disease in Tasmania in relation to the total number of infant deaths 1920-1929

year	1920	1921	1922	1923	1924	1925	1926	1927	1928	1929
Total deaths	374	451	324	326	296	287	232	256	300	255
deaths from diarrhoea	73	113	37	35	16	29	30	31	37	21
% of total from diarrhoea	19.5	25	11.4	11.7	5.4	10.1	12.9	12.1	12.3	8.2

(*Source* Department of Public Health 8:16. Abridged table)

This rate compares very favourably with an average annual infant death rate for the previous decade 1910-1919, of 75.5 infant deaths from diarrhoeal disease (JPP 1929-30, 3:18). The other big killers of babies, prematurity, bronchitis, bronchopneumonia-pneumonia and pneumonia had to wait for improvements in obstetrics and the discovery of antibiotics[2]. Diarrhoeal disease, however, as a killer was on the decline. During the 1930s the decline in infant deaths from diarrhoea was even more dramatic. In 1936 four Tasmanian babies died from gastro-enteritis, in 1937 none (JPP 1938-39, 8:13).

The work of the child welfare nurses had always been directed towards encouraging breastfeeding and promoting hygiene particularly in relation to infant feeding and baby care, practices which are still seen today as guarding against diarrhoea. How much of the decline in deaths from diarrhoea can be attributed to their efforts is difficult to determine. At the time many supporters of the movement saw the work of child welfare nurses as vital in saving lives. Others wondered, like Morris, why diarrhoea continued among infants in localities where child welfare centres had been established. There is no simple or dramatic answer. Disease epidemiology is an intricate field of study which has revealed the existence of multiple pathways for many diseases. Overcrowded houses, polluted water and milk supplies and ineffective sanitation were the breeding grounds for gastro-enteritis. Reforms were needed in all these areas before diarrhoeal disease could be eliminated. Equally however education in domestic hygiene must have helped. Using fly-screens, covering rubbish bins and food, washing hands, and boiling milk were all practices which would have contributed to the reduction of gastro-

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[2] Penicillin first became available in 1944, during the Normandy landings, to treat injured soldiers. See Lennard Bickel, *Rise up to Life*, Angus & Robertson, Sydney 1972.

enteritis. This sort of education appears to have been the mainstay of child welfare work.

Throughout the 1920s nurses also encouraged women to breastfeed their babies. They believed it to be of such vital importance in the prevention of illness, particularly gastro-enteritis, that they sometimes showed little patience and understanding of women who chose not to breast-feed. Gertrude Cumins, a Hobart nurse, commented disapprovingly of such women:

> The majority of dietetic troubles have arisen from sheer ignorance as to the proper feeding of infants. Too many mothers wean their babies on the slightest pretext, and then substitute a dried-milk food. One mother owning she [undecipherable] fed her baby on lactogen.
> (JPP, 1921-22 46:29)

What methods and language nurses used to persuade women to breastfeed is difficult to determine now. They were not all as rigid in their approach as Miss Cumins appears to have been. Jessie Peterson, a Launceston contemporary of Gertrude Cummins, blamed early weaning on '...overworked mothers, and in some cases, under nourished, also the failure to appreciate the importance of breast-feeding' in her report (JPP 1920-21, 40:24). There is some recognition in this statement of the impact of social and economic forces on women's lives.

Nurses do seem during the 1920s to have helped increase the number of women breastfeeding. Clara Bonnily throughout the 1920s kept figures for the number of women who attended her clinic and breastfed their babies. A gradual increase can easily be discerned.

Table 4.5 Wholly or partially breastfed **infants**

	Three months	six months	nine months
1924	85.5%	75.2%	66.4%
1925	80%	66%	61%
1927	87%	75%	70%
1928	91%	82%	75%

(*Source:* JPP 1925, 1926, 1928,1929 reports)

Even today the results of health education and health promotion are difficult to quantify. In relation to breastfeeding in the 1920s we have only Clara Bonnily's figures for the Hobart Centre, but other nurses also made passing

references to more women breast-feeding. In addition, safer artificial alternatives to breast-milk and more hygienic baby care practices generally, were encouraged by the centres. At the same time there was an evident decline in infant diarrhoea. All that can be inferred from this, is that along with improvements in sewerage, safe milk and water supplies, and a generally higher living standard, the work of the Child Welfare Service was influential in bringing about a decrease in diarrhoeal disease in infants.

It seems therefore, that the establishment of the Tasmanian Child Welfare Service had, throughout the 1920s, only a marginal impact upon the overall infant death rate. Despite its main aim being to bring about a reduction in the incidence of infant illness and death, it is only in the area of diarrhoeal illness that the service had significant impact, leading to the reduced occurrence of that condition.

