

**Searching For the Springs of Health:
Women and Working Families in Winnipeg's
1918-1919 Influenza Epidemic**

Esyllt Wynne Jones

**Submitted to the Faculty of Graduate Studies in partial fulfillment of the requirements
for the degree of**

Doctor of Philosophy

**Department of History
University of Manitoba
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SEARCHING FOR THE SPRINGS OF HEALTH:
WOMEN AND WORKING FAMILIES IN WINNIPEG'S 1918-1919
INFLUENZA EPIDEMIC

BY

ESYLLT WYNNE JONES

A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University
of Manitoba in partial fulfillment of the requirements of the degree
of

Doctor of Philosophy

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Abstract

In the winter of 1918-1919, a pandemic of influenza crossed the globe, killing as many as 50 million people. This dissertation is a local study of influenza in Winnipeg, Canada. It dissects the social responses to the disease from four different perspectives: that of the public health and medical authorities; middle class Anglo-Canadian women volunteers who provided nursing care and material relief to the city's poorer influenza victims; working class and immigrant families; and organized labour. The dissertation argues that the influenza epidemic, coming on the heels of the devastating Great War, and arriving in the midst of class, ethnic, and gender conflicts, played a role in deepening the social cleavages of Winnipeg society in the period, particularly those of class and ethnicity. Class and ethnic tension was not the inevitable outcome of the epidemic. Rather, it was the result of the social inequality of the disease's impact—working families represented a disproportionately high number of influenza's victims—and the failure of public authorities to mount a compassionate and cooperative community effort to fight the disease. The volunteerism of middle class Anglo-Canadian women, too, failed to build the bonds of community.

Labour believed that the state response to influenza was a betrayal of principles of justice and public good. Workers' families bore the brunt of public closures and layoffs. A spirit of mutualism sustained families and neighbourhoods through the disease, and contributed to the mobilizing successes of the workers' movement in 1918-1919. The trauma of the epidemic suggested the fragility of the social order, and workers' capacity to build an alternative society. Their vision of social transformation included the creation of the "springs of health": a living wage, quality housing, and equal access to a democratic medical system. Many working families, nevertheless, found it difficult to recover from the loss of spouses and children. Their stories suggest that influenza had a long-term impact upon the evolution of post-war Canada that we are only just beginning to understand.

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This dissertation is dedicated to my much loved son, Dylan, and to the memory of my father, Emlyn Jones.

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The common welfare is the workman's goal,
The common use of all the common wealth.
The common rights of every common soul
And common access to the springs of health.

And every man a workman by and by,
His own employer, his own king and priest,
Nor any rich or poor, nor low or high,
When all the world's monopolies have ceased.

—anonymous proletarian poet, 1905¹

¹ Quoted in Craig Heron, "Labourism and the Canadian Working Class," *Labour/Le Travail* 13 (Spring, 1984). Reprinted in Laurel Sefton MacDowell and Ian Radforth, eds., *Canadian Working Class History: Selected Readings*, 2nd edition (Toronto: Canadian Scholars' Press, 2000), p. 333.

Chapter 1 - Introduction

The ‘Spanish’ influenza pandemic of 1918 – 1919 has in the past several years become a subject of intense popular and academic historical interest.¹ In the wake of influenza scares in the 1970s, and inspired by Alfred Crosby’s research on the epidemic in the United States, influenza was rediscovered by historians as the “forgotten pandemic.” Scholarly work on the 1918 – 1919 epidemic emerged at a steady pace in the 1980s, then with greater intensity in the last decade. Concern over ‘super bugs’ resistant to antibiotics, and the emergence of AIDS as a global pandemic of proportions not seen in the twentieth century, have led to a popular rediscovery of fears of epidemic disease. More recently, anxiety that contagious diseases may be used as a form of biological

¹ The body of literature dealing with influenza in 1918-1919 is now quite extensive, and includes: W.I.B Beveridge, *Influenza: the Last Great Plague* (New York: Prodist, 1977); Alfred W. Crosby, *America's Forgotten Pandemic: The Influenza of 1918* (New York: Cambridge University Press, 1989); Niall P.A. S Johnson and Juergen Mueller, “Updating the Accounts: Global Mortality of the 1918-1920 ‘Spanish’ Influenza Pandemic,” *Bulletin of the History of Medicine* 76, (2002); Robert Katz, “Influenza 1918-1919: A Study in Mortality,” *Bulletin of the Institute for the History of Medicine* 48 (1974); K. David Patterson and Gerald F. Pyle, “The Geography and Mortality of the 1918 Influenza Pandemic,” *Bulletin of the History of Medicine* 65 (1991); Howard Phillips, *Black October: the Impact of the Spanish Influenza Epidemic of 1918 on South Africa* (Pretoria: The Government Printer, 1990); Terence Ranger, “The Influenza Pandemic in Southern Rhodesia: A Crisis of Comprehension,” in David Arnold, ed., *Imperial Medicine and Indigenous Societies* (Delhi: Oxford University Press, 1989); Geoffrey Rice, *Black November: The 1918 Influenza Epidemic in New Zealand* (Wellington, New Zealand: Allen and Unwin, Historical Branch, Department of Internal Affairs, New Zealand, 1988); Fred R. van Hartesveldt, *The 1918-1919 Pandemic of Influenza: The Urban Impact in the Western World* (Lewiston: The Edwin Mellen Press, 1992). For the Canadian context see Janice Dicken McGinnis, “The Impact of Epidemic Influenza: Canada, 1918-1919,” in S.E.D. Shortt, ed., *Medicine in Canadian Society* (Montreal: McGill-Queen's University Press, 1981); Maureen Lux, “‘The Bitter Flats’: The 1918 Influenza Epidemic in Saskatchewan,” *Saskatchewan History* 49, 1 (1997); Margaret Andrews, “Epidemic and Public Health: Influenza in Vancouver, 1918-1919,” *BC Studies* 34, (Summer, 1977); Anne Herring, “‘There Were Young People and Old People and Babies Dying Every Week’: the 1918-1919 Influenza Pandemic at Norway House,” *Ethnohistory* 41, 1 (1994); Mary Ellen Kelm, “British Columbia First Nations and the Influenza Pandemic of 1918-1919,” *BC Studies* 122 (1999).

terrorism has contributed to a heightened awareness of human vulnerability. In the specific case of ‘Spanish’ influenza, the mystery of the disease’s etiology and the scale of mortality it caused has piqued the interest of epidemiologists, geographers and historians alike.² This interest culminated in a 1998 conference devoted to the epidemic, hosted by the University of Cape Town, South Africa.³

As regionally-based research yields new knowledge about the epidemic all over the globe, the mortality estimates for the pandemic are constantly revised—upward. It is now argued that over fifty million people died as a result of being infected with this particular virus, and that the period over which deaths occurred extended into 1921.⁴ This dissertation contributes to the growing number of local studies of the influenza epidemic, and is one of only a small number on the Canadian experience of the disease. It documents the epidemic in Winnipeg, which in 1918 was the third largest city in Canada, and one of the country’s most ethnically diverse. This is a social history of disease, and as such explores the role of the epidemic in articulating and re-defining boundaries of social difference, particularly the boundaries of ethnicity and class that so profoundly marked Winnipeg society in this period. Like many other historians of epidemic disease, I argue that this epidemic deepened and exacerbated class and ethnic conflict.

² There are numerous newspaper and magazine articles, television programs, and web sites dealing with the 1918-1919 epidemic. Probably the most well known popular monograph on the disease is Gina Kolata, *Flu: The Story of the Great Influenza Pandemic of 1918 and the Search for the Virus That Caused It* (New York: Farrar Strauss and Giroux, 1999).

³ A group of papers from this conference, edited by Howard Phillips, will be published in fall 2002 by Routledge.

⁴ Johnson and Mueller.

This story of influenza, however, differs from the accustomed narrative of social conflict in the epidemic moment. Unlike urban centres in Europe and North America struck by cholera in the mid- nineteenth century, or colonized Asian nations warding off plague at the turn of the twentieth, Winnipeg did not erupt into violent confrontations between public health authorities and popular resisters. While the progress of the disease among the poor and immigrants was carefully monitored, they were not openly vilified for the spread of influenza. In fact, influenza lacked a convenient scapegoat, because it was brought to Canada and spread across the country by returning veterans of the First World War, young men of whom Manitobans were particularly proud. Popular opposition to state measures was muted. Although vaccination was urged, it was not compulsory, and was not widely resisted. Quarantining and placarding did not provoke riots or attacks on health officials. The labour movement, at the peak of its post-war strength, rather than overtly opposing measures such as a ban on all public gatherings, argued for labour's right to material security during and after this devastating epidemic, and the state's obligation to provide it. Why conclude, then, that influenza was a force of social division rather than a successful test of community cohesion?

This question is answered through an evaluation of the impact of influenza upon different layers of Winnipeg society, slicing through them at this particular historical moment, as though they were layers of a cake. The study begins by looking at the actions of public health officials and the medical profession, and concludes with working class families, progressing from the most to the least visible actors in this story. While much of this analysis follows in the footsteps of previous social histories of epidemic disease, three 'layers' of this study are distinctive. The first is an examination of the intersection

of gender with categories of class and ethnicity in framing the volunteerism of women in Winnipeg in response to the disease. Gender is rarely considered in studies of epidemics, and even more rarely have scholars discussed the role of women of the dominant classes in maintaining boundaries of ethnicity and class. Women's volunteer role was the glue that held together an ordered public response. Their official status as heroines of the epidemic, however, disguised the contradictory and disruptive aspects of contact between volunteers and poor victims, and the human interaction that threatened to leak beyond the boundaries of social hierarchy embedded in the response of Winnipeg's elite to the disease. These issues are broached in Chapter 3.

The second layer, the subject of Chapter 5, examines the nature of the epidemic experience among working families. It asks how the working class and poor coped with the epidemic's disruption to their livelihoods and family life. Influenza was not democratic in its effects; those lower in the social hierarchy suffered greater hardship. Influenza threatened the fragile framework of survival for many working families, but it also created among immigrant and working class communities a heightened awareness of their mutual reliance, and their ability to sustain themselves in a time of crisis. As Evan Stark argued twenty-five years ago, epidemics can act as a theatre or stage for "collective self-recognition and for the reconstruction of collective identities."⁵ Such an awareness replayed itself in essential neighbourhood support for the 1919 Winnipeg General Strike.

Attention to the family as a site of disease management reveals not only how ordinary people lived through the epidemic moment, but also how the disease shaped their future

⁵ Evan Stark, "The Epidemic as Social Event," *International Journal of Health Services* 7, 4 (1977), p. 687.

lives. A critical reason for influenza's enormous impact was that it left so many broken and separated families, single parents, and orphaned children. Chapter 6 of this study follows mothers, fathers, and children through time to see how they reshaped their lives, exploring the material and emotional impact of influenza in the years after the epidemic's passing. The case files of the Manitoba Mothers' Allowance program and the Winnipeg Children's Home have made it possible to view in some detail the challenges influenza posed to families. They also demonstrate the enormous burden the epidemic placed upon both private and state social welfare institutions from 1918 through the 1920s. Indeed, the Mothers' Allowance program in Manitoba was dramatically altered in scale and scope as a result of the epidemic.

These chapters clearly reveal that the worlds in which the wealthy and the poor battled disease were vastly different. The third layer of this study examines class and ethnic conflicts generated by the epidemic, particularly the response of Winnipeg's labour movement, the subject of Chapter 4. Labour expressed an awareness of the unequal and unjust impact of influenza in its demand that "men cannot be allowed to starve in an epidemic." In this message of citizenship and entitlement, labour argued that the state had an obligation to provide for the families of breadwinners taken off the job by public health measures, and for the surviving family members of influenza victims. It is one of the most revealing paradoxes of the influenza epidemic that labour appeared not weakened by its losses, but strengthened. Despite convictions held by health officials and reformers that working class and immigrant neighbourhoods were helpless, incapacitated, and powerless in the face of the disease, the labouring people of Winnipeg in fact mobilized to defeat an incumbent mayor at the polls, and elected a record number of

labour city councilors in November 1918. On the heels of a successful general strike vote taken in October 1918, workers again voted for a sympathetic general strike in support of building and metal trades workers in May 1919, setting off the largest labour confrontation in Canadian history.

Influenza lay over these pivotal events in the history of working class and ethnic Winnipeg like a fog, more *zeitgeist* than catalyst. It permeated the family, working life, friendship, and labour activism of thousands. The experience of influenza was melded into these extraordinary times, which included the Armistice and the end of a long brutal war. Canadian war novelist Will Bird's *And We Go On* depicts the young soldier Tommy longing to join his fallen comrades beneath the white crosses in France. His death follows, not in battle, but of influenza, a few days after the Armistice.⁶ The inseparability of influenza and the close of the war is again movingly captured by Jay Winter in *Sites of Memory, Sites of Mourning*. Describing the death from influenza of avante-garde French poet, Guillaume Apollinaire, Winter writes that when Apollinaire lunched with his friend, the poet Blaise Cendrars, on November 3 1918, they chatted of "the subject of the day, the epidemic of Spanish flu which had more victims than did the war."⁷ By November 9, Apollinaire was himself dead of influenza. His funeral took place on the 11th, the day of Armistice. Cendrars later spoke of the confused grief that made him unable to absorb the reality of his friend's death even thirty years later: "It was fantastic ... Paris celebrating.

⁶ For a discussion of *And We Go On*, see Jonathan Vance, *Death So Noble: Memory, Meaning, and the First World War* (Vancouver: UBC Press, 1997), p. 194-196.

⁷ Jay Winter, *Sites of Memory, Sites of Mourning: The Great War in European Cultural History* (Cambridge: Cambridge University Press, 1995), p. 21.

Apollinaire lost. I was full of melancholy. It was absurd." Civilians and soldiers alike, who died in warfare or of disease, "inhabited not the kingdom of the dead, but the kingdom of the shadows."⁸

Influenza Crosses the Globe

The 'Spanish' flu arrived in Winnipeg at the end of September 1918, and lingered into the spring of 1919. Nearly 1300 Winnipeggers died during the epidemic, and many thousands were infected.⁹ According to data published in 1919 by Major F.T. Cadham, at the peak of the epidemic in early November, there were nearly 700 new cases reported daily.¹⁰ The disease reached the city on the second of its three global waves. The first, spring¹¹ wave has been traced to a military camp in Kansas, which experienced an epidemic beginning on 5 March 1918. The first wave spread across much of Europe in the spring, reaching North Africa, India, China, and Australia by July. The second wave, by far the deadliest, has been traced to France. It very rapidly spread across the globe in the fall of 1918, carried along by trade and transportation routes and by demobilizing soldiers. A less severe third wave followed early in 1919.¹² The reasons for the virility of

⁸ Ibid., p. 20.

⁹ These statistics are only for what was then the City of Winnipeg, and do not include suburbs such as St. James, St. Boniface, or Transcona.

¹⁰ Frank Cadham was a colleague of Dr. Gordon Bell's at the Provincial Laboratory, who enlisted with the Canadian Expeditionary Force. See his article "The Use of a Vaccine in the Recent Epidemic of Influenza," *The Canadian Medical Association Journal* 9 (1919), p. 525.

¹¹ The seasons referred to here and elsewhere are the seasons in the northern hemisphere.

¹² Patterson and Pyle; Johnson and Mueller.

the fall wave are still unknown. Some scientists have proposed that an initial virus mutated in France into a new form to which there was little prior immunity.¹³

Victims of influenza generally fell into two categories. There were those who became relatively mildly ill and recovered within a few days, and those who after a few days developed respiratory complications and often died. Initial symptoms could be mild. They included "general depression," chills, fever, headache, pain in the legs and back, weakness and dizziness, sore throat and congestion. As one contemporary noted, "The natural variations in the course of the disease are legion, our influence on them is problematical."¹⁴ In some cases, these symptoms intensified: fevers reached 105 degrees or higher, and were accompanied by nausea and frequent vomiting; patients developed respiratory infections (bronchitis and pneumonia), with cyanosis resulting either from decreased oxygen in the blood, or from toxic effects in the body. In some cases, the entire body turned a lilac hue. Patients breathed very rapidly, and had profuse nosebleeds. The pulse slowed and blood pressure lowered, indicating circulatory failure. One Canadian military physician noted the "indescribable foeter" of the patients,¹⁵ an odour that was also described as "pungent", like very musty straw.¹⁶ In its later stages, the disease also

¹³Some scientists argue that the two waves, if not the identical virus, were certainly caused by related viruses. Patterson and Pyle (p. 8) have observed lower overall mortality rates in parts of the world where the population was exposed to the first wave.

¹⁴C.E. Cooper Cole, "Preliminary Report on Influenza Epidemic at Bramshott in September-October 1918," *Canadian Medical Association Journal* 9 (1919), p. 48.

¹⁵ *Ibid.*, p. 42.

¹⁶ Phillips, p. 130.

affected the nervous system, and both psychosis and delirium were noted. Some physicians believed suicides could be linked to the disease. Many patients experienced palsy or partial paralysis. After the epidemic had abated, physicians noted these nervous system effects, leading to a conjecture that one reason for the deadly quality of the virus may have been a possible relation to encephalitis. (An epidemic of encephalitis lethargitis (swelling of the brain) followed the flu.)

Basic nursing care—keeping the patient clean, warm and fed—could make a difference for influenza sufferers, but medicine provided no efficacious therapy. This should not be surprising since little was known about the etiology of the disease. During the influenza pandemic of 1889-1890, the German scientist Richard Pfeiffer had discovered a particular bacterium in the throats of those suffering from the disease. He argued that this was the causal agent of influenza, and it was appropriately named Pfeiffer's influenza bacillus. But there was no overall consensus that this bacillus was the disease agent. Again in 1918, many flu sufferers were found to have Pfeiffer's bacillus present in their throats and sputum, although this was not always the case. Attempts to infect animals and humans with influenza using Pfeiffer's bacillus were generally unsuccessful. To add to the confusion, most patients had streptococci, pneumococci, and staphylococci present in their bodies as well.¹⁷ Some scientists suspected that influenza was a "filtrable virus," but contemporary knowledge and technology were inadequate to establish the existence of an influenza virus at this time.¹⁸

¹⁷ Cadham, p. 519-520.

¹⁸ Beveridge, p. 2-3.

Physicians were frustrated by their inability to treat influenza effectively. "Our attempts at therapy were exercises in futility," one recalled.¹⁹ Since sulpha drugs or antibiotics had not yet been discovered, complications such as pneumonia were deadly. Nevertheless, medical practitioners did attempt to cure their patients. The range of treatment options was wide, and presented a distinct nineteenth century character. Venesection (blood letting) was sometimes used to relieve toxemia, along with injections of saline or glucose/saline combinations, either interstitially or intravenously, or "per rectum".²⁰ Oxygen was given to those suffering from bronchial infection where facilities were available. Enemas were used, as well as turpentine, for relieving abdominal distention. Alcohol was often administered as a stimulant, as were strychnine and atropine. Some were convinced that camphor in oil had some positive effect, although patients often died in any case. If sedation was needed, cool sponging was a mild treatment; more interventionist was the use of various pharmacological preparations, including veronal, codeine, heroin, and morphine. Milder pain was treated with aspirin. Chest pain was relieved through the use of mustard leaves, plasters and poultices, and 'cupping'.

