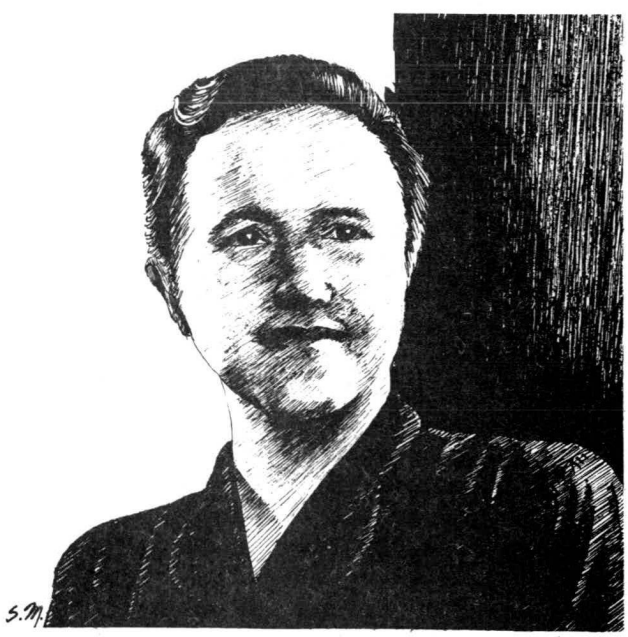
Efforts to Reduce Infant Maternity Mortality in Canada Between the Two World Wars

by Suzann Buckley

During the late nineteenth and early twentieth centuries, various reformers tried to reduce the high incidence of infant and maternal mortality in Canada. But their efforts were essentially confined to piecemeal activities which produced limited results.(1) After World War I, however, the situation changed. At that time, the Dominion Government concluded that the loss of lives in the war should be offset by ensuring the production of future generations of healthy Canadians. Consequently, in 1919 the Government established the Dominion Department of Health which included a Division of Child Welfare.(2) Also, in the early 1920's the Government agreed to provide an annual grant of between $5,000 and $10,000 in order to assist the newly organized volunteer agency, the Council on Child and Family Welfare.(3) Dr. Helen MacMurchy headed the Child Welfare Division and Charlotte Whitton directed the Child and Family Welfare Council. These two personalities dominated the infant and maternal mortality reform efforts in the decades between the two world wars. An examination of their work and the issues raised by



DR. CHARLOTTE WHITTON, 1944

them may provide some perspective for current activities pertaining to women and health.

MacMurchy's interest in infant and maternal mortality did not originate with her appointment to the Child Welfare Division. In the early 1900's, shortly after she had commenced practicing, MacMurchy had compiled a series of reports on infant mortality for the Ontario Government. These reports had pointed out that the inter-related factors of poverty and unsanitary living conditions were the chief reasons why nearly 7000 infants (under one year of age) died annually in Ontario. Despite the admission that rich babies lived while poor babies died, MacMurchy had not called for substantial economic changes in society. Instead, in the typical Progressive manner, she had recommended ameliorative measures. Particularly, she had stressed the idea of breast-feeding as an immediate answer. Breast-feeding would avoid the risks of unpasteurized milk and provide an infant with some immunity to an unhealthy environment. The Canadian people, she had argued, must be convinced of the necessity of preventing infant mortality by breast-feeding.(4)

In view of this conviction, it is not surprising that one of the first tasks undertaken by MacMurchy in her post at Child Welfare was the publication of a series of free pamphlets which emphasized the merits of breast-feeding. In these materials on infant and maternal care, commonly known as the Little Blue Books, MacMurchy equated breast-feeding with patriotism and artificial feeding with treason: "You can nurse the baby, and you will, for you know it is better for the baby, better for you and better for Canada. It saves the baby's life." (5) Of course, as the materials made plain, the mother must be healthy in order to breast-feed. The pregnant woman must therefore make an effort to secure prenatal and natal care.