Although women took up the cause of child welfare with enthusiasm, and both supported the idea and brought their babies to the centres, this commitment appears to have been of limited value in bringing about a dramatic reduction in mortality and morbidity. Yet its supporters saw it as successful. What then was the nature of its success?

It is important to remember that many improvements in health are not reflected in morbidity and mortality statistics. The early child welfare nurses were women of their time, they believed in the power of medicine and science to help mothers and babies. While often authoritarian in their attitudes, they nevertheless offered help and hope to women, hope that motherhood could be better, more rewarding and considerably less heart-breaking. A large part of the advice they gave women was concerned with diet and hygiene. They stressed the importance of breastfeeding, eating a balanced diet, boiling milk, covering meat, washing hands and regular bathing. This advice was compatible with other 'quality of life' changes occurring within Australian society. During the time of this study, housing was becoming more functional, some slum housing was demolished, water on tap became common in even poor areas and sewerage was extended throughout urban areas (Reiger 1985:48). In addition to information and advice about modern parenting, the child welfare service provided a free health service for all families. Although concerned primarily with education in well baby care, the nurses were able to arrange free medical care in their centres for sick children.

It is likely that a combination of these factors brought about a significant change in child health and that this contributed to the success of the service with mothers.

Largely, however, I believe the child welfare movement was successful because it reinforced dominant constructions of womanhood common in society at the time. The 1920s saw a resurgence of a belief that motherhood was women's most important role and one of great value to society. However motherhood was not sentimentalised as it had been in the 19th century, but rather reconstructed as a fulltime career for women, one requiring skills and knowledge in diet, hygiene, health and organisation. The child welfare services offered women one way of acquiring those skills and the self esteem that went with doing a job well in the eyes of their community. This success of child welfare services, the building of self esteem and self confidence was not however the sort of success which could be quantified in the way that a reduction in infant mortality could be. It was in fact an invisible success.

Chapter 5: A return to the beginning - nurses and constructions of motherhood

Central to my interest in motherhood constructions was curiosity - curiosity about their origins, their impact upon women and the way nursing agencies might reflect and reinforce them in their service delivery. I chose to study the development of the Tasmanian child welfare services between 1918 and 1930 in order to understand and to illustrate the support given by nursing agencies to a powerful, early twentieth century construction, scientific motherhood, one which still influences present day nursing practice.

What I came to realise from this study was that changes in motherhood constructions come from social, economic and intellectual shifts within the broader society over time. Taking an historical perspective allows this relationship to be seen more clearly (Tosh 1991:27). Scientific motherhood as a construction emerged in Australia as a result of a number of powerful forces within late 19th century society. Among these were concerns about the size and quality of the Australian population as well as the nation's geographical position in relation to Asia, and its isolation from other European population centres. Policies directed, in the first instance, towards encouraging women to have more children and then later towards reducing infant mortality stemmed from these concerns.

Another influence leading to the development of scientific motherhood was the concept of 'separate spheres' that is, different arenas and responsibilities for men and women's work (Fox and Lake 1990:179). The position of the early feminist movement in regard to this concept is interesting. Saunders and Evans (1992:322) claim that despite the diversity of views held by members of the women's movement in the early part of the century, all groups accepted that the women were naturally nurturing and self-sacrificing. Given the pervasiveness of the belief that women belonged in the private rather than the

public domain, early feminists were perhaps realistic in focusing upon gaining recognition for the contribution of women to society as mothers and homemakers. Clearly, powerful social forces were operating at the beginning of this century which led to a redefinition of motherhood along rational, efficient, and therefore, supposedly scientific lines. This relationship, between social influences and a particular view of mothering, demonstrates how changes over time within a society produce changes in mothering.

It could be argued that motherhood constructions provide guides to what might be seen as appropriate ways of mothering. However, one problem with their appropriateness for all women is that, as many writers have pointed out, motherhood constructions tend to impose middle-class mothering norms upon women (Knapman 1993:113; Reiger 1985:128; Weiner 1994:1360 Phoenix, Woollett and Lloyd 1991:18). Middle-class supporters of scientific motherhood accepted that all women, not only working-class women, would need education in its major tenets. As a result, in Tasmania child welfare centres were established in all types of localities, middle-class, working-class, urban as well as rural. The very first centres were placed in central city areas. This distribution of centres supports Reiger's (1985:174) claim that scientific motherhood was directed, not specifically at the industrial poor, but at all women. It was in fact an attempt to comprehensively make over motherhood in line with the latest developments in modern scientific thought. It must be said, however, that while child welfare reformers believed that the principles of scientific motherhood should be taught to all women, it was a system of child rearing which was more difficult for the poor to adopt than women from other social groupings. The evidence of Public Health Department reports shows that during the 1920s health officials did not hesitate to classify those women who failed to incorporate into their child care the major principles of scientific motherhood, as ignorant, irresponsible and in need of education and supervision. It seems likely that poor women would have been overly represented among those labelled as 'ignorant'.