Home remedies were likewise numerous. Eileen Pettigrew's research among flu survivors demonstrates the variety of ways people attempted to both prevent and treat the flu. Some wore cotton bags holding a lump of camphor, or mothballs, around the neck to prevent infection.

¹⁹ Isaac Starr, "Influenza in 1918: Recollections of the Epidemic in Philadelphia," *Annals of Internal Medicine* 85 (1976), p. 516-518.

²⁰ Cole, p. 47.

Some people put their faith in violet-leaf tea, goose-grease poultices, garlic buds, castor oil, salt water snuffed up the nose, or hot coals sprinkled with sulfur or brown sugar and carried through the house accompanied by clouds of billowing smoke. A sip of oil of cinnamon allowed to seep around the tonsil area could do no harm, or one could try a mixture of warm milk, ginger, sugar, pepper, and soda for a soothing drink.²¹

Those with symptoms of chest congestion and pain were treated with chest poultices, made of hot bran, lard mixed with camphor and chloroform, or lard mixed with turpentine. Sore throats were treated by one New Brunswick woman by steeping dried hops leaves in vinegar, and applying them damp to the throat.²²

A decade ago David Patterson and Gerald Pyle published the data generally accepted by historians as a good estimate of global mortality. They suggested that the pandemic probably resulted in 30 million deaths. This was a significant increase from the estimate of 21.5 million reached by Edwin Oakes Jordan in the 1920s.²³ The results of recent research, however, would seem to demand that this estimate again be increased: 50 million is now the proposed figure.²⁴ The limitations of statistics on influenza morbidity and mortality are well recognized; they are known to be “inconsistent and of questionable validity, accuracy, and robustness”²⁵ given the inadequacy of reporting and recording of health and mortality data in the past. Yet, if anything, the data are likely to reflect an

²¹Eileen Pettigrew, *Silent Enemy: Canada and the Deadly Flu of 1918* (Saskatoon: Western Producer Prairie Books, 1983), p. 110.

²²*Ibid.*, p. 115.

²³ Edwin Oakes Jordan, *Epidemic Influenza: A Survey* (Chicago: American Medical Association, 1927).

²⁴ Johnson and Mueller, p. 115.

²⁵ *Ibid.*, p. 107.

underreporting of deaths through nonregistration, lost records, and misdiagnosis.²⁶ As Johnson and Mueller have recently argued, the most sensible approach to the statistics is not to ignore them, but to recognize their limitations. This is the approach taken toward mortality data for Winnipeg, which are discussed in detail in the following chapter.

Much of the most recent work being done on the influenza pandemic covers not Europe and North America, but the colonial world.²⁷ It is clear that northern countries suffered far lower death rates than did many nations in Africa and Asia. Patterson and Pyle conclude, "poor populations suffered more than wealthier ones with better food and shelter. Differential access to health care probably also had some impact; there was no specific therapy for influenza or its complications, but supportive care was useful."²⁸ Estimates suggest there were between 14 and 18 deaths per 1000 population in Africa, with sub-Saharan Africa losing as many as 23 per 1000 population. The average death rate for the Asian continent is in the 20 to 34 per 1000 range. British India (including what is now Pakistan and Bangladesh) experienced 18 million deaths; this staggering number reflected the size of its population. The average rate for Europe is thought to be 4.8 deaths per 1000 population; for Canada, the figure proposed is 6.2 per 1000, based upon a likelihood of 50,000 deaths.²⁹ The overall effect of influenza is clear in a

²⁶ Ibid.

²⁷ For a compendium of these studies see the sources used by Johnson and Mueller.

²⁸ Patterson and Pyle, p. 13.

²⁹ Patterson and Pyle, p. 14-15; Johnson and Mueller, p. 111 – 114.

comparison of Canadian death rates for 1917, 1918, and 1919, which were 12.7, 15.9 and 13.7 per 100,000 respectively.³⁰

Some comparisons between death rates in Winnipeg, Canada, and other countries are provided in the following table.³¹

Table 1:
Comparative Mortality in the Influenza Pandemic

Location	Death Rate
Cameroon	445.0
Western Samoa	236.1
South Africa	44.3
Indonesia	30.4
Nigeria	24.2
Mexico	20.6
New Zealand	<20.0
Spain	12.3
Italy	10.7
Egypt	10.7
France	7.3
Winnipeg	6.6
United States	6.5
Canada	6.1
India	6.1
England and Wales	5.8
Finland	5.8
Norway	5.7
Germany	3.8
Australia	2.7

This table shows some of the extreme variation in experiences with the disease. Even these averages, however, mask differences in mortality by region or community, race, ethnicity, and class. There is ample evidence, for example, that indigenous peoples had appalling death rates from influenza, as they had from other epidemic diseases since the

³⁰Dicken McGinnis, p. 458.

³¹ This table is constructed from data in the tables in Johnson and Mueller, p. 110 – 114.

beginning of colonization. The Maori in New Zealand, for instance, had a death rate of 42 per thousand population.³² Some indigenous communities suffered even greater losses. According to Ann Herring's research, one-fifth of the population died during six weeks of the epidemic in Norway House (a Cree/Métis community in northern Manitoba), a death rate of 183 per thousand, compared with a death rate of 26 per thousand for the preceding decade.³³ This extraordinary mortality was probably due to the fact that the community had few provisions on-hand, and relied upon hunting and fishing to maintain the food supply. The northern climate was also perilous for the ill, who could not keep their homes warm, as was the isolation of the communities. Herring describes the tragedy Norway House faced:

Village life undoubtedly broke down when the flu struck and entire families would have been without an able-bodied individual to feed them or keep the fire going in the cold, subarctic winter. Many of the ill contracted pneumonia after going out to replenish dwindling food and fuel supplies, dying shortly thereafter.³⁴

First Nations in British Columbia experienced a death rate of 46 per one thousand population, compared with a death rate in the non-Native communities of 6.21 per one thousand.³⁵ The devastation of the epidemic figures prominently in published histories written by First Nations people.

³² Johnson and Mueller, p. 114.

³³ Herring, p. 88.

³⁴ Ibid., p. 90.

³⁵ Kelm, p. 25. This figure is likely low due to inadequate record keeping on the health of Aboriginal peoples and underreporting of the disease.

The isolation of a still largely rural Canadian population could pose a potential barrier against contagion in some cases, but if a community was struck, being far away from help could be fatal. Eileen Pettigrew's popular history of influenza in Canada, *Silent Enemy*, quotes the journal of Reverend Henry Gordon, who gave the following account of the epidemic at Grenfell Mission on the Labrador Coast:

It has struck the place like a cyclone, two days after the Mail boat had left. After dinner I went on a tour of inspection among the houses, and was simply appalled at what I found. Whole houses lay inanimate all over their kitchen floors, unable to even feed themselves or look after the fire ... I think there were just four persons in the place who were sound... A feeling of intense resentment at the authorities, who sent us the disease by the Mail-boat, and then left us to sink or swim, filled one's heart almost to the exclusion of all else. The helplessness of the poor people was what struck to the heart ... It was very upsetting, people crying, children dying everywhere.³⁶

Villagers and homesteaders on the prairies faced similarly frightening circumstances. Maureen Lux describes the impact of influenza on a village near Battleford, Saskatchewan:

The general store at Paradise Hill sat empty except for the dead bodies of the store-keeper and his wife. Inside a nearby tent there were three more victims. The eerie silence was only broken by the sounds of a young boy digging graves for his dead mother, father, brother and sister.³⁷

Rural residents had little or no access to physician or nursing care. The province had few hospitals in rural areas, and distance and poor communication hampered volunteer efforts to help. In Saskatchewan, rural death rates were nearly twice the provincial rate, at more

³⁶Pettigrew, p. 25-27.

³⁷ Lux, p. 3

than 10 deaths per thousand.³⁸ The provincial health bureau received disturbing reports of starving livestock with no one to tend them, and entire families found dead.

These differential impacts of influenza suggest the importance of factors such as access to medical care, the quality of living conditions, and the overall level of health and disease resistance of groups within the population in shaping influenza mortality. Such factors were critical in urban settings as well. Some historians have argued that influenza killed without regard for social or economic hierarchy; that the pace of its spread and its extremely contagious nature left little opportunity for class, gender, or racial/ethnic divisions to emerge in the pattern of disease morbidity and mortality. Despite the observation that poor and colonized nations suffered extremely, Patterson and Pyle argue against poverty as an important factor within developed countries: "Influenza advanced so quickly that the urban hierarchical effects common to many diffusion processes were not important."³⁹ Likewise, Alfred Crosby, author of the most comprehensive general history of the pandemic in the United States, concludes, "by and large the rich died as readily as the poor."⁴⁰ Geoffrey Rice's work on New Zealand rejects the popular memory of the class-based impact of influenza in Christchurch:

Probably the most enduring and often-encountered feature of popular recollections of the influenza epidemic in Christchurch is the belief that most deaths occurred in Sydenham [a working class suburb] and amongst working class people. ... there is no clear evidence that the epidemic hit any particular

³⁸ Ibid., p. 8.

³⁹ Patterson and Pyle, p. 21.

⁴⁰ Crosby, p. 227. Sandra Tomkins argues that the disease in Britain "was remarkably democratic in its victims." See "The Failure of Expertise: Public Health Policy in Britain During the 1918-1919 Influenza Epidemic," *Social History of Medicine* 5, 3 (December 1992), p. 446.

social group harder than another; the distribution reflects the proportions of the population at large.⁴¹

Examining the spatial distribution of mortality in Christchurch, Rice concludes that it was highest in areas of poor quality housing, such as tenement or cottage housing; and in areas of the city known for poor sanitation:

... there seems a reasonable case for correlation between unsanitary housing and lower levels of general health and hygiene among the inhabitants of such areas. Assuming widespread primary infection, people living in such conditions would tend to have lower resistance to pneumonic complications. The importance of housing quality and sanitation as a factor in at least some of the epidemic deaths seems undeniable, in view of the fact that ... population densities do not always correlate with concentrations of mortality.⁴²

On the basis of a single source (a public health nurse Rice refers to as a "legendary figure") he goes on to argue that middle class homes were as likely to be unsanitary as those of the working class and poor. He concludes that, "unlike cholera," influenza did not distinguish by class.⁴³

Yet, there is considerable evidence that socio-economic status did have an impact. Contemporary anecdotal reports and statistical analysis in the United States, for example, strongly suggest that working class and immigrant districts of large and medium-sized urban centres had difficulty addressing the scale of infection in their communities, and that death rates in these areas were disproportionately high. Alfred Crosby provides two community studies dealing with the epidemic in Philadelphia and San Francisco. The flu

⁴¹Geoffrey Rice, "Christchurch in the 1918 Influenza Epidemic: A Preliminary Study," *New Zealand Journal of History* 13, 2 (1979), p. 124.

⁴²Rice, p. 126.

⁴³ Geoffrey Rice, *Black November: The 1918 Influenza Epidemic in New Zealand*, p. 144.

had hit Philadelphia fully by early October, causing 2,600 deaths the second week of October and 4,500 the following week. Estimates of those struck with the flu rose into the hundreds of thousands. The shortage of medical and nursing personnel, hospital beds, and other social services was overwhelming, and nowhere was this worse than in the poor immigrant areas of the city. Crosby writes:

In the best of times the doctors, nurses, and social workers who worked in the vast slums of Philadelphia and the other great cities of eastern America were pitifully few. Now they were absurdly unequal to the problems facing them and often sick themselves. The recent immigrants they served, more often than not young adults, were, of course, especially susceptible to the 1918 flu. ... Visiting nurses often walked into scenes resembling those of the plague years of the fourteenth century. They drew crowds of supplicants - or people shunned them for fear of the white gowns and gauze masks they often wore. They could go out in the morning with a list of fifteen patients to see and end up seeing fifty. One nurse found a husband dead in the same room where his wife lay with newly born twins. It had been twenty-four hours since the death and the births, and the wife had had no food but an apple which happened to be within reach.⁴⁴

Mortality statistics for Philadelphia reflected these conditions:

... the pandemic had struck heavily everywhere, but somewhat more heavily in the immigrant slums than elsewhere in the city. In fact, some 1,500 more of those with mothers born abroad had died than those with mothers born in the United States. Especially susceptible had been those with mothers from Scandinavia, Austria, Russia, Hungary, and Italy.⁴⁵

Similarly, in San Francisco the poor and recent immigrants were the hardest hit. Their living conditions were deficient, and overcrowding was a serious problem in Chinatown

⁴⁴Crosby, p. 76. For a study that explores some of the factors involved in immigrant experience of influenza see Robert Katz, *op cit*. Katz argues that many recent European immigrants to America had come from rural areas, and therefore were less likely to have acquired immunity from earlier influenza epidemics, particularly that of 1889-90. He also sees crowded and poor quality housing, unhealthy working conditions, and strenuous manual labour as important factors. (p. 420-21).

⁴⁵Crosby, p. 87.

and other immigrant districts. Crosby argues that poor communication between city authorities and Chinese immigrants led to large numbers of unreported flu cases.⁴⁶ Limited assistance was therefore available from the usual sources. A disproportionate number of immigrants died, Italian and Irish immigrants in the greatest number, according to available data.⁴⁷

A study based upon questionnaires administered by enumerators to 100,000 “white” Americans in the 1920s by the United States Public Health Service concluded, “there were marked and consistent differences in [influenza’s] incidence among persons of different economic status.”⁴⁸ This study is rare for its statistics on the numbers of individuals infected with influenza; data on infection rates are normally notoriously understated because so few cases were actually reported to health authorities. The study gives a clear sense of the scale of influenza infection: probably three out of every ten Americans became ill with the disease. But the financially secure were apparently less likely to develop influenza. The morbidity rate for the most “well-off” was 252 per thousand population; that for the “very poor” 365 per thousand.⁴⁹ And the middle and upper classes were less likely to suffer mortality as well. After allowing for differences in

⁴⁶ For a fascinating study of the labeling of San Francisco’s Chinese immigrants as a source of contagion in this period, see Nayan Shah, *Contagious Divides: Epidemics and Race in San Francisco’s Chinatown* (Berkeley: University of California Press, 2001), Chs. 1 and 2.

⁴⁷ Crosby, p. 96,99.

⁴⁸ Edgar Sydenstricker, “The Incidence of Influenza Among Persons of Different Economic Status During the Epidemic of 1918,” *Public Health Reports* 46, 4 (1931), p. 155.

⁴⁹ The study divided households into four categories based upon the enumerator’s “impression of its economic condition” at the time of “her” visit: well-to-do, moderate, poor, and very poor.

age distribution in different classes, the study found that the death rate was one-third higher among the poor than the more well-off, and nearly three times as high among the very poor. Although there are no detailed epidemiological studies of the influenza epidemic in Canadian cities, sources similar to Alfred Crosby's suggest that the disease had a particularly severe impact among the working class and immigrants in Canada as well.⁵⁰ According to published data from Winnipeg's health department, working class, immigrant districts of the city had a higher death rate than did the wealthier areas.⁵¹

The inequality of influenza's diffusion and impact raises some important questions about the role the disease played in workers' unrest and militancy in Winnipeg following the First World War. The existing literature provides few points of comparison. Maureen Lux refers to influenza as the "midwife" of industrial unrest, arguing that the epidemic highlighted the lack of adequate housing and medical care available to workers. In May 1919, 1,200 to 1,400 Saskatoon workers went on strike in sympathy with the Winnipeg General Strike. Among them were the city's Teamsters, who had received only limited sick leave during the influenza epidemic, compared with much more generous provisions for salaried civic employees. In March 1919, the Teamsters complained to city council that "if sickness or any other unforeseen thing overtakes us, we either have to borrow or fall on charity, which does not seem fair after the long hours of toil we put in for just our daily bread."⁵² Given the many revolutionary and reformist movements emerging around

⁵⁰ Kelm, p. 33; Lux, p. 10-11. An exception is Margaret Andrews, p. 25. Andrews states that "unlike such communicable diseases as tuberculosis and typhoid fever, influenza did not show a clear preference for the poorly fed and poorly housed." She presents no data, however.

⁵¹ These data will be discussed in more detail at the conclusion of Chapter 2.

⁵² Lux, p. 11.

the globe in this period, it is worthwhile for historians to question whether influenza played a part in creating the necessary conditions for revolt.

Social Context

The defining symbol of early twentieth century Winnipeg is the one hundred and twenty five miles of tracks in the rail yards that marked a boundary between the prosperous bourgeois Anglo-Canadian world south of the tracks, and the slums of British and European immigrants and workers on the north side. Gerald Friesen has described Winnipeg at the beginning of the twentieth century as “the most volatile of Canadian communities notorious for the aggressive self-confidence of its capitalists and for the gulf that separated the north end [and other] working class districts, from the more prosperous neighbourhoods south of the Assiniboine River.”⁵³ The term ‘North End’—Foreign Quarter’, ‘CPR Town’⁵⁴, or, ‘Jewtown’ in the more nativist press⁵⁵—was (and remains today) symbolic, not merely denoting a geographic location. The district has been depicted in works of literature like John Marlyn’s *Under the Ribs of Death* as a

⁵³ Gerald Friesen, *The Canadian Prairies: A History* (Toronto: University of Toronto Press, 1984), p. 361.

⁵⁴ Alan Artibise, *Winnipeg: A Social History of Urban Growth, 1874-1914* (Montreal: McGill-Queen’s University Press, 1975), p. 158.

⁵⁵ Henry M. Trachtenberg, “The old clo’ move:” Anti-Semitism, Politics, and the Jews of Winnipeg, 1882-1921 (Ph.D. dissertation, York University, 1984), p. 168.

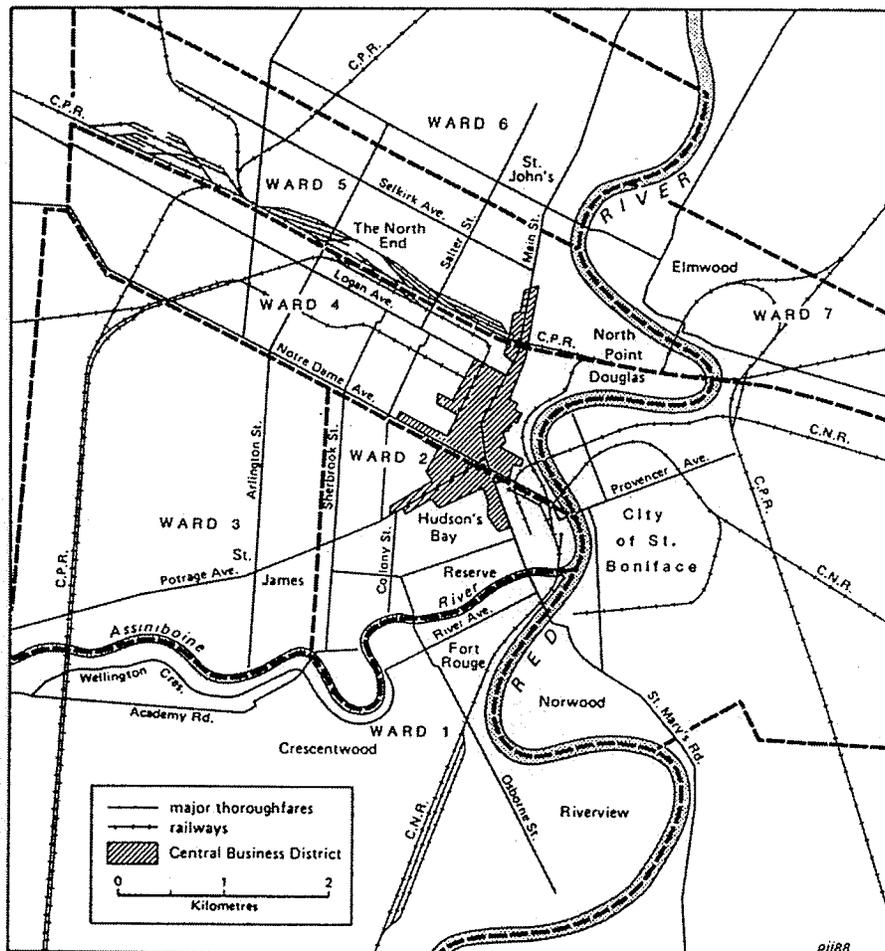


Figure 1: Winnipeg Streets and Ward Boundaries⁵⁶

“dirty, foreign neighbourhood ... an endless grey expanse of mouldering ruin.⁵⁷ Using food as its point of reference, James Gray’s popular memoir, *The Boy From Winnipeg* recalls that “in the North End we were seldom much beyond range of the odour of garlic;

⁵⁶ Daniel Hiebert, “Class, Ethnicity and Residential Structure: the Social Geography of Winnipeg, 1901-1921,” *Journal of Historical Geography* 17, 1 (1991), p. 16.