Besides enlisting the average citizen in the campaign to promote infant and maternal well-being, MacMurchy worked to stir up the interest of medical men and women's organizations. In this effort she was assisted by Helen Reid. Reid was a prominent member of many philanthropic organizations and the representative of child welfare and social services on the Dominion Council of Health, an advisory body to the Department of Health. In October 1919, at the first meeting of the Dominion Council of Health, Reid requested the Department of Health to produce information for the Dominion Council on such topics as prenatal care, infant feeding and hospital and home treatment of maternity cases.(6) MacMurchy readily complied. Drawing upon data from her own investigations and from figures provided by the recently established Dominion Bureau of Statistics, MacMurchy presented her findings on maternal mortality to the Dominion Council in June 1923.(7)

MacMurchy's report documented a maternal mortality rate of approximately 5.6 per 1,000 (per live births) and it attributed the high rate to inadequate medical care. The number of prenatal clinics was insufficient and physicians' services for natal care were deficient. The problems of insufficient and deficient care were especially acute in remote areas. Unlike in towns or cities where there might be some clinics, in outlying areas women generally were dependent for prenatal care upon the overburdened, relatively few Red Cross, Victorian Order or public health nurses. With respect to natal care, many women in outlying areas were hampered by lack of finances. Physicians often were reluctant to make a long journey to attend to a birth if payment of the case could not be guaranteed. Frequently, it could not be promised. As a result, women were forced to rely upon untrained attendants who functioned as midwives. The vulnerability of women in outlying areas was vividly attested to by a letter, included in the report, from a woman in western Canada:

> I know of two neighbours about to be confined. Both have already large families, neither one expects to have a doctor as they feel the expense will be hard to bear. . . . I can't refuse to help yet I do not feel equal to the task. . . . This is the normal state of affairs all through western Canada except close in towns or cities.(8)

MacMurchy's straightforward presentation of the maternal mortality situation provoked much discussion among the medical men on the Dominion Council. They concluded that action must be taken: "There is a public opinion being educated that is going to demand service and if we do not provide it, then we are going to be told how it will be."(9) These individuals evidently used MacMurchy's findings to prod other members of the profession into acknowledging the issue. In December 1924 at the first conference on medical services, the Canadian Medical Association requested the Department of Health to institute a comprehensive inquiry on maternal mortality.(10)

MacMurchy conducted the two-year study by randomly canvasing 1000 physicians on the instances and causes of maternal deaths. Her report, presented in the form of anonymous letters of advice from physicians and others, addressed itself to six questions and answers:

(1) What is the rate of maternal mortality in Canada?

    5.5 per 1000 (per live births).

(2) How does it compare with the maternal mortality rate of other countries?

    Of nineteen countries, Canada is the fourth highest. (The United States, Scotland and Belgium are higher).

(3) Is it excessive?

Yes.

(4) What proportion of births occur with no medical or nursing care for mother and child?

A substantial proportion are unattended.

(5) Are medical fees too high?

Here, the report cautiously concluded: "From the point of view of the patient there is some reason to think that this may sometimes be the case."

(6) What has been done recently to deal with the problem?

Some efforts have been made in other countries (for example, the use of qualified midwives in England), but nothing substantial has been done in Canada.(11)

The report also presented a series of tables on urban and rural maternal mortality rates, the causes of deaths and Provincial rates.(12) With the exception of British Columbia, the urban rate of 6.6 per 1,000 (per live births) exceeded the rural 4.7 per 1,000. The chief causes were sepsis, haemorrhage and eclampsia. The figures for the Provinces for 1926 were:

Province	Rate	Actual Number
Saskatchewan	7.1	145
British Columbia	6.6	65
New Brunswick	6.4	66
Alberta	5.9	85
Manitoba	5.9	87
Ontario	5.6	381
Quebec	5.2	427
Nova Scotia	4.7	51
Prince Edward Island	4.0	7

There was no interpretation of this data. MacMurchy intended the tables, like the report itself, primarily for public information. Once informed, the public was responsible for drawing conclusions and for acting upon them.(13)

Some might argue that MacMurchy should have used her report not only to inform but also to interpret in order to marshal public opinion behind a definite plan of action. But this would have been difficult for MacMurchy. A previous attempt to stimulate change by such a tactic had been painful and unsuccessful. In 1910 and 1911 when serving as a medical inspector of schools in Toronto, she had "found that educational red tape was tying hard-and-fast knots in medical progress."(14) She had protested to the school board, thereby causing "consternation in a camp which had taken it for granted that a woman inspector is not to exercise the faculty of observation--to say nothing of reflection."

(15) She had "stuck to her guns like two men and a British soldier thrown in,"(16)and she had carried the battle to the newspapers. But ultimately she resigned. Thereafter she had behaved thusly: "absolutely refus[ing] to commit herself on any opinion whatever. It is doubtful if she would give you a recipe for stuffed tomatoes. She would just loan you the cook-book and hold it responsible."(17) To inform rather than to interpret and to confront had become MacMurchy's only tolerable and tolerated modus vivendi.