The historical data was viewed around three major themes. One powerful theme I called, philanthropy, by which I meant the early support of voluntary women's organisations for the establishment of child welfare services. The evidence suggests that Tasmanian women actively campaigned for child

welfare services and succeeded in gaining considerable support from the press and public figures for their establishment. Once the services existed, women flocked to child welfare centres. It seems reasonable to surmise from this that the centres provided an opportunity for women to acquire skill and knowledge in the only major area open to them at the time, mothering and homemaking. In part this desire for new mothering skills may have stemmed from the fear, realistic at the time, of babies dying. One of the problems the historical researcher encounters is that, in the past, the voices of ordinary people have rarely been recorded. It is difficult therefore to discover why so many women so quickly and willingly began regularly to attend child welfare centres. What need did the centres meet? Was it simply the desire, to develop different mothering skills viewed at that time as better than the practices of the past? Did the centres provide an opportunity for women to meet other mothers? The isolation of women as mothers has been an ongoing concern of Family and Child Health Services throughout the 1980s and 1990s, is it possible that women in the 1920s were just as isolated and in need of mutual support? We know why health workers and public health officials supported the child welfare centres, but how women perceived them and the benefits they might gain from them is less easily discerned. There is a need for further research directed towards uncovering the voices of women as mothers in the early decades of this century.

The second theme central to this work was the concept of 'training' in relation to mothers and babies. At the beginning of the twentieth century science was held in such high esteem that it was regarded as capable of providing solutions to most human problems. Professional, scientifically reinforced, training was believed to give health workers the expertise necessary to supervise and train mothers. However, although the label 'scientific' was applied to motherhood in the 1920s, the content of the advice given to mothers was actually more likely to have been influenced by popular management theories of the time than scientific research (Gillespie 1982:17; Owen 1987:5). The outcome was nevertheless a shift of authority from women as natural mothers in control of mothering practices, to professional experts. This shift in authority can be viewed as a direct result of the idea, new in the early twentieth century, that women needed training to fulfil their mothering responsibilities competently.

The final theme explored in this study was the way child welfare services disseminated the message of training for both mothers and babies throughout the Tasmanian community. I called this theme, the use of propaganda. In doing so I deliberately chose to reflect the terminology widely used, without any apparent derogatory overtones, in the 1920s. What was quickly revealed by the data was that early child welfare nurses were innovative and committed propagandists who left no stone unturned in order to reach women with their message. In the foundation years of the service the nurses maintained a high public profile and used this to push for public health reforms in the interests of mothers and babies. Towards the end of the 1920s the public voice of nurses became more subdued. They still spoke publicly but only on clinical issues relating directly to their work. For example, there are no more statements from them in the press about the evils of sub-standard housing and the need for a pure milk supply. Just why they restricted themselves to clinical issues after the middle of the 1920s is difficult to ascertain. It may have been that as the service was demonstrably successful in attracting women there was no longer a need for nurses to be high profile public figures. There is some evidence in 1920s editions of The *Medical Journal of Australia*, (not used in this thesis), of the concern felt by doctors about the activities of child welfare nurses.

The primary sources used in this study have revealed evidence of differences in the views held by child welfare nurses, doctors and health officials regarding mothers. This difference is shown in the language used by the various parties. The half-yearly and yearly reports written by the early child welfare nurses and recorded in the parliamentary papers make fascinating reading. While the nurses are obviously constrained by the official style of the reports and perhaps by the authority of those they were reporting to, differences between them, in attitudes and interests, are revealed. There is evidence also that many high profile nurses like Myrtle Searle had a ready sympathy and appreciation of the practical difficulties many women faced as mothers. Public health officials blamed the high infant death rate on the ignorance of mothers and this stance was supported by articles in the press. On the other hand, nurses often blamed social factors, as well as lack of knowledge among women, for high levels of infant ill health and death.

This study reveals that nurses were concerned and frequently expressed their concern about the effects of many social issues on the health of babies. Such issues were unemployment, hardships stemming from industrial strikes and the ill health of parents, poor housing, contaminated water and milk supplies and under-fed and over-tired mothers. On the other hand, the statements of health officials contained in the Public Health Department reports almost exclusively concentrate on a supposed relationship between child ill health and maternal ignorance. From my examination of primary sources it may be suggested that some discrepancies existed between the views of child welfare nurses and public health officials with regard to women's mothering capabilities. This might be a fruitful area for further research.