⁵⁷ John Marlyn, *Under the Ribs of Death* (Toronto: McClelland and Stewart, 1957, reprinted 1993), p. 9. Marlyn emigrated from Hungary as an infant with his parents, in 1912. He grew up in the north end.

in [South End] Fort Rouge the smell was unknown.”⁵⁸ At the end of the First World War, spatial segregation was based upon the intersection of ethnicity and class. The majority of the residents in wards 4, 5, and 6 were working class; 71 percent of all unskilled workers resided in the area north of Notre Dame Ave. At the same time, almost all European immigrants lived north of the Canadian Pacific Railway yards.⁵⁹

The north end was Winnipeg’s *terra incognita*.⁶⁰ It was a place apart, virtually unknown to most in the middle and upper classes, physically isolated from the southern part of the city by the rail yards, which were often clogged with the freight and passenger trains that limited freedom of movement across the city. The wealthy and poor lived in “largely separate worlds.”⁶¹ As a result, as Winnipeg historian Alan Artibise noted nearly thirty years ago, “the image of the north end held by those living in the rest of the city was rarely disturbed by reality.”⁶²

The city experienced two decades of very rapid population growth around the turn of the twentieth century: 1881-1891 and 1901-1911. Before the outbreak of war stopped immigration, Winnipeg attracted many migrants from Britain and Europe. Alan Artibise has calculated that 84% of the city’s population growth in the years 1890 – 1914 was due

⁵⁸ James H. Gray, *The Boy From Winnipeg* (Toronto: Macmillan, 1970), p. 11.

⁵⁹ Hiebert, p. 70-73. German and Scandanavian immigrants settled in the central neighbourhoods of the city, and in Elmwood.

⁶⁰ The term is Gareth Stedman Jones’s to describe working class London. See *Outcast London: a Study in the Relationship Between Classes in Victorian Society* (Oxford: Oxford University Press, 1971), p. 14.

⁶¹Hiebert, p. 61.

⁶²Artibise, p. 160.

to in-migration. It should be remembered, however, that the city in this period remained as a whole dominated by Anglo-Canadians. In 1916, 52 percent of Winnipeggers were foreign-born, but over half of these immigrants were British. (Another 14 percent were Slavic immigrants, another 8 percent Jewish). Anglican and Presbyterian faiths were preponderant. Immigrants of non-British backgrounds were, nonetheless, increasingly shaping Winnipeg's urban milieu, and in particular its working class neighbourhoods. European migrants gave the north end of the city in particular a cosmopolitan, multi-ethnic ambiance. A vast majority of Winnipeg's Jewish population, its Slavs and Scandinavians, lived north of the tracks, as did nearly one quarter of Germans.

The railway yards were the centres of industrial and manufacturing activity, employing workers at sawmills, in light manufacturing (such as tractors), bridge and iron works, scrap yards, machine shops, concrete manufacturers, and offices and services to support these operations. To the east of Main Street in Point Douglas were the meat packing plants and the flour mill. Because of limited transportation, many workers lived in the vicinity of these workplaces, "in a maze of buildings and tracks, noise, dirt, and smell," according to Alan Artibise.⁶³

Developers took advantage of the demand for inexpensive housing north of the railway, building small houses on small lots, organized along a monotonous grid pattern. There were few parks or green spaces. Cheap building materials were common, usually wooden frame, with few brick dwellings constructed. Tenements were also built to house the maximum number of workers and their families for the lowest cost. Despite the poor

⁶³ Artibise, p. 159.

quality of much of the district's housing, however, it was still too expensive for many working families. In 1908, city investigators discovered that the average cost of a wood frame house was \$3,000. Earning on average \$500 per year, unskilled workers could not afford to own homes. Average rental in that year was \$20 per month, which, again, given an annual income of \$500, would have constituted a considerable portion of the working family's budget.

By 1921, most workers of British origin lived outside of the north end⁶⁴ in districts surrounding the Canadian Northern Railway yards at the end of Logan Avenue; in central Winnipeg, between the commercial district and the Assiniboine River; and in Elmwood and Transcona, suburbs to the east. St. James, to the west, had developed into a working class suburb by the end of the war. It is here where protagonist Craig Forrester, a war veteran, goes to visit his fellow soldier Jimmie Dyer, in Douglas Durkin's novel *The Magpie*.⁶⁵

Working families were often mobile, moving in and out of the north end as their income and circumstances permitted. James Gray recalls in his memoir *The Boy From Winnipeg* that slight improvements in his family's fortunes led them to move, first out of the north end into central Winnipeg, then across the river to Fort Rouge. John Marlyn's *Under the Ribs of Death* notes similar mobility among European immigrants, although

⁶⁴ Hiebert, p. 73.

⁶⁵ Jimmie Dyer dies of a mysterious illness, described as a heart ailment (not influenza) not long after Armistice, leaving a widow and young child. This loss radicalizes Dyer's widow, Millie. Douglas Durkin, *The Magpie* (Toronto: Hodder and Stoughton, 1923). For an analysis of the *The Magpie* that outlines the novel's exploration of class relations at the close of World War I, see Robert Wardhaugh, "A Real Time and Place: Douglas Durkin's Post-War Winnipeg," *Prairie Fire* 20, 2 (Summer 1999).

they tended to move to better areas within the north end. The north end was by no means monolithically poor. Neighbourhoods generally improved in economic status the further away from the railway lines.

In residential districts close to the Assiniboine River, the very rich and the working class lived no great distance apart. As a boy, Gray delivered newspapers to the bourgeois families living within easy walking distance of his own family's apartment blocks. He recalls being baffled by the wealth of the residents of Armstrong's Point, and going through his newspaper subscription list with his father, learning an unsatisfactory lesson in the class divisions of his world:

There's Thomas Ryan, the big shoe merchant who owns that big building behind the fire hall ... Mr. Bain has that big wholesale company, and Lady Schultz. Her husband was a wealthy doctor. And look, here is Mr. Speirs of Speirs-Parnell the bakers ... and Sir Charles Tupper the famous lawyer ... and the Reverend C.W. Gordon the famous author and Senator McMeans who is a rich politician." ... My father had heard of practically everybody on my route. But merely identifying the subscribers begged my question: How did people get rich enough to live in such houses? ... I fell asleep night after night searching for the answer to that question. It never came.⁶⁶

During the First World War, economic conditions for many working families in prairie cities were, as John Herd Thompson argues in *The Harvests of War* "almost as desperate as those of the recession which preceded it."⁶⁷ In 1914, the region remained in an economic downturn that had lasted two years, with devastating impacts upon workers in Winnipeg, culminating in a public protest by the unemployed in May 1914. The over

⁶⁶ Gray, p. 123.

⁶⁷ John Herd Thompson, *The Harvests of War: the Prairie West, 1914-1918* (Toronto: McClelland and Stewart, 1978.), p. 47.

reliance on the export of wheat had caused problems in the agricultural economy. Railway construction had largely stalled, and the operations of the railways themselves were financially compromised. Financial credit was tight, restricting investment. These economic realities led to large numbers of railway employees being laid off or having their work week shortened. The outbreak of the war did nothing to improve the situation. Most of the firms in industries that benefited from the war were located in the East, and had little effect on employment on the prairies. For example, a Commission of Immigration report in the spring of 1915 found about two thousand skilled British tradesmen (engineers, boiler makers, machinists, electricians, iron moulders, etc.) unemployed in Winnipeg. There is evidence that an exodus of these skilled workers from Winnipeg took place at the time.⁶⁸

Ethnic minorities in Winnipeg faced heightened discrimination. All Austro-Hungarian subjects, including Ukrainians from Galicia and Bukovina, were considered 'enemy aliens' and suffered disenfranchisement, compulsory registration and monitoring, internment in labour camps, and censorship of their publications. These wartime measures were by no means inconsistent with prevailing attitudes toward southern and eastern European immigrants.⁶⁹ As Mariana Valverde and others have demonstrated, belief in the racial superiority of Canadians of Anglo-Saxon ancestry was not confined to a nativist fringe, but was rather deeply embedded in the thinking of social purity and reform movements in this period, and linked to fears of miscegenation and racial

⁶⁸ Ibid, p. 56.

⁶⁹ Ibid., p. 74-90; Donald Avery, *Dangerous Foreigners: European Immigrant Workers and Labour Radicalism in Canada, 1896-1932* (Toronto: McClelland and Stewart, 1979), p. 65-89.

degeneration.⁷⁰ In the context of heightened tensions during wartime, and growing labour radicalism, European immigrants were also viewed as a source of social disruption and disorder.

Although an improved labour market situation beginning in 1917 could have raised living standards for workers, inflation was seriously eroding buying power by the end of the war. Tracing the wages of several categories of male workers (some unionized, others not), and establishing the cost of an average 'basket' of twenty eight consumer goods (food items, fuel, and rent), Harry Sutcliffe has generated a consumer price index for the period 1910 to 1920. His study also measures real income by calculating the changes in the purchasing power of wages. From 1910 to 1919, the cost of living rose by nearly 68 percent. During the war, between 1915 and 1918, costs increased by 42 percent; if the cost of clothing is included, the increase was nearly 47 percent. These increases would not have been so severely felt had not wages remained largely stagnant. In reality, working families were having to cope with extremely rapid increases in the cost of basic necessities, without any commensurate improvement in income. Throughout the war, there were fuel shortages, and people were forced to use less efficient, more expensive,

⁷⁰ Mariana Valverde, *The Age of Light, Soap, and Water: Moral Reform in English Canada, 1885-1925* (Toronto: McClelland and Stewart, 1991) and "'When the Mother of the Race is Free': Race, Reproduction, and Sexuality in First-Wave Feminism," in Franca Iacovetta and Mariana Valverde, eds., *Gender Conflicts: New Essays in Women's History* (Toronto: University of Toronto Press, 1992); Howard Palmer, *Patterns of Prejudice: A History of Nativism in Alberta* (Toronto: McClelland and Stewart, 1982); Angus McLaren, *Our Own Master Race: Eugenics in Canada 1885-1945* (Toronto: McClelland and Stewart, 1990). For racism directed against Asian Canadians in Western Canada, see James W. St.G. Walker, "A Case for Morality: The Quong Wing Files," in Franca Iacovetta and Wendy Mitchinson, eds., *On the Case: Explorations in Social History* (Toronto: University of Toronto Press, 1998); Madge Pon, "Like a Chinese Puzzle: The Construction of Chinese Masculinity in *Jack Canuck*," in Joy Parr and Mark Rosenfeld, eds., *Gender and History in Canada* (Toronto: Copp Clark, 1996).

and dirtier lignite coal to heat their residences. Coal shortages in the winter of 1918-1919 made it likely that many influenza victims were suffering in underheated homes.⁷¹

Sutcliffe traces what happened to the real income (wages adjusted by cost of living) of several groups of workers, including the building and metal trades, printing trades, electric street railway workers, and municipal employees. With the exception of some metal trades workers, such as blacksmiths, who won considerable wage increases after they struck in 1918, workers across these categories experienced sharp declines in real income after 1915. Significantly, the bottom of the real income curve was in most cases reached in 1918 or 1919, the winter of the epidemic. This period, then, was one of severe financial crisis for Winnipeg workers and their families.

Many families survived the hardship of the war years without a male breadwinner. Soldiers' wives were eligible for allowances through the Canadian Patriotic Fund. These were, however, below the accustomed income of many working class women. Wives were subject to strict regulation and inspection from middle class women administrators.⁷² Women stretched household budgets, and pressured the federal government to control prices. James Gray recalls the popularity of Victory Gardens in Winnipeg during the war, grown on the many vacant lots left by real estate developers after the crash of 1913. Schools, particularly in the north end, he notes, grew Victory

⁷¹ Joseph Harry Sutcliffe, "Economic Background of the Winnipeg General Strike: Wages and Working Conditions." (M.A. thesis, University of Manitoba, 1972).

⁷² Cynthia Comacchio, *The Infinite Bonds of Family*, (Toronto: University of Toronto Press, 1999), p. 68-69; Nancy Christie, *Engendering the State: Family, Work, and Welfare In Canada* (Toronto: University of Toronto Press, 2000), p. 46-80.

Gardens “on a grand scale.”⁷³ His family had one, which he was responsible for weeding. In it his mother, who had grown up on a farm, grew beans, peas, lettuce, cucumbers, tomatoes, turnips, cauliflower, potatoes, and carrots. What they did not consume during the summer months, she carefully preserved, and used to make soups and pork and beans in the winter. His mother economized, purchasing food and cooking “on a mini-scale,” as Gray describes it. There was very limited red meat in the diet, but more eggs and poultry. His mother was able to purchase eggs thirty dozen at a time from friends in rural Manitoba, as well as farm chickens, which she stored frozen outdoors. The family ate “as much homemade bread as we could hold, covered with molasses or Rogers’ Golden Corn Syrup.”⁷⁴ According to Gray, his Jewish, Ukrainian and Polish friends in the north end ate similar foods, although differently prepared. If these hardships contributed to inadequate nourishment in children and adults, the result may have been a lowered resistance to influenza and its complications.

Crowded and poor quality housing conditions also likely played a part in disease rates. The war certainly did nothing to alleviate an already existing housing shortage. The construction of houses and apartment blocks had all but stopped. In 1913, 2,051 new houses were built in Winnipeg; from 1915-1917, only 135 were constructed, and only nine new apartment buildings. Existing housing stock, particularly in the central and north end districts, was inadequate, and considered an important factor in relatively high

⁷³ Gray, p. 91.

⁷⁴ Ibid., p. 113.

rates of disease, particularly tuberculosis, in these districts. A housing survey undertaken by the city's assistant health inspector in fall 1918 concluded:

The condition [sic] in [District IV and V] are extremely unfavourable as compared with District II. Here we find the most families living in one, two and three roomed suites, the houses are older, the rooms smaller, and there are more children to the family. There are 3,199 children living in these two districts and 1,100 of these children belong to families none of whom have more than 3 rooms. In District IV only 2 houses out of 417, and in District V only 12 houses out of 515 have the storm windows so arranged that they may be opened.⁷⁵

This report suggested that many working class and immigrant families were living in accommodations where windows could not be opened to allow for proper ventilation. This could very well have been an important cause of high infection rates.

Access to medical care also may have contributed to the differential impact of influenza. To this, and the public health context of the epidemic, we now turn.

Public health in Winnipeg

Constitutionally, state responsibility for health in Canada in 1918 belonged to the provincial level of government, with the exception of federal responsibility for quarantine and marine hospitals. The province of Manitoba created its first permanent board of health and passed its first *Public Health Act* in 1893. The act allowed for a six person board (four of whom should be medical practitioners), a provincial superintendent of health, a secretary and a provincial bacteriologist. Reflecting prevalent attitudes that immigrants posed society's most serious disease threat, the provincial board was

⁷⁵ City of Winnipeg Health Department, *Report on Housing Survey of Certain Selected Areas Made May to December 1918*, p. 69-70.

responsible to the Minister of Agriculture and Immigration.⁷⁶ The *Public Health Act* was significantly revised and expanded in 1911, to include milk inspection, food regulation, the protection of water supplies, sewage disposal, housing regulation, and changes to infectious disease control measures.⁷⁷

Basic sanitation was to occupy considerable energy and resources in Canadian public health well into the twentieth century.⁷⁸ Sanitationism, however, was increasingly overtaken by the impact of bacteriology upon public health practices. Beginning in the last two decades of the nineteenth century, the science of bacteriology was embraced by practitioners of public health. An intellectual shift occurred in the field from the importance of the environment in disease causation, to the role of the individual as disease vector, the importance of personal and domestic cleanliness, and the existence of risk populations.⁷⁹ There was a growing emphasis upon the detection of disease in

⁷⁶ A separate health department would not be formed until 1928.

⁷⁷ Ross Mitchell, "Public Health in Manitoba," *The Development of Public Health in Canada* (Ottawa: Canadian Public Health Association, 1940), p. 90.

⁷⁸ Jay Cassel, "Public Health in Canada," in Dorothy Porter, ed., *The History of Public Health and the State* (Amsterdam: Clio Medica, 1994), p. 290-293.

⁷⁹ Dorothy Porter, *Health, Civilization and the State: A History of Public Health From Ancient to Modern Times* (London: Routledge, 1999), p. 139-140; George Rosen, *A History of Public Health* (Baltimore: Johns Hopkins University Press, 1993), p. 270-471; Nancy Tomes, *The Gospel of Germs: Men, Women, and the Microbe in American Life* (Cambridge, Massachusetts: Harvard University Press, 1998), p. 23-67. Michael Worboys argues in *Spreading Germs: Disease Theories and Medical Practice in Britain, 1865-1900* (Cambridge: Cambridge University Press, 2000) that the transformation in public health arising out of germ theory began earlier than 1880. He also argues that "it was only after 1895 that bacteriologists played a major part in public health." (p. 235) This periodization is precisely in line with Manitoba's public health developments. For further information on British public health in this period see Anne Hardy, *The Epidemic Streets: The Rise of Preventive Medicine in London, 1830-1910* (Oxford: Oxford University Press, 1993), p. 289-294.

individuals, including healthy carriers.⁸⁰ “It became imperative for public health agencies to know who was infected with preventable diseases and where they were, so that cycles of transmission could be halted.”⁸¹ The need for new technology and manpower to detect disease led to the establishment in 1898 of a provincial laboratory in Winnipeg, which tested for typhoid, tuberculosis, and diphtheria, among other diseases.⁸² It was run by Dr. Gordon Bell, who was not only the provincial bacteriologist, but also the pathologist and bacteriologist at the Winnipeg General Hospital, and a professor at the Manitoba Medical College. Bell was to remain provincial bacteriologist, and an enormously influential figure in public health in Manitoba, until his death in 1923.⁸³ An upgraded provincial laboratory was opened in 1906. This lab was to play an important role in manufacturing serum for vaccination during the influenza epidemic.