Despite the lack of detailed implications in the report, certain inferences were fairly clear. Prenatal care and medical competence should have prevented a substantial number of deaths by sepsis, haemorrhage and eclampsia. The problem of maternal mortality caused by economic factors was not limited to western, outlying areas. The statistics for Quebec and Ontario suggested a high urban rate of maternal mortality. Subsequent studies confirmed this fact, and, in the case of Montreal, linked poverty with maternal mortality. Rather than suffer the economic distress of trying to support another child, many married women in Montreal gambled fatally upon abortion.(18) Also, as the report implied, social obstacles sometimes compounded economic elements. Some Indian and immigrant women refused to reject their traditional reliance upon female attendants(19)and unwed mothers often failed to seek care or resorted to abortions because of shame.(20) Thus, as the report concluded, the maternal mortality problem was complicated. It was not, however, irresolvable. The "long march to the grave"(21)could be deflected if the public and the medical profession would concern themselves with it.

MacMurchy's report managed to stimulate various groups. Women's organizations took a variety of approaches to the problem. All of them tried to publicize the issue. The National Council of Women of Canada, for example, set up a special committee on maternal welfare. This committee instructed local branches to generate community interest in maternal mortality. One result of this project was to link Mother's Day celebrations with publicity about the number of mothers dying in childbirth.(22) In Ontario, the United Farm Women recommended two proposals: the Dominion Government should establish a research branch on maternal mortality; and the Dominion and Provincial Governments should cooperate to institute a maternal insurance or allowance board to subsidize doctors in rural, remote and thinly populated areas.(23) Among medical organizations, the Canadian Nurses Association began to explore the possibility of obstetrical training for nurses and the Red Cross pledged to expand its services.(24) The Canadian Medical Association and several regional medical societies appointed special

committees on maternal mortality. All of these committees directed their attention to the possibility of increased obstetrical training programmes for doctors.(25) On the governmental level, British Columbia appointed a Royal Commission to inquire into state health insurance and maternity benefits and the Manitoba and Ontario Governments undertook studies of the causes of maternal mortality in their provinces.

The Manitoba and the Ontario reports, like MacMurchy's, involved canvassing physicians on the causes of mothers' deaths. These studies were more substantive than MacMurchy's report. For example, the reports documented that the greatest risks in childbearing were for the first child and after the fifth child and that many deaths from the major killers, toxemia and sepsis, were preventable by proper medical care. Also, the reports clearly stated that there was a link between maternal mortality and economic factors. Impoverished women were usually too weak physically to have a safe delivery. Furthermore, a lack of money deterred women from seeking institutional care. Yet when births took place at home, poverty often contributed to unsanitary delivery conditions.(26) These reports did not propose any remedy for the vicious economic circle but the British Columbia Royal Commission recommended a course of action. Convinced by witnesses who had presented many stories about "the life of the mother being lost simply because money was a matter beyond her resources,"(27)the Commission urged the creation of a state health insurance scheme which would include maternity benefits. The insured woman employee or the wife of an employed insured male would be eligible for medical and hospitalization services or a cash benefit of up to $25.(28)

Besides these efforts of suggesting the need for medical and socio-economic improvements, in the 1930's some began to argue that the maternal mortality problem should be approached from other perspectives. One of the first to speak out was Dr. H. Benge Atlee, the head of obstetrics and gynecology at Dalhousie Medical School. In articles in the Canadian Home Journal Atlee posed the question: are women sheep? He then argued in the affirmative on the basis that women "have not yet learned to work in a body for the improvement of their lot."(29) Unless they acquired this necessary solidarity, the maternal mortality problem would not be resolved. Women, he urged, should "organize with [their] sisters in working out a truly feminine way of life."(30) This would entail banding together to insist "on better obstetrical training on the part of their medical attendants."(31) Despite this appeal to women to unite as a pressure group, Atlee was not encouraging them to reject traditional roles. Concerned about the steadily declining

birthrate, Atlee merely wanted women to demand better care in order that they might produce more and healthier babies. According to him, almost every woman became a mother and mothers belonged in the home:

> Every realist will concede that so long as the home is to remain the ideal of this civilization, woman's part in the communal life must be different from man's. It is the man's place to build and subsidize the home; the woman's place to rear the young in it. . . .(32)

Not everyone took Atlee's approach to the maternal mortality problem. Nora Henderson, a journalist from Ontario, espoused a feminist position by urging women to move away from their limited role of ameliorating problems associated with a male-administered society. Obtain political power, she exhorted, in order to diagnose and possibly to eradicate, rather than merely to relieve, such matters as maternal mortality.(33) Another feminist, Charlotte Whitton, personally demonstrated an interest in having women play more than the conventional role of social mother in matters of reform. Later renowned for her remark: "Whatever women do they must do twice as well as men to be thought half as good. Luckily it is not that difficult,"(34) Whitton was determined to have women play a decisive role in social reform.

From 1926 in her post at the Child and Family Welfare Council, Whitton had been very active in trying to reduce the infant mortality rate from 101.9 per 1,000 live births.(35) Under her tutelage, a number of conferences, exhibits and publications had attracted attention to the problem. In 1932 when MacMurchy reached retirement age, Whitton suggested to the Minister of Health that MacMurchy's functions might be "more economically and energetically pursued outside the department."(36) In a commentary on MacMurchy's focus, Whitton bluntly stated: infant and maternal mortality were not simply medical problems. She was disenchanted with MacMurchy's emphasis on this aspect and she was determined to have social workers and physicians work together in order to deal with all the ramifications of infant and maternal mortality. Also, she intended to suggest solutions in addition to informing and educating the public.(37)

It was an auspicious time to argue to the government about saving money. Despite MacMurchy's vehement objections to "a lay person"(38)running the show, the transfer of the Child Welfare Division to the Council was approved. One of the first projects undertaken by Whitton was to have her lay and medical staff develop an elaborate publicity campaign which clearly connected medical and socio-economic elements of maternal mortality.(39) Another major effort involved arranging a lecture tour of Canada by Dame Janet Campbell,

a well-known expert on maternity and child well-being. Campbell spoke extensively about the usefulness in England of qualified midwives and she urged that nurses in Canada should be trained in obstetrics.(40) Campbell, backed by Whitton, thus called upon nurses to challenge the medical man's monopoly on obstetrics.

In 1938, before Whitton had been able to implement many of her desired reforms, the grant to the Council was substantially reduced. This, the Government maintained, was because of plans to reestablish within the Department of Health "an active division of Child and Maternal Hygiene."(41) Whitton was unable to prevent the return of the infant and maternal mortality issue to the large department. She was also powerless to keep the division in the hands of a lay administrator who would continue to combine medical and social reform efforts. As a result of these changes, the Council's work pertaining to infant and maternal mortality virtually came to an end and in 1941 Whitton resigned as executive director.

In assessing the efforts of MacMurchy and Whitton one must credit them with contributing significantly to the reduction of infant and maternal mortality in Canada (by 1943, infant mortality was 54 per 1000 live births; maternal mortality was 2.8 per 1000 live births). They had awakened public and professional attention to a serious problem, thereby forcing some change. Many women who heretofore had been isolated from medical care were reached by the various materials issued by MacMurchy and Whitton. Some doctors who had been previously unconcerned with maternal mortality were more responsive to the issue. But MacMurchy and Whitton failed in at least one important respect. MacMurchy by intent and Whitton by circumstances did not bring about the mobilization of Canadian women to participate on a unified basis on many levels. As a political pressure group, women remained as 'sheep,' thereby limiting the amount of change which could be accomplished. Judging from the experiences of MacMurchy and Whitton perhaps the political bonding of women should be one of the priorities of those currently seeking to improve the situation with respect to the health of Canadian women.

NOTES

1. Terry Copp, The Anatomy of Poverty (Toronto: McClelland and Stewart, 1974), pp. 93-100; T.R. Morrison, "'Their Proper Sphere' Feminism the Family and Child Centered Social Reform in Ontario, 1875-1900," Ontario History, LXIII, Nos. 1, 2 (March, June 1976); Veronica Strong-Boag, The Parliament of Women (Ottawa: National Museum of Man, 1976), pp. 206, 265, 296, 311.

2. Canada, Public Archives (hereinafter PAC), RG 29 (Records of the Department of Health and Welfare), Vol. 19, 10-3-1, vol. 2, report to the vice-chairman on the establishment of a federal department of public health, 25 October 1918; ibid., memorandum for Newton Rowell, 12 January 1920.