Interesting dilemmas around the issue of social control, particularly in relation to expert supervision of mothering practices have arisen for me from this study. At the time of the establishment of child welfare services, social control was viewed as desirable in the interests of the state (MJA 1923:269: JPP 1921-22, 65:17) The primary sources I have drawn upon illustrate that doctors, health officials and journalists firmly believed in the necessity of supervising and educating women in mothering. It is also clear that controlling women as mothers was central to the philosophy of the child welfare movement. However, some writers (Knapman 1993; Reiger 1985) suggest that women colluded for their own purposes with this movement. We know that many women actively demanded access to information about a rational technical approach to home management and mothering. What we cannot know and what therefore clouds the issue of social control over mothers in the 1920s is the level of contestation and negotiation which took place within the clinic setting between mothers and nurses.

There is a need for further nursing research of child health services. These services, so long accepted and so often overlooked, have played a major role in Australia in supporting and reinforcing constructions of motherhood. Historical and sociological analyses have largely typecast them as agents of social control (Deacon 1985:167; Waters 1983:26). Developing a more rounded picture might be possible if further research was directed towards bringing to light the experiences of the women who used them and the women who worked within them.

This study has increased my understanding of the inevitability of the constructed nature of motherhood and the part played by child health services in reinforcing dominant social mores and values among women. I am convinced that understanding the origins of motherhood constructions reduces their power over women's lives. On a personal note, had I known more about how motherhood is socially constructed I would have been better placed to deal with the health workers I consulted during Timothy's first year. I might also have been spared a considerable amount of anguish and guilt because my experience failed to match the dominant image of competent happy motherhood presented to me. Finally, understanding the development of motherhood constructions, the impact they can have upon women and the role child health services play in supporting them, has heightened my awareness of the way I practise as a nurse working with mothers.

Appendix: Thoughts on historical research

To uncover the story of the early Tasmanian child welfare services I used an historical research method. Although as an undergraduate I had studied history, this was the first time I had attempted a substantial piece of historical research. A brief mention of some of the problems I encountered may be of interest to other nurses considering doing historical research.

Perhaps my first problem was in finding my focus and in defining the questions I wanted to ask of the sources. Although I had known from the beginning the broad area I was interested in, narrowing this down to something I could actually work with, was difficult for me. I was interested in everything to do with the subject and was constantly getting side-tracked. The volume of historical source material can seem overwhelming in the beginning stages of research. I had to learn to leave, perhaps for a later date, much that was fascinating. Of course the problem is knowing what will be needed later on. Inevitably, it seems now, I found myself returning to the Tasmanian parliamentary papers many times. Although at first daunting, I gradually began to see these publications with new eyes. Discussions and investigations, which took place in the early years of the Century relating to nursing and public health issues, are recorded within them. I now look on parliamentary records as a valuable primary source.

Historical research cannot be done without using primary sources. When we read about the past in historical writings, '... we stand at one remove from the original sources in question' (Tosh 1991:32). We are reading the interpretation of another writer. Studying original documents allows us the possibility of constructing fresh and original interpretations about the past. Primary sources include original documents and artefacts as well as oral history.

The area I was interested in for this study steered me towards particular primary sources to do with families and nursing. Sources I looked at included Victorian and Tasmanian parliamentary papers and archival material, including photographs, letters, expense accounts, pay claims, policy statements, papers of organisations, training school curriculum. I also read old nursing text books and numerous books written for parents. Members of

the public made available to me for viewing photographs, old Baby Health books, certificates of training, newspaper cuttings and in one case handwritten lecture notes. In addition, I conducted a comprehensive and systematic search of Tasmanian newspapers of the period and the *Medical Journal of Australia.*

Secondary sources, that is other scholarly works of historical research, provided a context for my particular research. I drew particularly upon the work of historians and sociologists of the family, mothering or childhood. While also reading some more broadly based 19th century and early 20th century Australian social history, I particularly sought any writing which related to the domestic position of women during those times.

I was concerned that I had been unable to locate any original material which identified how consumers of child health services felt about the service between 1918 and 1930. I had anticipated this difficulty, for the women I was interested in would have been born around the turn of the century and I suspected there would be little recorded giving their point of view. In this I was correct and therefore my account of the early Tasmanian Child Welfare Services is a partial one, for it is a narrative largely told from the perspective of health officials and nurses. While I had no difficulty locating primary sources relating to Health Departments and voluntary organisations, interest in ordinary people, beyond a time when oral history can be used, was less easily satisfied.

Another difficulty I encountered was how to interweave theory, historical data, and my own experience as a mother and nurse, while keeping the work coherent. The reading, grouping, searching and discarding continued throughout the whole time I was writing. The outcome of the constant working and reworking through the data was the emergence of three themes: philanthropy, training of mothers and babies and the use of propaganda. Developing these themes was for me a useful way of telling much of the story of the early Tasmanian Child Welfare Service.

Child health nursing services have been largely overlooked by nurse historians, although they are intimately linked to the history of the women of this country. The historical relationship between women as nurses and women as mothers in Australia requires further research.

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