The *Public Health Act* mandated each municipality/county in the province to appoint a health officer (preferably a physician), who would report to a provincial superintendent. The province also was to appoint regional health inspectors, to monitor conditions and

⁸⁰ The standard study of the stigmatization of immigrants and women workers as healthy carriers of disease is Judith Walzer Leavitt, *Typhoid Mary: Captive to the Public's Health* (Boston: Beacon Press, 1996).

⁸¹ Worboys, p. 235.

⁸² For a summary of recent work on the importance of the laboratory to medicine in this period, see Andrew Cunningham and Perry Williams, eds., *The Laboratory Revolution in Medicine* (Cambridge: Cambridge University Press, 1992), Introduction. For a provocative study dealing specifically with the impact of the laboratory upon conceptions of infectious disease, see Andrew Cunningham, “Transforming Plague: The Laboratory and the Identity of Infectious Disease” in the same volume.

⁸³ J.G. Fox, “The History of Provincial Health Laboratory Services in Manitoba,” *University of Manitoba Medical Journal* 49 (1979). Bacteriology was central to medical professionalization in this period. See Porter, p. 160.

assist municipal health officers. Manitoba's provincial government (like other Canadian provinces) delegated a significant amount of responsibility for health matters to municipal governments, including delegating the authority to take measures such as quarantine against infectious disease. In reality, most health matters were managed by municipalities in this period, with little support, financial or otherwise, coming from the province. Many were not up to the challenge. Alan Artibise, whose study of municipal government in Winnipeg before the First World War remains the most comprehensive analysis of public health issues in this period, has criticized the city's inattention to health concerns, and argued that "public resources were directed almost exclusively towards growth-producing programs," with little regard for health.⁸⁴ In a rapidly growing city,⁸⁵ a lack of adequate medical care and public health infrastructure resulted in a prevalence of infectious diseases such as typhoid fever, scarlet fever, diphtheria, tuberculosis and venereal disease, and a high death rate.

The city of Winnipeg did not enact its first comprehensive health bylaw until 1899. In 1900 the first full time health officer (Dr. Alexander Douglas) was appointed. Smallpox vaccination measures were taken, and the gathering of mortality statistics begun. These were small steps, however, and few immediate gains were made in the health status of the community.⁸⁶ In fact, health status deteriorated. Between 1900 and 1907 the death rate in

⁸⁴ Artibise, p. 223.

⁸⁵ Winnipeg's population grew from 42,340 in 1901 to 136,039 in 1911. Its population in spring 1919 was 183,595.

⁸⁶ Other cities did not necessarily do a great deal better. Toronto appointed its first salaried health officer in 1883, in response to a conditional grant offered by the federal government. See Heather MacDougall, *Activists and Advocates: Toronto's Health Department, 1883-1983* (Toronto: Dundurn Press, 1990). Vancouver, a city of 106,000 in 1914, did not appoint a full time health officer until 1904. Its health

Winnipeg never fell below 18 per one thousand population, and was over 20 per thousand in five of these years. Typhoid was a major reason for these rates, and an important catalyst for change. The city had the highest typhoid death rate of any North American or European city in the period, and suffered severe epidemics in 1904 and 1905.

Winnipeg's problems with typhoid were caused by its unsanitary water supply and inadequate sewer systems. The poorer districts of the city surrounding the railroad tracks were particularly hard hit in typhoid epidemics. Most homes lacked sewer connections and running water, conditions that reflected both the residents' poverty and the failure of city council to devote resources to public health infrastructure. Nevertheless, observers tended to blame the immigrants themselves. An investigation conducted by three local physicians concluded: "the filth, squalor, and overcrowding among the foreign elements is beyond our power of description."⁸⁷ A further investigation by Chicago's Dr. Edwin Jordan warned civic leaders that the sanitary problems of the city's poorer districts were a "menace" to the health of the entire city, and that "in sanitary matters the welfare of one section of the city is inseparably connected with that of another."⁸⁸ Indeed, typhoid had spread south into more prosperous neighbourhoods. Reforms were finally begun, including the building of a new aqueduct to secure a safe water supply (which was completed in 1918), and a campaign to connect all Winnipeg homes to sewer lines.

department did, however, have a proportionately larger staff by the First World War than Winnipeg. See Margaret Andrews, "The Emergence of Bureaucracy: The Vancouver Health Department, 1886-1914," *Journal of Urban History* 12, 2 (February 1986), p. 133-146.

⁸⁷ Quoted in Artibise, p. 229.

⁸⁸ Ibid, p. 231.

A new health bylaw, passed in 1905, established a public health committee of city council. Enhanced street cleaning and scavenging measures were taken. The number of health department staff more than doubled in the following year to thirty-four, mostly additional health inspectors, some of whom could speak languages other than English and could communicate more effectively with the city's immigrants. Appropriations rose from \$36,000 in 1904 to \$130,000 in 1906.⁸⁹ In 1911, the city opened the King Edward hospital for the treatment of tuberculosis; the King George V hospital followed in 1914 for patients with diseases such as typhoid, scarlet fever, diphtheria, smallpox, and (as it turned out) influenza.⁹⁰

Thus, the Winnipeg health department evolved and professionalized along lines fairly consistent with the North American pattern.⁹¹ The health department's approach developed into "a combined program of rigid inspection and education"⁹² in the second decade of the twentieth century. Immigrants and workers were largely the targets of both. As the above reference to the "filth" and "squalor" of "foreign" living conditions attests, the districts where European immigrants congregated were viewed as *loci* of disease, and individual immigrants as disease carriers. The health department began to publish

⁸⁹ Ibid., p. 232-235.

⁹⁰ Ian Carr and Robert Beamish, *Manitoba Medicine: A Brief History* (Winnipeg: University of Manitoba Press, 1999), p. 58.

⁹¹ Although Artibise argues that Winnipeg was an exceptionally bad case of civic neglect, much of what is described here was unfortunately not uncommon in North American cities. See John Duffy, *The Sanitarians: A History of American Public Health* (Urbana and Chicago: University of Illinois Press, 1990), p. 175-218.

⁹² Artibise, p. 235.

pamphlets in several languages to be distributed among immigrants in the north end, a strategy that it was to employ again during the influenza epidemic. Public education was developed further in 1911 through a monthly health bulletin, which included articles such as “Proper Ventilation,” “Food Storage and Preparation” and “Rats – A Warning.” The department also ran a series of health lectures in cooperation with the All Peoples’ Mission, located in the north end.⁹³

Before the opening of the King George municipal hospital, most victims of infectious diseases were cared for in one of the city’s privately run hospitals, the largest of these being the Winnipeg General Hospital. The exception was victims of smallpox, the most dreaded of infectious diseases in the early twentieth century. Ian Carr and Robert Beamish describe the city’s smallpox isolation hospital (or, pest house) which, like pest houses everywhere, must have been feared and loathed by the city’s poor, who were its principal clients:

The fate of patients sent to the smallpox hospital, or pest house, was not pleasant. They were taken in a horse-drawn wagon, past the cemetery in which victims were buried. The pest house, originally a shack, isolated on open prairie, was rebuilt [in] about 1900 on Logan Street a mile west of the city centre, 100 yards away from both road and railway track, near Brookside Cemetery. A high, board fence surrounded the four small one-story buildings and a tent. Two more tents stood outside the fence. Patients would try to escape, and some were shackled.⁹⁴

⁹³ Ibid, p. 237-238.

⁹⁴ Carr and Beamish, p. 65.

Smallpox declined in significance during these years. Credit was given to compulsory vaccination, an issue that generated some controversy in working class and immigrant districts of the city.⁹⁵

The Winnipeg General Hospital was founded in 1872. It provided inadequate accommodations in its early years, and treated mostly contagious disease cases, particularly typhoid. A new building was opened in 1884, with six wards. Patients were to pay a fee of \$2.50 per day, and to contribute labour such as making beds, cleaning and doing laundry. From its opening, however, most patients could not pay, and the revenue from a municipal grant far outweighed revenue from patients in the facility. In 1886, the General opened an 'outdoor' dispensary to treat the poor, but it appears to have provided care to only a small number of patients in its early years.⁹⁶

Given the rapid growth in Winnipeg's population after 1900, it is perhaps not surprising that complaints of hospital overcrowding emerged, particularly during periods of epidemic disease. In 1908 the city appointed a special Hospital Commission (composed of three local physicians) to investigate the problems with hospital care in the city. The investigators discovered that Winnipeg had approximately the same number of hospital beds relative to its population as did Montreal, and twice as many as Chicago. The problems with hospital care were caused, it seemed, by poor organization and hazy lines of accountability. The General lacked a strong medical superintendent and Board of Directors, to whom the medical staff were responsible. A superintendent was appointed

⁹⁵ Opposition to compulsory vaccination is considered in detail in Chapter 4.

⁹⁶ Carr and Beamish, p. 29-31.

soon after. The report's authors also suggested that the sick poor were placing heavy demands upon the General, and that the facility should show discipline in responding to them. "All recipients of hospital treatment should pay their way as far as possible, thus preserving their independence and preventing pauperization, which tends to sap their moral fibre," they argued. Neither should the facility interfere with the workings of the medical marketplace: "Care must be given over the provision of outdoor treatment, lest there be injustice to young physicians who largely depend for support on the poorer class of patients."⁹⁷

If the General was "the hospital of the anglophone majority,"⁹⁸ it was also a facility that often had a troubled relationship with the broader community. As the facility expanded and consolidated its resources, it increasingly demonstrated the failings outlined in Charles Rosenberg's critique of the modern hospital:

The vision looked inward toward the needs and priorities of the medical profession, inward toward the administrative needs of the individual hospital, and inward toward a view of the body as mechanism and away from that of the patient as social being and family member.⁹⁹

⁹⁷ Quoted in Carr and Beamish, p. 57-58.

⁹⁸ Ibid., p. 31.

⁹⁹ Charles Rosenberg, "Inward Vision and Outward Glance: The Shaping of the American Hospital, 1880-1914," in David Rothman and Stanton Wheeler, eds., *Social History and Social Policy* (New York: Academic Press, 1981), p. 21. Rosemary Stevens argues that the First World War only strengthened the role of the acute care hospital over a more socially-based medicine, in *In Sickness and In Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1989), p. 80-104.

Hospitals and the physicians and nurses who staffed them responded to their patients within systems of class and ethnic bias.¹⁰⁰ The hospitals' 'inward vision' did generate criticism. By 1918, labour had been fighting a ten-year battle to democratize the General's structures to allow for greater community accountability, and demanding that better medical care be provided to residents of the north end, to little avail.

Jay Cassel has argued that no laypersons exercised significant influence over public health in this period.¹⁰¹ Although Cassel may be underestimating the importance of labour and others, particularly women's reform groups, to the public health policies of Canadian municipalities, the argument made by working people that ill health was a function of poverty, poor housing, and dangerous workplaces had little apparent effect. Influenced by the philosophy of the "new public health,"¹⁰² officials and advocates were more likely to understand, at least in theory, that economic conditions were a major cause of disease and infant mortality. Nevertheless, they maintained that education would make the difference—regardless of the structural causes of ill health. Immigrant mothers were held responsible for infant mortality rates that continued to increase despite preventive health measures such as milk depots and Little Mothers' Leagues.¹⁰³ As city health officer

¹⁰⁰ David Gagan and Rosemary Gagan, "'Evil Reports' for 'Ignorant Minds'? Patient Experience and Public Confidence in the Emerging Modern Hospital: Vancouver General Hospital, 1912," *Canadian Bulletin for the History of Medicine* 18 (2001); Charles Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987), p. 286-309.

¹⁰¹ Cassel, p. 284-285.

¹⁰² Concise descriptions of the new public health are given in Duffy, p. 205-211; McDougall, p. 13.

¹⁰³ In 1912, one in five infants in Winnipeg died before their first birthday (excluding stillbirths). For a summary of infant mortality in this period, see Artibise, p. 237, Table 28.

Douglas argued in 1911, “we feel that no matter how bad the economic conditions, a very large number of children’s lives could be saved if mothers only know [sic] proper infant care ... It is along educational lines that the most important work in preventing infantile mortality is to be done.”¹⁰⁴ Yet, the measures that seemed to have the greatest impact were not the educational efforts of the health department, but the health care provided to mothers and children by privately run organizations such as the Margaret Scott Nursing Mission.

Founded in 1904, the Margaret Scott mission was a unique health care institution in Winnipeg. It was located on George Street in Point Douglas, near the immigration sheds. It was operated by an all-female Board of Management, and had a ten member male Advisory Board. Its mandate was to provide nursing care to the poor of the north end of the city. Its founder, Margaret Scott, was from a bourgeois Ontario background, but was widowed in her early twenties. To support herself she worked as a stenographer before founding the Mission.¹⁰⁵ She was a deeply religious Protestant woman, whose vocation arose out of an ethic of considerable personal self-sacrifice.¹⁰⁶ Her spiritual attachment to the work of benevolence was summarized in Psalm 155:1, often cited in the Mission’s

¹⁰⁴ City of Winnipeg Health Department, *Annual Report*, 1991, quoted in Artibise, p. 237.

¹⁰⁵ Helena McVicar, *Margaret Scott, A Tribute. The Margaret Scott Nursing Mission* (Winnipeg: 1939), p. 6-7.

¹⁰⁶ Marion McKay, “Caring in Turbulent Times: a Social and Cultural Analysis of the Board of Management of the Margaret Scott Nursing Mission,” (unpublished paper, 2000), p. 6. “By 1898, she was living in a small room above the Coffee House on Lombard Avenue, and entirely dependent on the generosity of philanthropic citizens ... for her own personal needs. ... For the remainder of her life, Mrs. Scott never accepted a salary for her work, and lived in the trust that, through the generosity and commitment of other Christians, God would sustain her work.”

Annual Reports: "If in trying to serve God I have been privileged to cheer and comfort others my highest aim has been attained."¹⁰⁷

The organization received considerable financial support in this period from prominent Winnipeg philanthropists, and many of the female Board were wives of leading businessmen. The Mission also benefited from City of Winnipeg grants, and a close working relationship with both Douglas and the Winnipeg General Hospital, which sent some of its senior nursing students to work at the Mission.¹⁰⁸ It functioned within a classic feminine philanthropic paradigm, which emphasized the incapacity of the poor, and the superiority of Anglo-Canadian values and culture. Like other private and public welfare agencies, the Mission emphasized the dangers of pauperization among its charges, and carefully investigated each application for nursing care.¹⁰⁹

Before the creation of the city's Bureau of Child Hygiene (1913), the Mission's visiting nurses provided extensive maternal and child health care in the north end. It was their positive results, Artibise argues, that inspired Douglas to create a program of visiting nurses as part of the new Child Welfare Bureau. The Bureau opened a house in the north end where mothers could bring their babies, and it provided free medication, clothing, and food in some cases.¹¹⁰ By the end of the First World War, the Bureau employed nine nurses, and operated a Babies' Clinic and Milk Depot. The Bureau had

¹⁰⁷ Ibid., p. 6.

¹⁰⁸ Ibid.

¹⁰⁹ Ibid., p. 24.

¹¹⁰ Artibise, p. 238.

also taken over its operation from Ladies' Service League, who had initiated the project in 1908 to provide free formula and medical care to poor mothers. By 1919, two attending physicians—Dr. R. Rorke and Dr. E. Richardson, both physicians at the Children's Hospital—conducted approximately four thousand examinations per year.¹¹¹ The clinic was also used as a training facility for nurses and medical students.¹¹²

Neighbourhood-based nursing care services, both public and private, formed an important component of the response to influenza in 1918-1919. Hundreds of immigrant families were treated by Mission nurses who were familiar with their living conditions and health needs.¹¹³ But the epidemic overwhelmed all health care agencies in Winnipeg, particularly during the peak weeks of infection and mortality in November. The following chapter lays out the actions of health authorities and the trajectory of the epidemic.

¹¹¹ CWA, *Report of the Bureau of Child Hygiene*, 1919.

¹¹² Harry Medovy, *A Vision Fulfilled: The Story of the Children's Hospital of Winnipeg, 1909-1973* (Winnipeg: Peguis Publishers, 1979), p. 38-39.

¹¹³ See Chapter 3.

Chapter 2 - "Every Citizen a Health Officer": Influenza in Winnipeg

The citizens of Winnipeg, like many others across the globe, found themselves awaiting the arrival of the 'Spanish' influenza epidemic in their community in the last weeks of September 1918. Those reading the daily press were aware of the progress of the epidemic across the United States, and the impact it was having in Boston and New York, which were among the first North American cities to suffer large scale loss of life that fall.¹ News soon arrived of the devastation of the disease in eastern Canadian cities including Montreal, Ottawa, and Toronto, all of which were affected before the end of September.² The spread of influenza from community to community seemed unstoppable. As increasingly alarming reports appeared in the press, health authorities attempted to calm themselves and the public with assurances that the flu was not dangerous unless the signs of illness were neglected. In the meantime, civilian and military health personnel prepared to deal with the arrival of the first known influenza victims in the city: fifteen sick soldiers who were scheduled to arrive on a military train on the evening of September 30, 1918.³

The role of returning soldiers in spreading influenza is well documented. Canadian medical historian Janice Dicken McGinnis argues that the decision of the Canadian

¹ Influenza struck Boston on September 14, 1918 and New York shortly thereafter. MFP, October 3, 1918, p. 1.

² WT, September 26, p. 1.

³ WT, September 30, p. 1.

military to send apparently healthy soldiers from a quarantined barrack in Quebec City to western Canada via train hastened the spread of the disease across the country.⁴ Along the way west, soldiers became ill, and were handed over to health authorities at several points. This train reached Calgary on 2 October and dropped off one officer and fourteen privates; McGinnis believes these individuals to have been the source of infection in Calgary's epidemic. By the time it reached Vancouver, the train had been quarantined in its entirety. It was this same train that dropped off sick soldiers in Winnipeg on Sept. 30th.

Even had these soldiers not been disease carriers, influenza would likely have found its way to the city from various other potential sources. From the eastern coast of the United States, the disease spread inland, arriving in Chicago in mid-September, making it likely that trade between Winnipeg and American centres facilitated transmission. Non-military travel westward from eastern Canada also spread the disease. However, military channels of infection must be considered as a crucial vector for the prairies, and certainly were the main vehicle for transporting the disease across North America as a whole.