3. PAC, RG 29, Vol. 97, 156-2-2, memorandum on the Council on Child and Family Welfare.

4. Helen MacMurchy, The Report on Infant Mortality (Toronto: King's Printer, 1910, 1911, 1912). For an analysis of MacMurchy within the Progressive context see Michael Piva, "The Condition of the Working Class in Toronto, 1900-1921." Ph.D. dissertation, Concordia University, 1975, 201-206; 224-226.

5. Helen MacMurchy, The Canadian Mother's Book (Ottawa: King's Printer, 1930 edition), p. 51.

6. PAC, MG 28, I, 63 (Minutes of the Dominion Council of Health), Vol. 1, 1st meeting, 9 October 1919.

7. PAC, MG 28, I, 63, Vol. 1, 8th meeting, 19 June 1923.

8. Helen MacMurchy, Maternal Mortality in Canada (Ottawa: King's Printer, 1928), p. 56.

9. PAC, MG 28, I, 63, Vol. 1, 11th meeting, 16 December 1924.

10. MacMurchy, Maternal Mortality, pp. 30-31.

11. Ibid., pp. 60-65. The report was in some ways an elaboration of the findings she presented in 1923.

12. Ibid., p. 41. 13. Ibid., p. 26.

14. PAC, microfilm reel 16, Toronto Public Library Scrapbooks on Women, p. 103.

15. Ibid., p. 101. 16. Ibid. 17. Ibid.

18. Ester M. Beith, "Prenatal Nursing Supervision," Canadian Public Health Journal, XXVIII (December 1937), 592-95.

19. F.W. Jackson, et al., "A Five Year Survey of Maternal Mortality in Manitoba, 1928-1932," Canadian Public Health Journal, XXV (March 1943), 118.

20. J.T. Phair and A.H. Sellers, "A Study of Maternal Deaths in the Province of Ontario," Canadian Public Health Journal, XXV (December 1934), 566.

21. MacMurchy, Maternal Mortality, p. 26.

22. MG 28, I, 25 (Records of the National Council of Women of Canada), Vol. 119, various newspaper clippings; Dr. W.B. Hendry, "Maternal Welfare Campaign," Social Welfare, XIII (June 1931), 1, 186.

23. Canada. Department of Pensions and National Health, Annual Report, 1928-29, pp. 125-126.

24. Ibid., 1930-31, pp. 133-34. 25. Ibid., p. 132.

26. Jackson, et al., "A Five Year Survey;" Phair and Sellers, "A Study of Maternal Deaths."

27. PAC, MG 28, IV-1 (Records of the CCF), vol. 158, Report on State Health Insurance and Maternity Benefits, British Columbia, p. 24.

28. Ibid., p. 54.

29. H. Benge Atlee, "Are Women Sheep," Canadian Home Journal, XXXIV (November 1931), 9.

30. Ibid., p. 80.

31. Atlee, "The Menace of Maternity," Canadian Home Journal, XXIX (May 1932), 9.

32. Ibid., p. 8.

33. PAC, MG 27, III, C 4 (Agnes MacPhail Papers), Vol. 5, file 28, various newspaper clippings.

34. Canada Weekly, Vol. 3, No. 6 (5 February 1975), 3.

35. The statistics for 1926 were:

Province	Rate	Actual Number
Quebec	142.0	11,666
New Brunswick	106.3	1,095
Alberta	85.3	1,233
Saskatchewan	81.6	1,678
Ontario	80.6	5,295
Nova Scotia	78.5	881
Manitoba	76.5	1,122
Prince Edward Island	69.1	121
British Columbia	58.6	580

36. MG 28, I, 10 (Records of the Social and Economic Council), Vol. 17, Charlotte Whitton to Murray MacLaren, 28 September 1933.

37. Ibid., Vol. 18, Charlotte Whitton to W. Dawson, Managing Editor of the Canadian Home Journal, 15 June 1934.

38. RG 29, Vol. 97, 156-2-2, memorandum on the transfer.

39. Ibid., 15th Annual report of the Council on Child and Family Welfare, 1934/35.

40. MG 28, I, 10, Vol. 5, file 17, entire file on Campbell's tour.

41. MG 28, I, 25, Vol. 75, Major C.G. Power to Charlotte Whitton, 21 June 1938.