The first media report of flu being present in the city was a story in the *Winnipeg Tribune* on the evening of September 30 announcing the arrival of the infected soldiers. They were immediately quarantined at the Imperial Order of Daughters of the Empire (IODE) military hospital in Tuxedo, in the south end of Winnipeg. By the next day, the number of ill was increased to twenty-three. On Monday, October 7, it was reported that

⁴ Janice Dicken McGinnis, "The Impact of Epidemic Influenza: Canada, 1918-1919," in S.E.D. Shortt, ed., *Medicine in Canadian Society* (Montreal: McGill-Queen's University Press, 1981), p. 451.

two of these men had died, and two others lay near death. Although the victims were isolated, the disease quickly appeared elsewhere in the city. On the same day, the *Tribune* reported the illness of a civilian, living on Guelph Avenue, in the city's south end. According to reports in the *Manitoba Free Press*, this woman had just returned from visiting family in Montreal. Her house was immediately quarantined. Although the newspaper article did not point fingers, it was well known that the flu had been widespread in Montreal for at least a week. It is unclear whether this woman was the first civilian case. The previous Saturday, the *Tribune* had printed an article suggesting that influenza had been discovered among school children in Fort Rouge, although the article was equivocal: "No Spanish 'Flu' in City Schools," the headline proclaimed.⁵

There were eventually to be many disagreements among Winnipeg's public and business elite regarding the appropriate response to the presence of the disease in the community. But the first sign of dissension appeared among the press itself. The *Free Press* did not confirm that the flu had actually arrived in the city until it reported the deaths of the two soldiers on Tuesday, October 8. In that article, it was conceded that the soldiers had arrived in Winnipeg "about two weeks ago."⁶ The *Tribune*, by contrast, followed the projected arrival of sick soldiers at the end of September, and questioned military authorities in Winnipeg about the extent of the disease among its men. By October 9, the *Tribune* was concerned that the truth about the seriousness of the situation among the military was being kept from the public. "Officers of the Canadian Army

⁵ WT, October 5, 1918, p. 5.

⁶MFP, October 8, 1918, p. 8.

Medical Corps are endeavoring to prevent information about soldiers affected with the disease from reaching the public," the *Tribune* accused. "It is officially reported today that there is no sign of any outbreak of flu' among local soldiers."⁷

At the outset, then, the main daily papers were rivals in their coverage of the epidemic, the *Tribune* aggressively reporting both rumours and official information, the *Free Press* preferring a more cautious approach. The *Free Press* did not explain its own silence on the issue during the first week of October. But the paper remained preoccupied with the war effort. Its editor, John W. Dafoe, was an avid commentator on war issues.⁸ Given the arrival of influenza in the final crucial weeks of the war, it is perhaps not surprising that a journalist with his interests would choose not to focus primarily upon the epidemic. Nevertheless, the epidemic never would consistently make front-page news in the *Free Press*.⁹

Dr. Alexander Douglas, the city's health officer, realistically pointed out that it was extremely unlikely that Winnipeg would escape the epidemic. He advised those who became ill to go to bed, and suggested that everyone avoid crowds.¹⁰ For several days, civic and provincial health authorities and elected officials debated the best course of

⁷WT, October 9, 1918, p. 1.

⁸ Murray Donnelly, *Dafoe of the Free Press* (Toronto: Macmillan, 1968).

⁹ The paper was in good company in this regard. The epidemic was front page news in the New York Times only twice. Lawrence Koblenz, "A Judgement in Time: Medical Responses to the 1918-1919 Influenza Epidemic in the United States," Paper presented to *The Spanish Flu After 80 Years Conference*, Cape Town, South Africa, 1998, p. 23.

¹⁰WT, October 3, 1918, p. 10.

action. Legally, the provincial government held the authority to declare influenza a “contagious or infectious disease” under *The Public Health Act*.¹¹ When a disease became thus classified, a complex set of rules fell into play. Physicians and school and hospital officials were required to report to health authorities all suspected cases, and to provide information regarding the name, age, and sex of any victims. Deaths also had to be promptly reported. Municipal health officers were delegated the power of inspection, isolation and quarantine, placarding, and the authority to mandate the disinfection and fumigation of property. They also had the option to close schools and prohibit public gatherings under the *Act*.¹² Local governments in Manitoba carried the burden of implementing the measures that were enabled by the Provincial Board of Health (a voluntary board, with the exception of the Secretary). As an indication of the extensive practical authority held by local health officials, Winnipeg's medical officer of health was given the power to take whatever actions he deemed necessary without the approval of city council.¹³

The first known death of a civilian sent an immediate message that this was not a disease of the poor. On Thursday, October 10, it was announced that Mrs. A.K. Dysart, the wife of a prominent Winnipeg 'King's Counsel', herself an active philanthropist who was President of the St. Joseph's Orphanage auxiliary, died the previous afternoon of

¹¹ *Statutes of Manitoba*, 1911, “An Act Respecting the Public Health.”

¹² *Ibid.*, p. 222-246.

¹³ MFP, October 12, 1918, p. 4.

pneumonia, "contracted through Spanish influenza."¹⁴ Mrs. Dysart had just returned from a visit to relatives in Eastern Canada. Another civilian death occurred the following day, and there were now 18 additional confirmed cases of flu in the community.

The Provincial Board of Health, chaired by Dr. Gordon Bell, met October 11, and that day declared Spanish influenza a "contagious or infectious disease." In a public proclamation issued by the Provincial Board of Health's Secretary, Dr. M Stuart Fraser, the Board suggested a number of actions that were now open to local health authorities to curb influenza.¹⁵ In addition to requiring the reporting of all cases of the disease, authorities had the power to enforce the isolation of disease victims; the disinfection or destruction of bedding, clothing, dishes and cutlery; and the prohibition of "any unnecessary gatherings ... about stores, street corners, or other public places."¹⁶ But the measure that attracted the most attention was what became referred to as the ban on public meetings. The list of those affected by the meeting ban included "theatres, schools, boarding schools, the university, the medical school, churches, lodges, exhibitions, and all public meetings."¹⁷ Winnipeg health officials were now able to enact and enforce any or all of these measures.

¹⁴WT, October 10, 1918, p. 1.

¹⁵WT, October 11, 1918, p. 1.

¹⁶PAM, GR 1548, Box 12, Province of Manitoba, Provincial Board of Health Minutes Books, October 11, 1918.

¹⁷MFP, October 11, 1918, p. 1.

Prior to any official announcements, rumours about the government's response were circulating through the mainstream press, the public's main source of information throughout the epidemic. There were occasional discrepancies in the information available in Winnipeg's newspapers, and the timing of the ban on public gatherings in Winnipeg is a good example of the problems encountered by health officials when they relied upon the press as a means of communicating with the public. The *Tribune* reported that the Provincial Board of Health was declaring all public meetings prohibited as of Friday afternoon, October 11. It stated that Winnipeg authorities had been planning to implement the ban as of Saturday, but speeded up their timing after the provincial announcement was made.¹⁸ The *Free Press*, however, reported only that public meeting places were ordered closed as of midnight, Saturday October 12.¹⁹ It remains unclear precisely when authorities began enforcing the edict.

Rates of infection and death were not consistently reported at the beginning of the epidemic. Later on the press would publish daily counts, provided by health officials. On October 10, the *Tribune* reported that there were thirty-four reported cases of influenza in Winnipeg, and that military troops were experiencing an outbreak. This high number of civilian cases was not confirmed in the *Free Press*, which through the end of that week predicted the epidemic would be no worse than the influenza of the 1880s.²⁰

¹⁸WT, October 11, 1918, p. 1.

¹⁹MFP, October 12, 1918, p. 1.

²⁰ Although we know relatively little about them, there were regular influenza pandemics throughout the 17th and 18th centuries. The 1889-90 wave was known as the Asiatic influenza, and is thought to have originated in Russia in May 1889. That fall it spread rapidly throughout the world, reaching North America

Even in these early days, with civilian deaths unconfirmed, the public's fears were growing. Information about the epidemic was widely available in the press, but also came from friends and relatives in other communities, through letters or perhaps from visitors. Canadians were not forbidden to travel, although trains were eventually to be searched by quarantine officers. Health officials and community elites were at the outset worried about the impact of fear in itself; such fear and panic could generate social instability and hamper the efforts of health authorities to control the public's behaviour and mobility. There were admonitions to the public to "keep up its nerve"²¹ matched by reassurances that "that situation is being met philosophically by all."²² Editorials in the *Free Press* notably adopted this attitude.

However, at the same time that it undertook to promote stability and reduce the possibility of hysteria, the *Free Press* began to publish accounts and opinions that were far from reassuring. "The death rate is higher from Spanish influenza than any other known disease, excepting the 'Black Death' which swept over England in the 17th century," it claimed. "Local physicians state that the cases which have been reported so far in Winnipeg are of a more serious character than those in eastern Canada and Europe" an article announced on October 12.²³ These contradictory messages were to remain

in December. It resulted in high infection and mortality rates, particularly in cities. See W.I.B. Beveridge, *Influenza: The Last Great Plague* (New York: Prodist, 1977), p. 29-30.

²¹MFP, October 11, 1919, p. 9.

²²MFP, October 12, 1918, p. 1.

²³MFP, October 12, 1918, p. 4.

prevalent throughout the epidemic, as the press attempted to provide hard facts (through statistics and vivid reportage of suffering victims), reassurance, and even humour. Among the most intriguing examples of the latter were the columns written by “Clarence Doodlemuss,” the “influenza editor” of the *Free Press*. The following is an excerpt from a column entitled “Clarence Has Difficulty in Keeping Eucalyptus Club in Decorous Mood:”²⁴

Last night we opened the lodge – club, I mean – by singing ‘Shall we gather at the oil tank,’ which, Hector says, is a favorite hymn of Rockefeller, pious old dear, and then I solemnly used the eucalyptus spray on each member, giving it a vicious squeeze when it came to the turn of the pretty maiden who so far forgot herself as to call me ‘Fifi,’ or ‘Beefy,’ or whatever the dickens it was.

Then a short paper was read by dear old Gowanlock on ‘Recreations of an Influenza Microbe,’ and he brought out his points with truly French clarity. Steeplechasing, I gathered, was the joy of the bally thing’s life, and should you see one on, say, your desk, you must slam it without mercy before the blighter has time to jump. The lecturer gave some whistling examples of the microbe’s various calls; when hungry, when in love, etc., and, by Jove, they were quite musical, you know. The censor, querulous old dear, had banned the lantern slides, it appears, the ‘Dance of the Microbes’ being rather too ‘free,’ if you follow me; at any rate, so he said, and we missed that.

The meeting was then thrown open, and Hector introduced the horrible subject of expectorating on the sidewalk ...²⁵

There were several of these columns over the weeks of the epidemic. Edwina Palmer and Geoffrey Rice have argued that humour was a healthy way to “make the crisis emotionally more manageable ... [and] to overcome the fear generated by a disease for which there were no effective preventives or remedies.”²⁶ Perhaps it ultimately failed in

²⁴ Eucalyptus was one of the most common popular remedy for symptoms of influenza.

²⁵ MFP, November 8, 1918, p. 10.

²⁶ Edwina Palmer and Geoffrey Rice, “‘Divine Wind versus Devil Wind’: Popular Responses to Pandemic Influenza in Japan, 1918-1919,” *Japan Forum* 4, 2 (October, 1992), p. 323.

this function. The column disappeared in mid-November as the epidemic reached its peak.

Some members of the community took seriously the power of the press to influence public attitudes and responses, and even to shape the unfolding of events. The *Tribune* published a portion of a letter it had received from several businessmen whose livelihoods might be affected by the flu ban. Their identities are unknown, but they may have been theatre owners or managers. These men blamed the *Tribune* itself for bringing about the public meeting ban: "If the *Tribune* had not given so much publicity to the epidemic and had not been so active in warning the public, the ban would not have been imposed... The other papers paid little attention to the epidemic and if the *Tribune* had followed their example this order would not have been issued." For its part, the editors of the *Tribune*'s editors described the letter as "a high compliment."²⁷

By October 12 there were 48 known cases of the flu in Winnipeg, almost all of them centred around the Assiniboine River. This apparently unlikely incubus of the disease in south Winnipeg—which was a relatively prosperous district—did not prevent some commentators from associating the disease with poverty and poor living conditions. The cold of the Winnipeg winter, and the shortage of expensive coal supplies, led one citizen to call for health authorities to control the spread of influenza by forcing landlords to heat their apartment blocks and rooms properly. "The health authorities make much of overcrowding by foreigners, owing to the bad air produced thereby, but they entirely overlook

²⁷WT, October 12, 1918, p. 1.

the bad air in which many people living in apartment blocks and rented rooms must exist"²⁸ The author noted that apartment dwellers were forced to sit in confined quarters in the kitchen to stay warm and were at risk of getting chilled. The potential impact of immigrants' living conditions and habits was closely monitored by health authorities, who watched carefully the progress of the disease in the north end.

The sick were encouraged to go to a hospital for treatment, and preparations were made for expanded hospital accommodation and the isolation of victims. Initially, cases were taken to the King George Hospital (the city-operated contagious disease facility), which admitted its first flu patient on October 11, a relatively mild case. Two days later, according to Medical Superintendent A.B. Alexander,

a Mother and Daughter were admitted, both extremely ill with high fever, great prostration. The Daughter had marked Pneumonia accompanied by delirium. ... The Mothers' (sic) condition was very poor. On first day we could find no sign of Pneumonia but on following day signs were in evidence and process rapidly spread and death ensued in two days. On the third day the daughter's condition improved, she became fairly rational and temperature dropped slightly and for 48 hours she made a good rally but again temperature flew up with further spread of lung involvement and she died on following day.²⁹

For many of the thousands infected with the virus, family or friends provided treatment at home. In the first couple weeks of the epidemic, grocery stores and pharmacies were overwhelmed with the demand for flu remedies. Eucalyptus oil was a very popular one in Winnipeg, and became difficult to find. Its price rose by one hundred

²⁸WT, October 12, 1918, Society Section, p. 5.

²⁹CWA, Council Correspondence 12020, Dr. A.B. Alexander, Medical Superintendent, Municipal Hospitals, "Report on the Spanish Influenza Epidemic to the Hospital Commission," December 10, 1919.

percent by mid-October, according to one media account.³⁰ Many of the flu remedies sold in pharmacies contained alcohol, and some citizens believed that liquor was beneficial. There was some public demand for the lifting of prohibition.³¹ Government health authorities, however, were unsympathetic, and had the support of the Protestant churches in continuing the prohibition of liquor sales.³²

By the end of the first week of the meeting ban, city health officials had developed a system for spatially tracking the progress of the disease in the city. This record-keeping system, which divided the city into four districts, was described in the *Tribune*. "A large map of the city clearly showing each street and apartment block is used. Yellow-headed pins designate the location on streets where patients are. As each new case is telephoned or otherwise reported to the department, a clerk places another pin on the map." Thus, "department officials can tell at a glance exactly where every flu case is located. ... Douglas and Watt [city health officials] know hour by hour" the location of influenza cases, it was claimed.³³ This was also known as the "spot system." The gathering of morbidity and mortality statistics and other standardized health information had a history extending back to anti-cholera efforts in the 19th century in Canada, and was further

³⁰WT, October 14, 1918, p. 10.

³¹ For further discussion on this, see Chapter 5.

³²MFP, October 14, 1918, p. 5.

³³WT, October 17, 1918, p. 3.

reinforced by the emerging science of epidemiology in the 20th century.³⁴ Public health experts believed that the first step toward controlling the spread of the disease was to be aware of each of its victims. With a less virulently contagious disease, this might have helped isolate carriers and contain its spread. The two-to-three day incubation period of influenza made isolation more difficult, as did the scale of infection. The city initially opted against compulsory placarding and quarantine.

During most of the month of October, it appeared that Winnipeg might not experience a severe epidemic. The number of cases grew steadily, but the death rate remained low, at less than three percent of reported cases.³⁵ Measures taken in response to the flu appeared to be having some effect, and strategies continued to evolve. There were plans to inspect all west-bound passengers on incoming trains, and to fumigate train coaches. Also debated were the compulsory wearing of masks,³⁶ and vaccinating the entire community.

³⁴ The assembling of vital statistics was pioneered in Prussia in the 17th century, by Johann Peter Sussmilch, and was integral to the framework of medical police. The science of statistics was further elaborated in post-revolutionary France by Rene Villerme, and by William Farr in England in the early 19th century. See Roy Porter, *The Greatest Benefit to Mankind* (New York and London: W.W. Norton, 1997), p. 293-294; 406. The gathering of data from ships' captains at Grosse Isle, Quebec during the 1866 cholera epidemic is noted in Bruce Curtis, "Social Investment in Medical Forms: the 1866 Cholera Scare and Beyond," *Canadian Historical Review* 81, 3 (2000), p. 361-363. Curtis writes: "Formalization, argues Pierre Bourdieu, allows one to move 'from a logic which is immersed in the particular case to a logic independent of the individual case.' Successful investments in forms create 'that constancy which ensures calculability over and above individual variations and temporal fluctuations.' Thus, recording mortality data on 'forms' generates order and categorizes events so as to make them more amenable to human intervention. For modern epidemiology and 20th century epidemics, see Naomi Rogers, *Dirt and Disease: Polio Before FDR* (New Brunswick, NJ: Rutgers University Press, 1992), p. 140-143.

³⁵ WT, October 18, 1918, p. 1.

³⁶ McGinnis, p. 455-456.

In mid-month, the medical director of Winnipeg General Hospital's pathology department Dr. William Boyd, was sent to the Mayo Clinic in Minnesota to investigate the possibility of using a vaccine being developed there by Dr. E.C. Rosenow.

The optimism of health authorities was much encouraged when the north end remained "remarkably free from the malady", according to their data,³⁷ in the third week of October. Health officials were especially concerned about the disease gaining a foothold among working class immigrants, and on October 19 further measures focused at North end immigrants were announced: "means [are being] taken to educate the foreign residents of that district as to the grave danger of delay in combating the disease. Literature, printed in Yiddish and Ruthenian, giving warning and advise (sic) will be distributed North of the CPR tracks today."³⁸ At this point, health officials were aware of 330 cases of influenza and eight deaths in total in the city.

Toward the end of October, the consensus among business, social and government leaders regarding the need for a continued ban on public gatherings began to unravel. Provincial Board of Health Secretary M. Stuart Fraser, who was given to talking at length to reporters, suggested on October 24 that the need for the ban in Winnipeg might soon be past. "In a week from now we shall be able to definitely determine when the crest of the wave is passed. If we find a general subsidence in the disease, then we shall have some idea when the ban may be lifted." These comments, of course, led the *Tribune* to

³⁷MFP, October 17, 1918, p. 5.

³⁸MFP, October 19, 1918, p. 5.

report on its front page, "Next Week - the End of Ban, Maybe!"³⁹ The provincial board was quick to stress the following day that the crest of the epidemic had not been reached. The editor of the *Tribune* supported concerns in the business community regarding financial losses caused by the meeting ban.

Despite a sense of optimism in mid-October, resources for isolating flu victims were increasingly strained. For several days after the first flu admissions at the King George, things were fairly quiet, but on October 18—called Black Friday by Dr. Alexander because his facility admitted twenty patients that day—the need to take further measures became clear. That week, nearly one hundred new cases were being reported every day. The Winnipeg General was also taking patients, but both it and the King George were filled with flu sufferers, and officials had to look elsewhere for locations to set up more beds. A reliance upon temporary facilities was not unusual during epidemics in Winnipeg; during a scarlet fever epidemic in 1910, an old building on the Exhibition Grounds was used to house victims.⁴⁰ As architectural historian Annmarie Adams has noted, the use of "borrowed buildings" was widespread during the First World War to meet the health needs of convalescing soldiers.⁴¹ The influenza epidemic added further impetus to this type of improvisation. Plans were made to hastily construct temporary facilities as quickly as possible. Formerly the site of a Protestant unemployment agency,

³⁹WT, October 24, p. 1.

⁴⁰ Ross Mitchell, "Dr. Alex. J. Douglas, 1874-1940," *The Manitoba Medical Review* (January, 1958), p. 48. While patients were housed there, the wooden structure caught fire. Fortunately, no one was killed.

⁴¹ AnnMarie Adams, "Borrowed Buildings: Canada's Temporary Hospitals During World War I," *Canadian Bulletin of the History of Medicine* 16 (1999), p. 25-48.

a building on the corner of Logan and Main Street known as the "Old Coffee House" was the first of these. The Board of Control voted to provide two hundred beds in this building.

The city's decision to use this building was not popular with the residents and business owners in the vicinity, who submitted a petition to City Hall on October 25, 1918. This petition was signed by about one hundred people, whose opposition was based upon the folly of housing the infected in a congested urban area:

We beg to point out that this district is very congested and consists of dwelling houses, apartment blocks, warehouses and offices and owing to its mixed character the danger of a spread of the epidemic would be very great. The district is in the heart of the City and is certainly not the right place for a hospital where contagious and infectious diseases are to be treated, especially in the case of an epidemic of this kind.⁴²

The petition was signed by many of the area's businesses, several of which were Jewish-owned, and the Jewish Colonization Association. Opposition to the temporary isolation facility appears to have been directed by small businessmen and Jewish merchants, but many individuals living on the streets nearby supported their campaign. The signatories to the petition demanded that the city reconsider its plan, and suggested that should the city go ahead, many would leave the area. "And, in such case, those who leave will probably take legal advice as to what their rights may be against the City of Winnipeg if they are forced to leave this district under such circumstances."⁴³ Their petition appears to have received little serious attention from the Council.

⁴² CWA, Council Correspondence 11624, October 25, 1918.

⁴³ Ibid.

Later, beds were opened in the LaSalle hospital (across the Red River) and the North Winnipeg Hospital (earlier known as the People's Dispensary).⁴⁴ The Children's Hospital on Aberdeen Avenue in the north end took an unknown number of sick children, and also cared for children who were not ill but whose parents were too sick to take care of them or who had died.⁴⁵ Hospitals in Greater Winnipeg, including St. Boniface Hospital, the Grace Hospital and the Victoria Hospital, took patients as well.

Finding nurses and doctors to care for patients was difficult. The city was already experiencing a severe shortage of medical and nursing personnel because so many had volunteered to serve overseas. The flu's highly contagious nature took a high toll on caregivers. At least six nurses who were tending flu patients in hospitals were sick themselves by mid-October. The demand for nursing could not be met by nursing students who staffed hospitals and by the few graduate nurses who were employed in hospitals or government departments. The province's public health nurses, and the city's tuberculosis and child welfare nurses, set aside other work to cope with the epidemic. Private sector health organizations also contributed. Records from the Margaret Scott Nursing Mission indicate that influenza began to consume their efforts about the third week of October.

Due to the shortage of trained personnel, a great deal of nursing care was provided by volunteers. Volunteer nursing efforts were initially organized by building upon the local

⁴⁴ L. Mary Shepherd, *Our Hospitals Through the Years* (Winnipeg: Comet Press, 1958), p. 31-33.

⁴⁵ Harry Medovy, *A Vision Fulfilled: The Story of the Children's Hospital of Winnipeg, 1909-1973* (Winnipeg: Peguis Publishers, 1979), p. 21-22.

Voluntary Aid Detachment (VAD) nursing branch. By October 15th, 50 VAD nurses were prepared to nurse flu cases. Having already received training, these women became a highly sought-after resource, but there were too few of them available. The call went out for more trained nurses to come forward, particularly graduate nurses who either worked privately or who had given up nursing after marriage. Those who had courses in First Aid or St. John's Ambulance were also highly valued. In the first few weeks of the epidemic, it appears that most of the volunteers were utilized in hospitals, but the demand in the community was soon overwhelming.

Every community touched by the influenza epidemic had to make challenging choices about what measures it should take to restrict the mobility and behaviour of the public in the hope of minimizing contagion. Officials and elected politicians were forced to make decisions knowing that no measure had successfully prevented the spread of the disease in any city. There was a great deal of disagreement among medical professionals across North America regarding the efficacy of various options. Although City Council and the health department would eventually be harshly criticized by the business community for the course of action they took, Douglas, his colleagues, and the Board of Control were presented with no obvious solutions. They had to weigh possibilities that could potentially contain the disease, but at the same time generate hostile backlash, and drain the resources of the community in enforcement.

The wearing of masks is one example. Other locations, including the province of Alberta, made the wearing of masks in public compulsory. The order raised all kinds of logistical challenges, including not only enforcement, but also the manufacture of

sufficient masks for everyone in the city. The masks were unpopular with the public, and evidence suggests “that they were generally not worn at all or just pulled into place when a policeman came in view.”⁴⁶ Some medical men also believed the wearing of masks to be counter-productive. Dr. Alexander, in his 1919 report to City Council on the epidemic, commented:

As to the use of masks, without doubt it is wise for Doctors, Nurses, and Attendants in hospitals to wear masks but their indiscriminate use by the public is often positively harmful. In hospitals masks are sterilized whilst with the layman the mask becomes infected with careless handling and accordingly is really a menace.⁴⁷

Since the beginning of the epidemic, members of the Women's Civic League had been requesting the city to order that bread be wrapped before sale as a measure to control infection. Its President, Mrs. James Munro, argued that unwrapped bread, because it was touched and handled by many individuals before it was eaten, constituted a public health risk.⁴⁸ The issue was debated at City Council, where the League made presentations. However, the decision not to require either masks or bread wrapping was made public on October 28.⁴⁹

⁴⁶ McGinnis, p. 456.

⁴⁷ CWA, Council Correspondence 12020, Dr. A.B. Alexander, Medical Superintendent, Municipal Hospitals, “Report on the Spanish Influenza Epidemic to the Hospital Commission,” December 10, 1919.

⁴⁸ WT, October 25, 1918, p. 8.

⁴⁹ WT, October 28, 1918, p. 1.

Dr. Douglas and Gordon Bell remained committed to a different course of action. William Boyd had returned to Winnipeg from Rochester with a vaccine on Monday October 21. Despite uncertainty regarding the efficacy of vaccination Boyd made strong claims for its usefulness. He was supported by others in the medical and public health community. The Provincial Laboratory immediately began manufacturing two hundred 50-dose bottles of the serum per day.⁵⁰ At the same time, Major Fred Cadham, a bacteriologist with the Canadian military stationed in Winnipeg, prepared his own vaccine, and administered it to nearly five thousand soldiers.⁵¹

Dr. Gordon Bell announced that the Rosenow vaccine would be available to the public on Thursday October 24.⁵² Although physicians provided the serum privately at a cost, the city also set up several public stations where the vaccine could be had for free - a measure that demanded considerable resources in terms of manufacturing serum and administering it. The free vaccinations began initially at the Medical College, and were later offered at several community stations.

Douglas and his colleague W.J.T. Watt, Chief Inspector of the city's Communicable Diseases department, had more faith in the possible benefits of vaccination than in placarding infected households. As Watt explained, "the placarding of houses would tend to make people unwilling to promptly report cases."⁵³ They were, however, facing

⁵⁰MFP, October 25, 1918, p. 8.

⁵¹ F.T. Cadham, "The Use of a Vaccine in the Recent Epidemic of Influenza," *Canadian Medical Association Journal* 9 (1919).

⁵²MFP, October 23, 1918, p. 5.

⁵³WT, October 29, 1918, p. 1.

increasing pressure for more stringent measures, because in the last few days of October, the daily numbers of those infected suddenly almost doubled, and then rose to nearly 300 new cases per day. There were over one thousand officially documented flu cases in the city, and it is likely that this number greatly underestimated the rate of infection. The fatality rate began to climb, with thirteen deaths in a twenty-four hour period reported on October 30. Both the provincial and civic health officers were extremely concerned. Douglas stated bluntly that Winnipeg was facing the most serious epidemic in its history. Dr. Fraser warned the public to follow government orders or face an escalation of the disease.

If everyone, laity and professional, would observe the strict letter of the law regarding this disease, I believe there would be a decline in daily reports ... The authorities are aware that persons are concealing influenza patients in their homes - that certain doctors are failing to report cases, and on every such occasion the spread of infection is assisted.⁵⁴

In the face of a rapidly changing situation, strategies shifted. Official attitudes hardened, criticism of inappropriate behaviour escalated, and new demands were placed on the public by the press, health officials, and other community leaders. According to the Winnipeg press, "medical men" started to view the measures taken thus far as inadequate to control the disease, and advocated that the Provincial Board of Health implement further restrictions upon public mobility.⁵⁵ At the end of October, a local man was fined for not providing information regarding flu infection in his building to the

⁵⁴WT, October 29, 1918, p. 1.

⁵⁵MFP, October 28, 1918, p. 10.

authorities. Street car conductors were publicly criticized for not limiting crowding on their cars during peak hours. A *Tribune* editorial urged the Winnipeg public to play its part in implementing and enforcing health measures in the community: "Every citizen should feel these days that he or she is a health officer. 'Help the authorities to suppress the flu' should be a Winnipeg motto."⁵⁶

On October 31, in a clear about-face, city public health officials announced they would commence the placarding of all infected houses. This action may have been taken under pressure from the Provincial Board of Health; civic and provincial health authorities had met that day. Throughout the epidemic, provincial health official Stuart Fraser tended to make accusatory statements with regard to public complacency and non-compliance with the law, arguing that "alien" residents of the province were concealing cases of illness from the authorities.⁵⁷ Education was another of Fraser's favourite themes. He argued that "the differences in the spread of the flu in the educated and uneducated districts is sufficient proof of the value of such education."⁵⁸

Fraser had in the days previous publicized his desire for strict quarantine, commenting that carelessness in observing health proclamations would not be tolerated, and cautioning the public that "there has got to be prosecutions to the limit if the law is not strictly observed."⁵⁹ Despite strong language, however, nothing had changed to make

⁵⁶WT, October 30, 1918, p. 4.

⁵⁷ WT, October 29, 1918, p. 1; November 8, 1918, p. 5.

⁵⁸ MFP, November 11, 1918, p. 5.

⁵⁹MFP, October 29, 1918, p. 5.

quarantine and placarding measures more practicable than before. In fact, public health staff in Winnipeg were stretched to their limit, and the police force was itself reduced by having twenty-five of its members down with the flu by the first week of November. To some extent, the threat of prosecution was undermined by the increasing sense of disruption in the community.

It was difficult to strike a balance between generating enough public concern to guarantee compliance with public health measures, and generating so much concern that fear evolved into panic. For this reason, the general approach of health authorities was to argue that there was no need for fear, provided people followed the rules. Judging from the public rush to vaccination stations in the city, the authorities had reason to be worried about how the community was responding. Toward the end of October, hundreds of people starting flocking to the Medical College to receive the free vaccination; one press report estimated that 500 people were waiting in line there on October 29th. To meet this demand, health authorities opened three additional stations, at the Gladstone, Aberdeen and Alexandra schools. All of these were in districts where workers and their families lived.⁶⁰ Although public health officials must have been pleased to see the numbers of people being vaccinated, police officers were needed to keep order among those waiting.⁶¹

⁶⁰MFP, October 29, 1918, p. 5.

⁶¹MFP, October 30, 1918, p. 7.

Public fear was represented and fed by rumours that the flu was really the Black Death.⁶² It was difficult for many to believe that this was any ordinary influenza or grippe; the mortality of the disease seemed to set it apart as a different and unfamiliar illness. Nevertheless, rumours that authorities knew the true nature of the disease and were hiding it from the people suggest a conspiratorial undercurrent, as if there were those who mistrusted the official explanation of the disease and felt they were being misled and perhaps manipulated.

The evolving reactions of state authorities were, in any case, replete with irony. The Victory Loan Bond campaign is the best example. Alfred Crosby, in *The Forgotten Pandemic*, harshly criticizes the American political and public health authorities who allowed fundraising for the war effort to go on as planned, despite the threat of contagion. The Victory Loan campaign began in Winnipeg on Monday, October 28th. It involved a number of different fundraising activities, including a door-to-door canvass by four thousand women canvassers, who covered all the residential areas of the city. Organizers of the bond drive felt they had considerably scaled back their operations compared with previous years: "Owing to the prevalence of influenza, the spectacular element will be missing this year. There will be no formal ceremonies, no addresses, and no parade. The parade itself would have done little harm, since it would all be in the open air, but the doctors feared the congestion in the street cars, the stores, etc."⁶³ But the fear of infection did not prevent women volunteers from visiting thousands of homes, many of which must

⁶² MFP, October 29, 1918, p. 13.

⁶³ MFP, October 28, 1918, p. 1.

have been infected with the flu. At the beginning of the campaign, houses were not being placarded, and volunteers had no way to avoid the sick. Douglas, whose opinion of the dangers of the door-to-door canvass remains unknown, did his best to protect these volunteers by using the data the health department had collected on flu cases to generate lists of infected houses. He provided the canvassers with these lists, and told them to wear masks when they visited infected households. It seems doubtful, however, that the lists could have been complete. Health authorities knew there were unreported cases of flu throughout the community. Perhaps some canvassers wore their masks to every home, but masks could not have been conducive to making the sales pitch for victory bonds.

The Victory Loan campaign was promoted relentlessly by the local press, particularly the *Free Press*. The amounts raised by the campaign were regularly reported, and the newspapers were filled with full-page advertisements urging the public to contribute money. There was explicit competition between Canada's cities for the best results; the previous year's total had to be at least matched, and preferably exceeded. Although the door-to-door canvass was by no means the most important source of dollars, it was the means through which average citizens were reached, and their patriotic feeling appealed to. Supporters often stated that no donation was too small. The campaign, therefore, was intended by social and political elites to act as a force for social cohesion during a traumatic period for the community. Canceling the campaign does not appear to have been seriously contemplated, although there were many private philanthropic organizations whose fundraising activities were curtailed or cancelled because of the epidemic.

The door-to-door canvass lasted two weeks. It was hampered (a “disturbing prospect” in Dafoe’s opinion)⁶⁴ but not stalled by the number of houses quarantined (after October 31) and by a shortage of volunteers. During their visits, canvassers encountered some disturbing situations. As one district team captain recalled, “I was standing at a counter one day last week waiting to canvass a man for Victory bonds while he was telephoning to someone the interesting information that he had been suffering from Spanish ‘flu’ for a couple of weeks. I nearly died but we sold him just the same.”⁶⁵

While the number of flu infections escalated dramatically in the week that followed the start of the Victory Loan campaign, it is not clear to what degree the fundraising drive was directly responsible. The Spanish influenza tended to have a trajectory in urban settings characterized by fairly slow growth followed by a sudden explosion of cases. Nevertheless, by this point the disease had been in Winnipeg for a month, and there was some evidence that public health measures were having an effect. Although the number of new cases reported per day was on the rise, the death rate remained relatively low. The flu had resulted in only about twenty deaths; over the next few weeks, it would kill about forty times that number. The Victory Loan campaign, in conjunction with Armistice celebrations, brought thousands of people in direct contact with each other, many of whom would not otherwise have had that contact. There seems little reason to disagree with Crosby's allegations that authorities showed poor judgement, and sacrificed public health to the financial needs of war.

⁶⁴ MFP, November 12, 1918, p. 5.

⁶⁵ MFP, November 2, 1918, p. 13.

The Victory Loan campaign very likely diverted the energy of women volunteers away from the desperate need for nursing in the community. An expanded volunteer nursing initiative was begun the first week of November. The Women's Volunteer Nursing Brigade, a project of the Winnipeg Women's Volunteer Reserve (VAD), and the Women Teachers' Club, was organized in the Medical College. Miss Russell, the head of the provincial public health nursing department, and Mrs. F.E. Langdale and Miss Nanna Robinson of the Winnipeg School of Nursing staff, began giving lectures to volunteers. They were to have a minimum of four days' training before being sent out to help nurse victims in their homes.

The flow of volunteers was slow, but began to grow with public appeals from the women who headed the Medical College volunteer bureau. "Urgent appeals" for more volunteers were printed regularly in the press. Women school teachers, who were not at work because of school closures, played an important role. Thirty-three teachers had completed their hasty training by November 4, and 25 more were already volunteering at the Logan Annex, as the Old Coffee House building on Logan and Main was now referred to. Still, the approximately one hundred sixty volunteers who were operating out of the Medical College by this time could hardly have met the demand; there were nearly six hundred new cases per day being reported by the 5th of November.⁶⁶ Many calls made to the volunteer nursing bureau could not be responded to, particularly if the call for help came at night.

⁶⁶MFP, November 5, 1918, p. 5.

By the beginning of November, the north end of the city was severely stricken. Statistics printed daily in the press indicated that the district suddenly had nearly double the number of new cases per day than other districts of the city. On November 2nd, for example, there were fewer than 100 new cases reported in each of Districts A, B, and C (south of the CPR), but 235 in the north end. City health authorities had carefully plotted the spatial distribution of the disease since early October, and made public their analysis. Until the end of October, it seemed that the disease was fairly evenly distributed throughout the city, after its spread outside of its original location near the Assiniboine River. But as the epidemic spread, it was clear that health authorities had lost the battle to restrict its progress in the immigrant and working class districts of the north end. They admitted that nothing further could be done but wait for the crest to pass and the disease to burn itself out.

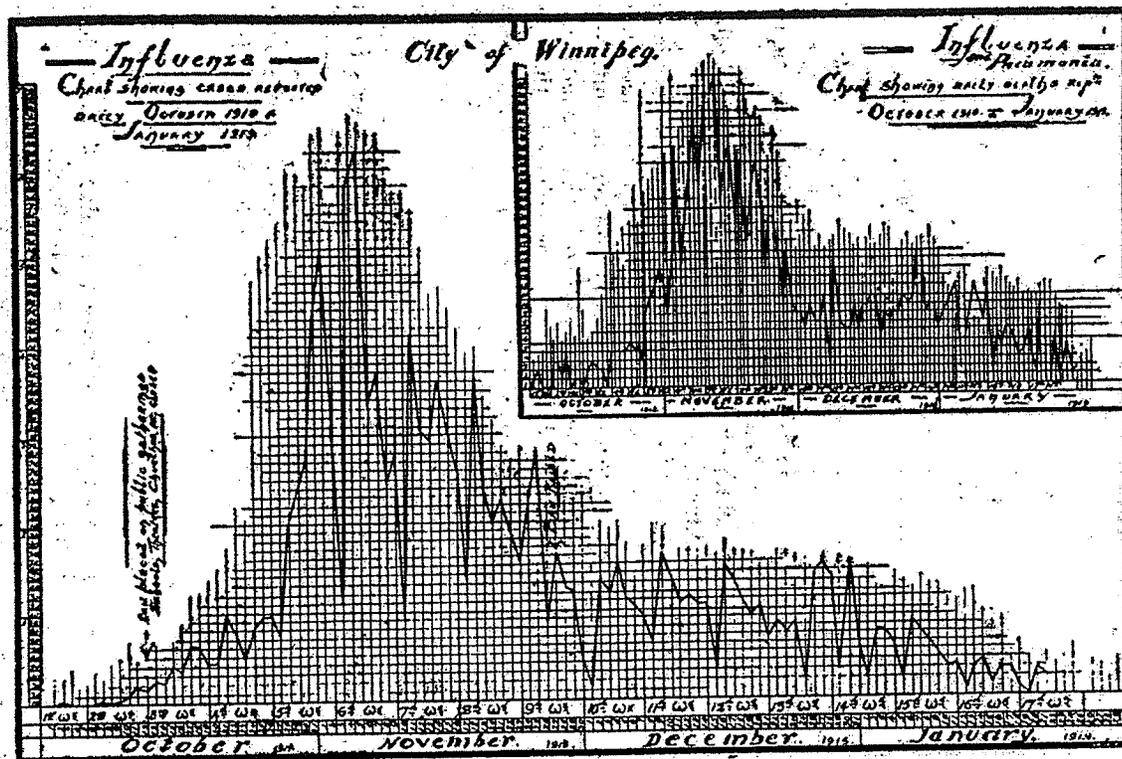


Figure 2: Influenza Cases at the Epidemic's Peak⁶⁷

Douglas publicly blamed Hallowe'en parties for the escalation in cases the first week of November. Mayor Davidson for the first time during the epidemic spoke publicly to the people of the city, warning them to take the disease seriously. But another potential opportunity for contagion was now arriving with the signing of armistice. On Thursday November 7 and Friday November 8, the *Free Press* announced that an armistice had been signed. Impromptu celebrations erupted throughout the city, dispelling the epidemic's "sensation of gloom."⁶⁸ On Saturday, November 9th, the *Tribune* and the *Free*

⁶⁷ F.T. Cadham, "The Use of a Vaccine in the Epidemic of Influenza," *The Canadian Medical Association Journal* 9 (1919), p. 525

⁶⁸MFP, Nov. 8, 1918, p. 13.

Press reported entirely contradictory opinions regarding the impact of the gathering of crowds upon the disease from the provincial and civic health officials. M. Stuart Fraser asserted:

I do not expect any increase in the "flu" rate because of yesterday's immense crowds ... The crowds always were moving and in the open air, and the "flu" germs had little chance to spread. A crowd like that is less of a danger than a small gathering in an enclosed space. The spirit of optimism which permeated everyone is the greatest deterrent of contagious diseases known. The mere happiness of everyone is sufficient to counteract the effects of the germ."⁶⁸

By contrast, Douglas was angry and in total disagreement: "If the public wants to crowd, it is up to the public. The people were told what to do to avoid the disease and if they don't do it it is up to them. Nothing more than we are doing can be done. I certainly expect worse conditions."⁶⁹ On Monday November 11, the Armistice was actually signed, and a "joyfest rage[d]" in the streets of Winnipeg, an unofficial and spontaneous celebration of the end of the long war.⁷⁰ The provincial government stated it would postpone any official celebration until after the flu ban had been lifted, but did not make any attempt to break up the congregation of people on the streets.

Pressure from the business community and some church leaders to lift the ban increased as the number of reported cases of flu began to fall slightly. But the disease now presented a puzzling aspect to health officers. Even as the number of reported flu cases declined, the number of daily deaths rose. Over the weekend prior to Armistice,

⁶⁸MFP, November 9, 1918, p. 6.

⁶⁹WT, November 9, 1918, p. 5.

⁷⁰ WT, November 11, 1918, p. 1.

there were fifty-two deaths, judged a "staggering toll" by the local press, and one that was not easily understood.⁷¹ One explanation was that these deaths were the outcome of the climb in infections early in that week; it was also suggested that the city might now be facing a new and more virulent disease.⁷² Another possible explanation for the apparent discrepancy between fewer cases but a higher number of deaths was that cases were not being reported. This likelihood prevented Douglas from being enthusiastic about lifting any portion of the meeting ban, even to allow for church services. The federal government had called upon churches across the country to celebrate a "Victory Thanksgiving." The Winnipeg Ministerial Association, which was generally supportive and cooperative with public officials, met to discuss appealing to provincial authorities to lift the ban for one Sunday. This permission was refused until early December.

With influenza apparently beyond the control of public health officials, the volunteer efforts of philanthropic women's organizations took centre stage. The presidents of all the major women's clubs in the city were asked to "personally appeal to their members" to volunteer to nurse flu victims. An emergency meeting of volunteers was held at the Alexandra School on November 10th. One outcome was the opening of five substations for food distribution across the city. A district nursing office was also opened in the Brooklands district, near the CPR shops, as this was now seen to be an area of extreme need. This district office was run by Mrs. H. Powles, a nursing sister who was employed in the CPR centre of the St. John's Ambulance.

⁷¹ MFP, November 11, 1918, p. 5.

⁷² MFP, November 11, 1918, p. 5.

Despite public appeals, however, the shortage of female volunteers was extreme and was probably an important factor in the number of men who now began to come forward. Many were members of the clergy, who volunteered alone or with their wives. The food kitchen in Weston, for example, was operated by Methodist pastors. But male schoolteachers also assisted, as did male social workers. These men were sent to delirious, difficult-to-handle cases, and took night calls.⁷³

Charity could not possibly meet the pressing, unmet needs in the poorer areas of the city. But little government planning or attention went into alleviating the impact of the disease upon stricken households. The food kitchen was providing over one hundred fifty families a day with food by the second week of November, relying entirely upon donations of food, labour, and money. Hundreds did donate food baskets, and eggs, dairy products and preserves were given by rural Manitobans.

Even the circumstances of the epidemic could not displace middle class perceptions that a firm hand was needed in giving assistance to the poor. The organizers of the emergency food kitchen had to respond to public accusations that help was going to those who could fend for themselves, and that free food was being provided indiscriminately. The food kitchens did charge for their services when families were able to pay. But, organizers pointed out, most of those requesting assistance were "families where the breadwinner is either down with the 'flu' or has died of it."⁷⁴

⁷³WT, November 11, 1918, p. 6.

⁷⁴WT, November 11, 1918, p. 6.

While the energy and material resources of the city's philanthropic infrastructure were tested, provincial and civic governments did little more than observe. The city government, true to its non-activist tradition, had to be pressured into providing financial support for relief efforts. As the crisis escalated, Mayor Davidson's indecisiveness and lack of leadership was a point of some concern to the local elite. According to the *Free Press*:

At the suggestion of several prominent citizens who are anxious that every nerve be strained to bring aid to the homes suffering from lack of nursing and care in the present epidemic, the *Free Press* interviewed Mayor Davidson with regard to the city making a grant to the nursing bureau and also to help out the work of the emergency kitchen. After giving the matter some consideration, the mayor decided that the whole enterprise of dealing with the "flu" rests in the hands of Dr. A.J. Douglas ... Dr. Douglas when interviewed stated that he would be very glad to recommend a grant to help the work of the women's committee ... if [they] would state the needs to him.⁷⁵

After the Armistice, news of conditions in the city became increasingly disturbing in several ways. For the first time, a direct link was made between the lack of medical and nursing care, and deaths. "People are truly and literally dying for want of help," the *Free Press* reported. Nurses were "on the verge of breakdown." The flow of incoming volunteers was insufficient to replace those burning out. Perhaps assuming that women were reluctant to come forward for fear of contracting the disease themselves, volunteer coordinators tried to convince the public that precautions were able to protect volunteers from contagion. However, nurses were in fact highly at risk of contracting influenza. Efforts to reassure women were rendered irrelevant when three VAD nurses died within

⁷⁵MFP, November 12, 1918, p. 5.

two days in mid-November. Still, it is remarkable that so many did offer their help. Four hundred volunteers were working at the Emergency Nursing Bureau by mid-November, and this number continued to grow, although many needs remained unmet.

Stories of families in extreme distress were increasingly common. A male captain in the Salvation Army, who had been visiting homes in the north end to try to find sick families who were too ill to get help, encountered the following scenario:

Five members of a family of six had contracted the disease and had been unable to advise the authorities. When the army captain called they had received no medical attention, and their wants had been attended by the remaining members of the family, who was a child of eight years of age.⁷⁶

And:

One most terrible case reported yesterday was that of a family at St. James, a father, mother and four children. All of them had the "flu" in various stages, but the little baby was terribly ill. They had no telephone in the house and thirteen times the father had dragged himself out to a nearby phone to try and get a doctor and when the district nurse arrived she found him near his home collapsed on the sidewalk and in tears because of his failure to get help for his children.⁷⁷

And:

A doctor hurrying away from a case of the "flu" yesterday was accosted on the street by a little child of seven. 'Come in and wake my papa and mama,' she said, 'they have been asleep for three days.' The doctor found the father and mother dead. The child herself was half starved as there was practically nothing in the house to eat.⁷⁸

⁷⁶MFP, November 13, 1918, p. 5.

⁷⁷MFP, November 14, 1918, p. 7.

⁷⁸Ibid.

The common theme in these stories is that entire families were stricken, and so quickly and traumatically that they could not—or perhaps chose not to—go to the hospital. As the epidemic reached its peak, a growing number of emergency hospital beds in Winnipeg remained empty, suggesting that hospital care was not meeting people's needs, was inaccessible for financial or other reasons, or was being avoided.⁷⁹ By November 15, there were at least fifty unoccupied hospital beds in the city. Officials calculated that there were about 6000 Winnipeggers suffering from the flu on any given day, but only 2000 in hospital. The hospital, not the home, was the best place for flu victims, they believed.

A summary of influenza statistics presented by civic health officials on November 18th indicated that 7,404 cases of influenza had been reported since the beginning of the epidemic, and 409 deaths caused by the flu had been confirmed. Officials knew that these figures were incomplete and did not reflect the reality of the situation. Nevertheless, the following day, W.J.T. Watt provided an analysis that suggested the death rate in the north end was "exceptionally high." Public health officials continued to monitor the situation, looking for signs that the epidemic had run its course. On November 21, press reports suggested that the turning point had been reached, with only 195 new cases being reported the previous day - the lowest number since October 26. There were still nearly

⁷⁹ Paul A. Buelow, "Chicago," in Fred R. van Hartesveldt, *The 1918-1919 Pandemic of Influenza: The Urban Impact in the Western World* (Lewiston: The Edwin Mellen Press, 1992), p. 132, 139-140. In Chicago, a survey of city hospitals in the midst of the epidemic found a considerable number of empty beds, many of them in private hospitals. The suspicion was that these hospitals were refusing indigent patients. The city's Influenza Commission threatened to revoke the licenses of any facilities denying care to the poor.

30 deaths per day, but this number was stable. Cases increased slightly the following day, but then began a steady decline. By November 30, there were 122 new cases reported, and 12 deaths the previous day.

City health officials may have come to regret their decision to openly share their statistics with the public. The day the number of reported cases began to drop, they began to face ever greater pressure to cancel the public meeting ban. The *Tribune* helped increase this pressure by stating on Friday November 22 that the ban would be lifted Saturday at midnight, according to a "semi-official" report. When no announcement lifting the ban was made, the paper then reported that the theatres and churches were very disappointed, as they had prepared for the ban being lifted. The clear implication was that officials had led the public along.

Douglas and city council finally announced on Monday, November 25 that the public meeting ban would be lifted that Thursday. The ban had lasted 46 days—the longest in North America, according to the *Tribune*—and was causing "considerable unrest among businessmen."⁸⁰ Douglas publicly denied that the meeting restrictions in Winnipeg were significantly different from those in other Canadian cities, which prompted the *Tribune* to print a list of public bans in other cities to prove its point.

The Provincial Board of Health met the morning of Saturday, November 22, where there was some vigorous debate. Douglas argued against immediately lifting the ban, and rebuffed the suggestion made by some health officials that the north end of Winnipeg be kept under the ban, while other areas would have the ban lifted. It is a clear indication of

⁸⁰WT, November 22, 1918, p. 1.

Douglas's authority that the lifting of the ban was held off until Thursday, and that it was applied evenly across the city. School opening was delayed until Monday, in order to give 160 teachers who had volunteered during the epidemic the weekend to rest before their return to work.

Despite Douglas's even-handedness and his ability to sustain the support of city council for his decisions, he and the civic health department came under very strong criticism from the business community, including a lengthy reprint in the *Tribune* of an accusatory and highly critical letter to health authorities. The letter cited inconsistencies in the actions of the health department, such as the contradictory scope of the meeting ban which closed schools and churches but did not close stores or limit streetcar transportation. The authorities were accused of "permitting" the false peace celebration on November 8th, in which thousands of people congregated in the streets. Douglas warned citizens to stay out of crowds, while urging them to do their Christmas shopping early. The lack of placarding and strict quarantine of victims from the start of the epidemic probably prolonged the epidemic, the article argued. The health department had "bungled" the situation.

Some of these comments without doubt had merit. The efficacy and intent of the public meeting ban and school closure were both debatable. Other cities made different decisions, and no course of action proved to be entirely successful. However, business and the press had been solidly behind the public ban at the outset. The management of the CPR, in particular, had applauded its wisdom (presumably because it restricted union meetings). The city's business elite had not called for strict quarantine early on and may

in fact have opposed such a measure as harmful to their business. To say after the fact that a more strict quarantine was necessary proved little - there was no way to prove or disprove that a strict quarantine would have been effective. The criticisms from the business community appear designed, in reality, to bully the health department into an immediate end to the meeting ban, and constituted a retaliatory attack blaming civic authorities for the loss of revenue over the previous two months. It is likely that the timing of the ban's cancellation on November 27 was determined above all else by the scheduled Winnipeg civic election, which went ahead as planned on November 29. Mayor Davidson lost the election, and the flu was considered a major factor in his loss of public support.

There was a tremendous rush to return to normal life and to consumer-oriented activities after the ban was lifted. The mainstream press highlighted the capacity of the community to rebound quickly from the experience, "kick[ing] off" the flu, and finding "its former gait with ease."⁸¹ The impact of the ban upon local commerce was most clearly demonstrated by the theatres, which had lost all their business during the seven weeks of closure. Theatres ran midnight shows on November 28, and the press reported these to be packed with enthusiastic audiences: "When the door opened there was a rush for the seats and as the band started up the playing of patriotic airs, the crowd entered into the spirit of the night and sang the choruses with a will."⁸² It "looks like good business,"

⁸¹WT, November 28, 1918, p. 8.

⁸²MFP, November 28, 1918, p. 4.

theatre managers noted.⁸³ In order to dispel concerns over contagion, theatres advertised that they disinfected the premises as many as three times per day.

Those with less secular leisure habits may have marched in the Salvation Army parade. Others may have attended church services in thanksgiving "for the ending of the war and the ending of the plague,"⁸⁴ such as the one held at the Christian Science Church on Nassau St. Most of the main church denominations, however, held their thanksgiving services on Sunday December 1st, which was also the first Sunday of Advent. Protestant church leaders, their belief in modern science and germ theory intact, reiterated their confidence that the Spanish flu had not been a "divine visitation."⁸⁵

The day following the Winnipeg municipal election, along with press coverage of election results, came reports of another wave of 'Spanish' influenza striking European cities. Even as Winnipeg was publicly celebrating the ending of the 'plague,' the epidemic was not over for everyone. There were still over 100 reported cases and 15 deaths per day in the city at the end of November. Volunteer nursing and diet kitchens began to scale down, but the need for their services had not disappeared. Twenty of the city's churches committed to supply food to the ill after November 28, when the central organization at Alexandra school would be dismantled. The work of the Emergency Nursing Bureau was transferred to the city's health department, although the women there agreed to keep it

⁸³WT, November 28, 1918, p. 8.

⁸⁴WT, November 28, 1918, p. 8.

⁸⁵WT, December 1, 1918, p. 5.

functioning until the end of that week, in order to facilitate the transition. The fall wave of the flu did not entirely subside until February 1919.⁸⁶

A third wave of influenza crossed the globe in the spring of 1919, and arrived in Winnipeg in mid-March. The spring wave of the disease had a less marked impact upon the city, with only 2342 cases reported to health authorities. There were no quarantines, no placarding, and no public meeting bans. However, there were 301 deaths. The fall wave had taken 915 lives. There was, then, a total of 1216 recorded deaths from influenza in the city of Winnipeg in 1918 and 1919.⁸⁷

Summarizing the Toll

It took some time for the city and provincial health authorities to arrive at statistical summaries of what the city had experienced, and when they did there were still many unanswered questions. It was believed at the time that the number of influenza cases was grossly underreported.⁸⁸ It is also very likely that the number of deaths was underrepresented in official figures. Officials knew that even under normal circumstances many births in the city were not reported, and that some deaths were still recorded only by church parishes, and not reported to city authorities. One of the mothers whose experience with influenza is recounted in Chapter 6 had only her priest to vouch that her

⁸⁶ CWA, Annual Report of the City Health Department, 1919.

⁸⁷ CWA, Annual Report of the City Health Department, 1919.

⁸⁸ Significant underreporting is now accepted by historians of the epidemic. See Niall Johnson and Juergen Mueller, "Updating the Accounts: Global Mortality of the 1918-1920 'Spanish' Influenza Pandemic," *Bulletin of the History of Medicine* 76, 1 (2002).

spouse had died of the flu when she applied to the provincial government for Mother's Allowance. She had no death certificate. The priest sent a letter to the Mothers' Allowance Commission verifying that he had attended the death of this man, and prepared his body for burial. There is no way of knowing precisely how many others similarly did not register deaths in the family.

Winnipeg's medical health officer reported a total of 2706 deaths by all causes for 1918, giving a death rate of 14.74 per thousand population. The impact of the flu is apparent when comparing this with the previous year's figure, which was 9.45 per thousand. For 1919, the death rate was 11.49, reflecting the fact that "this disease was taking an extensive toll during the early months of [1919]."⁸⁹

The city health department also tabulated influenza cases and deaths by district. District A was the area south of the Assiniboine River. District B began on the north side of the Assiniboine River, and stopped at Portage Avenue. District C covered the area north of Notre Dame Avenue and Portage Avenues, to the CPR tracks. District D lay north of the CPR tracks.

In their annual report to City Council, which was issued April 7, 1919, the department included a summary covering October 1918 to January 1919 inclusive.

⁸⁹ CWA, Annual Report of the City Health Department, 1919.

District	A	B	C	D
Cases	2261	3929	2871	4962
Deaths	103	269	240	449
Pop.	25606	57629	28691	41674
Cases Per 1000 Pop.	88.3	68.2	100.1	119.1
Deaths Per 1000 Pop.	4.02	4.67	8.36	6.73
Deaths Per 1000 Cases	45.6	68.5	83.6	90.5

As is clear from these statistics, there were variations in the impact of the epidemic in different areas of the city. Those areas of Winnipeg recognized as poor immigrant and working class neighbourhoods, Districts C and D, had a high death rate; the well-off District A, a much lower rate. The 'foreign' immigrant community north of the tracks was in particular greatly affected.

Aside from the important issue of underreporting of cases and possibly deaths, these figures have to be qualified in one important sense. Deaths were in some cases counted in the district where the individual died, not where he or she lived. Therefore, the figures for District C in particular are distorted, as both the Winnipeg General Hospital and the Logan Annex were located within this district. In addition, the recorded deaths for other districts may be lower than they should be, if people from those areas died of the flu while in either of the District C hospitals. However, the high death rate north of the CPR tracks, in District D, is probably more reliable. There were two hospitals located in that

area that took flu patients—the North Winnipeg Hospital and the Children’s Hospital. These institutions may have had patients from south of the tracks, but particularly in the case of the North Winnipeg Hospital, most patients were likely from the district. Given the age-distribution pattern of the disease, childhood deaths were relatively insignificant overall. The statistics from District D should be considered reliable, within the general constraints of the data.

Although it isn’t possible to arrive at a precise conclusion regarding relative infection rates and death rates based upon the city health department statistics, it is nevertheless reasonable to conclude that the north end did suffer disproportionately. The number of infections was extremely high. People in the poorest district were one-third more likely to get sick in the first place than people in the wealthiest. But even more striking is the high number of deaths relative to infection rates. Using the official number of cases, the north end had a case specific mortality rate that was nearly double that of the southern end of the city—90 deaths per thousand cases, as compared with 46 per thousand. This would lead to the conclusion that the poor of the north end were somewhat more likely to become infected, but much more likely to perish once ill than the city’s prosperous citizens.

Again, the reliability of these figures may be open to challenge, particularly if the number of unreported cases in the north end was disproportionately high compared with District 1. However, considering the available data as a whole, the severity of the influenza epidemic in the immigrant working class district of Winnipeg is clear. This conclusion is supported by numerous anecdotal accounts.

The city's health statistics confirm a familiar pattern: influenza's unusual impact upon young adults between the ages of 20 and 50. In Winnipeg, in the 1918 and 1919 waves combined, 68 percent of influenza deaths fell in this age category; 60 percent of all deaths were concentrated among men and women aged 20 to 39. Official statistics also suggest a higher mortality among males than females, although the difference between the number of male and female deaths in official data is less than 5 percent and may therefore not be significant. Data were not cross-tabulated by age and gender, so we do not know the gender distribution of deaths among the key age group, 20 to 39.

Children did die from the disease. There were 225 reported deaths of children under age 10, nearly three-quarters of whom were children under the age of three. An additional 100 children aged 10 to 19 died. The deaths of young children during the epidemic were noted by public health nurses and city officials, and were considered particularly unfortunate in light of the health department's efforts to lower infant mortality. In its 1919 report, the department of child hygiene concluded that the influenza epidemic had a marked effect upon infant mortality during the first few months of the year. For the first four months of 1919, the rate was 132 per 1000, while for the year as a whole it was 106.9 per thousand. (Infant mortality for 1918 was 91.8 per thousand.)

Furthermore, infant mortality statistics suggest that the district breakdowns in mortality mask the impact of the flu upon poorer neighbourhoods outside of the downtown and north end. In 1919, the department of child hygiene began to provide information about infant mortality by wards. There were seven wards in the city. [See

Figure 1] For both 1918 and 1919, the highest overall rates of infant mortality were experienced in wards II, V, and VII. The director of child hygiene observed that wards II and VII suffered terribly during the epidemic, and that this had a negative affect upon overall statistics for the years 1918 and 1919. Ward II had a rate of 150 infant deaths per thousand for 1918, the highest rate of any city district for that year; ward VII's rate for 1919 was 131 per thousand. Both of these were considerably above the average for the city overall. However, during the first four months of 1919, while influenza was still affecting the city, infant mortality in wards II and VII were 244 deaths per thousand live births, and 158, respectively. How to account for the extremely high number of infant deaths in ward II? The evidence suggests the important role housing conditions could play. The poor quality of housing and inadequate sanitation in the north end is well documented, but it was not the only district of the city where working people had a difficult time finding good accommodation. Ward II was populated with British and Canadian residents, but the district was not uniformly middle class. It also contained a pocket of poorer Anglo-Canadian workers, in the midst of a relatively prosperous area of Winnipeg. These residents could not afford to purchase homes, and lived in rooming houses and other rental accommodation. The bureau of child hygiene explained the variable patterns of infant mortality among Winnipeg's poor:

V and VI contain large foreign-born populations with low death rates during the first month of life, but high mortality from the first to sixth months, mainly due to improper feeding and pneumonia. ... Wards with British populations have high mortality during the first month of the infants' lives, especially noticeable in Ward II which contains a large rooming-house district with many young couples occupying one and two rooms.⁹⁰

By contrast, the lowest infant mortality during the epidemic was in ward III, which, according to the Bureau of Child Hygiene, "[was] the largest ward in the city and consist[ed] mainly of good class residences, with British families predominating. There is also a large section of Icelandic families, amongst whom infantile mortality has always been about half that of the other nationalities."⁹¹

These two categories of deaths—of young adults and of young children—are an indication of how devastating this disease was for young working class and immigrant families. The extremely contagious nature of influenza meant that infections often affected entire households. Many lost one or both adults, as well as one or more children. The disease also had an extremely negative impact upon poor pregnant women, as many as half of whom were likely to die if ill with influenza.⁹² Although there are no statistics available with regard to the mortality of pregnant women and their babies in Winnipeg,

⁹⁰ CWA, Annual Report of the City Health Department, Bureau of Child Hygiene, 1919, p. 126.

⁹¹ Ibid.

⁹² Alan P. Kendal and William P. Glezen, "Pandemic Influenza and Pregnancy: Lessons From the Past, and Consideration About Use of Live Attenuated Vaccines," Paper presented to The Spanish Flu After 80 Years Conference, Cape Town, South Africa, 1998. Of 200 cases of pregnant women with influenza in Philadelphia, 49% died. Data from Baltimore found 27% died, and one-half of all those who had developed pneumonia. The Philadelphia study also found that one-half of infants born to women with influenza died. The authors suggest that the flu's impact was particularly severe among poor and malnourished pregnant women.

the records of the Margaret Scott Nursing Mission suggest that many poor pregnant women suffering from influenza died soon after giving birth. Their babies consequently had a reduced chance of survival without maternal care and feeding.

In Winnipeg, social inequality was an important determinant of influenza mortality. What it was for working families to live with this social reality is not entirely captured by statistics. In later chapters, the nature of working class and immigrant experience during the epidemic will be explored more fully.

Chapter 3 – Gatekeeping Women’s Volunteerism

Meeting the need for medical and nursing care of thousands of influenza victims posed at times an almost impossible challenge for medical authorities. Although several hundred emergency hospital beds were opened to isolate and care for the sick, the health needs of the people were often met in Winnipeg in 1918 much as they had been in nineteenth century epidemics: through charity and volunteerism. Women played a central role both as professionals and volunteers, not only by providing care to diseased bodies, but also by bolstering a threatened sense of social order in a potentially chaotic context. When, at the peak of the epidemic, the local press demanded ‘who will come to the rescue?’ of the ill, the question was not ‘which gender?’ Caring for the diseased—washing their bodies, feeding them, ensuring their comfort and cleanliness, and easing their deaths—was seen as a female role and responsibility. Only rarely did men come forward to perform the tasks of basic nursing care for influenza’s victims.

The gendered construction of community response to epidemics is curiously unexamined in the historiography. Seminal works of epidemic history take for granted the gendered division of labour in social responses to epidemic disease.¹ Although the importance of nursing relief during the influenza epidemic has been recognized, it has not been interrogated. Alfred Crosby comments:

¹ For example, Richard Evans’s study of cholera in Hamburg limits itself to analyzing the gender differences in mortality rates. *Death in Hamburg: Society and Politics in the Cholera Years, 1830-1910* (London: Penguin Books, 1987), p. 450-469.

Nurses were more important than doctors because neither antibiotics nor medical techniques existed to cure either influenza or pneumonia. Warm food, warm blankets, fresh air, and what nurses ironically call TLC – Tender Loving Care – to keep the patient alive until the disease passed away: that was the miracle drug of 1918.²

The social dimensions of this healing role warrant further investigation.

Nursing historians have explored the contributions of trained nurses to fighting influenza and have argued that the epidemic was important to nursing professionalization in this period.³ However, female volunteerism in the epidemic extended to many women who were not trained nurses; most volunteers were, in fact, untrained. Little is known of their experience. Howard Phillips has briefly noted for the South African case the ideals of self-sacrifice exhibited by white middle class English speakers, for whom “‘doing one’s bit’ and helping others ... were deemed to be the highest principles of dutiful humanity.”⁴ Thus, Phillips observes, volunteer nurses were given “lyrical praise” for their self-sacrifice, even while being excluded from that country’s Influenza Epidemic Commission. What lay behind the public praise of women’s volunteerism? Did gendered

² Alfred Crosby, *America’s Forgotten Pandemic*, p. 7. Other recent full length treatments that document nursing’s role as well as that of women volunteers include Geoffrey Rice, *Black November : The 1918 Influenza Epidemic in New Zealand* (Wellington, New Zealand: Allen and Unwin, Historical Branch, Department of Internal Affairs, New Zealand, 1988); Howard Phillips, *‘Black October’: the Impact of the Spanish Influenza Epidemic of 1918 on South Africa* (Pretoria: the Government Printer, 1990).

³ Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990* (Toronto: Oxford University Press, 1996), p. 26. For nursing in the United States, see Rhonda Keen-Payne, “We Must Have Nurses: Spanish Influenza in America, 1918-1919,” *Nursing History Review* 8 (2000); Katrina Rodies, “That Great Call: The Pandemic of 1918,” *Nursing and Health Care Perspectives* 19, 5 (1998); Mary Westphal, “The Role of Nursing in the Influenza Pandemic of 1918-1919” *Nursing Forum* 25, 2 (1990).

⁴ Howard Phillips, p. 233.

roles fully confine the acts of women? What important class and ethnic boundaries found their expression in the ideal volunteer nurse?

Gender alone did not define the structure of volunteerism in Winnipeg. Gendered roles were intertwined with class and ethnic identity and power. The largest and most well-known volunteer initiatives—the nursing relief service and the diet kitchen—were organized and controlled by middle and upper class Anglo-Canadian women.⁵ Women of other classes and ethnicities were largely excluded. Caring for the ill, however, drew middle and upper class women into contact with the poor and the ‘foreign’, and facilitated a physical and social crossing of the boundary separating ‘north’ from ‘south’ Winnipeg. Fearing that social distinctions would become blurred in this time of crisis, relief coordinators used several gatekeeping strategies to restate and reinforce divisions of ethnicity and class.

During the intense and disruptive epidemic moment, women volunteers faced new and unsettling experiences. In the “contact zone” middle class Anglo-Canadian women volunteers entered into close connection with the diseased other. The term “contact zone” is borrowed from Mary Louise Pratt. Her study of colonial encounters and travel writing describes the “contact zone” as

the spatial and temporal copresence of subjects previously separated by geographic and historical disjunctures, and whose trajectories now intersect ... A “contact” perspective emphasizes how subjects are constituted in and by their

⁵ Lawrence Koblenz states that volunteers in the United States were “college girls, teachers, and wealthy matrons.” See his unpublished paper “A Judgement in Time: Medical Responses to the 1918-1919 Influenza Epidemic in the United States,” presented to The Spanish Flu After 80 Years Conference, Cape Town, South Africa, 1998, p. 18.

relations to each other. It treats the relations among ... travelers and "travelees," not in terms of separateness or apartheid, but in terms of copresence, interaction, interlocking understandings and practices, often within radically asymmetrical relations of power.⁶

The contact zone Pratt describes, unlike ours here, occurs on the colonial frontier, between peoples who are encountering each other for the first time in history. Nevertheless, conceptualizing interaction during the epidemic as a contact zone is fruitful when we consider the clear disjunctures in physical space and social power between the residents of north and south Winnipeg in this period. Perhaps more importantly, however, the concept captures some of the unexpected and extraordinary qualities of social interaction during the epidemic, when lives intersected and experience was shaped in ways other than the everyday. Volunteers faced quite exceptional risks to their physical and emotional health as they fought to save lives and encountered death in unfamiliar settings, sharing with strangers moments of extreme vulnerability and pain. Many of those they helped were poor; some did not speak the same language. While caring for and traveling among the diseased poor, volunteers met working families who were in dire need of assistance and accepted it gratefully. Others, however, resisted volunteers' perceived interference.

Pratt's insistence that subjects are shaped by their interaction with one another in the contact zone encounter suggests a useful theoretical approach for improving our understanding of how epidemics exacerbate social conflict, and deepen class and ethnic

⁶ Mary Louise Pratt, *Imperial Eyes: Travel Writing and Transculturation* (London: Routledge, 1991), p. 7.

divisions.⁷ The language used by the press, politicians, public health officials, and volunteer organizers to frame and explain the volunteer/victim encounter is particularly revealing in this regard. A narrative of feminine heroism, drawing comparisons between influenza volunteers and soldiers, emerged as the epidemic reached its peak. The heroic woman volunteer—white, respectable, and knowable—diffused the potentially disruptive contact and interaction between north and south by restating the superiority of the city’s dominant Anglo-Canadian elite, and their difference from the north end’s diseased others.

As was established in the previous chapter, the spread of influenza after its arrival in the city at the end of September 1918 was initially relatively slow. Perhaps this was due to the early action by civic health authorities to ban public gatherings and close schools. But toward the end of October, the number of cases began to escalate; in the last days of October, the daily numbers of those infected suddenly doubled, rising to nearly 300 cases per day. After Armistice celebrations flooded the streets of Winnipeg, the city’s Medical Officer of Health admitted that the disease was beyond the control of authorities and stated that little could be done but to watch the disease run its course.

What remained to be done, however, was caring for the thousands of ill and their families. Nurses in particular were needed to staff emergency hospital beds, but the available contingent was inadequate. Winnipeg was, like most other North American

⁷ Historian of cholera Francois Delaporte derides the “hackneyed claim that in time of epidemic class hatreds are exacerbated.” This is not to say that he denies this claim, but rather that in his view disease does not exist independent from social “practices”. The challenge is to unveil the practices underpinning social conflict and disease. *Disease and Civilization. The Cholera in Paris, 1832* (Cambridge, Massachusetts: The MIT Press, 1986), p. 8.

cities, experiencing a severe shortage of trained nurses, partly due to the number of women who had volunteered to nurse overseas in the war effort, but also due to the poor pay, working conditions, and residential accommodation offered student nurses during this period.⁸ Therefore, the first call for women volunteers was to help nurse the sick in hospital beds.

Conditions faced by volunteer and trained nurses on these emergency influenza wards were far from ideal. At the Winnipeg General Hospital (WGH), flu patients were isolated on the South Wards I and II. In May 1918, several physicians had complained to the House Committee about the inadequacy of the South Wards for treating medical patients.

Their concerns included:

out-of-date methods of ventilation and heating, lacking of sun balconies, difficulty of approach to wards ... The insufficient provisions for bathroom and lavatory accommodation in the event of an outbreak of typhoid would seriously handicap the nurses in their work, and might menace the wellbeing of other patients in the wards.⁹

In September 1918 Dr. Collins, Superintendent of the resident medical staff, had received approval from the House Committee for a ward re-organization that would close the south wards. But before the bed reallocation could take place, the physicians on the House Committee recommended that South I and II be used to house flu victims.¹⁰ A serious complaint was the lack of an elevator. Patients and supplies had to be carried on

⁸ Kathryn McPherson, p. 56; Ch. 2.

⁹ PAM, MG10B11, Box 18, Winnipeg General Hospital, House Committee Minutes, May 1918.

¹⁰ PAM, MG10B11, Box 17, Winnipeg General Hospital, Board of Trustees Minutes, October 7, 1918.

stretchers up stairs to reach the influenza wards.¹¹ An additional ‘flat’ was eventually opened at the General, with similar drawbacks. The Old Coffee House if anything was even less serviceable. It was a three-story building, again with no elevator. According to the recollections of Elsie Robertson, who was the nursing Supervisor at this building, (also known as the ‘Annex’) incoming patients were carried up to the wards by ambulance men. Food and supplies had to be put into a dumb waiter, which, when loaded, was almost impossible to move.¹²

The highly contagious nature of influenza, and the demands placed upon nurses and volunteers, resulted in many of them becoming ill themselves. More than one-third of Winnipeg General’s graduate nursing staff and twenty percent of nursing students were infected with influenza.¹³ Ethel Johns, who at the time of the epidemic was Superintendent of the Children’s Hospital, reported that two-thirds of her staff became ill; all, fortunately, recovered. “We feel specially grateful to our medical staff when we remember their unflinching care of our staff during the epidemic,” Johns noted in her annual report. “Under the most difficult circumstances they rendered us a service we shall not soon forget.”¹⁴ Olive Irwin, who was in her first years of nursing training at WGH in the fall of 1918, recalled:

¹¹ PAM, MG10B11, Box 18, Winnipeg General Hospital, House Committee Minutes, September 18, 1918.

¹²L. Mary Shepherd, *Our Hospitals Through the Years* (Winnipeg: Comet Press, 1958), p. 33.

¹³ Ethel Johns, *The Winnipeg General School of Nursing, 1887-1953* (Winnipeg: Winnipeg General Hospital School of Nursing Alumni Association, 195?[n.d.]), p. 51.

¹⁴ PAM, Children’s Hospital of Winnipeg, Annual Report, 1918.

I had that flu ... we were in a section by ourselves. They were pretty short of nurses. We were just put to bed. I don't remember any medication or anything that was given to us. It was just like a very severe cold ... I got out of bed in about three weeks ... There were a great many flu patients [in the hospital], they had a whole ward.¹⁵

Those who became ill were expected to return to nursing the sick as soon as they recovered. Olive Irwin remembers being too weak to climb a full flight of stairs without stopping after returning to her work on the influenza ward. She also remembers the emotional toll that caring for dying patients took on the nurses. One of her classmates was relieved of her duties on the ward after being unable to cope, because "it was one death after another, it was very harrowing."¹⁶ That this experience could be more than some could bear is affirmed in the recollections of a teacher who volunteered to nurse soldiers in Pittsburgh. She was assisted on the ward by a young male university student. One evening after having taken five bodies to the morgue, "he just put his head down on the desk and sobbed."¹⁷ There were, as well, those who lost their lives to influenza contracted while caring for the sick. Seven nurses, some trained and others volunteers, died of the flu.

¹⁵ Winnipeg General Hospital School of Nursing Alumni Association Archives, Kathryn McPherson, "Nurses and Their Work: Oral Histories of Nursing in Winnipeg, 1920-1940," Interview with Olive Irwin. Mrs. Irwin was the sister of suffragist Nellie McClung.

¹⁶ Ibid.

¹⁷ Mary Wilson Sage, "Pandemic Influenza, Pittsburgh-1918," Paper presented to The Spanish Flu After 80 Years Conference, Cape Town, South Africa, 1998, p. 13.

As pressing as the need for hospital beds and doctors and nurses to staff them was, it soon became apparent that there was an even greater need for nursing care in the community. City child welfare and tuberculosis nurses were re-assigned to this work during the course of the epidemic. Although these women were experienced in working with the poor and immigrants in particular, there were far too few of them to cope with the demand. The Margaret Scott Nursing Mission, a charitable health care agency serving the north end, was overwhelmed with requests for assistance. The Mission's records indicate that it provided care during the epidemic to many poor immigrants who may not otherwise have received any medical aid.¹⁸ In many cases, nurses found entire families infected and ill, both parents and children, with no one well enough to provide even basic nourishment and hygiene. In the last three months of 1918, the work of the Mission was almost entirely given over to treating poor flu victims. There were 1380 home visits made to patients, and nearly four hundred more in early 1919.¹⁹ The organization had to respond to this crisis without its director of nursing, Miss Beveridge, who became quite ill with influenza, and was twice hospitalized with complications. The work of the Mission's nurses was assisted by volunteers, and by many physicians – as many as thirty

¹⁸ PAM, MSNM, MG10B9, Boxes 7-10, Applications for Nursing, Attendance and Relief, 1908-1921. These records are among the few extant that document the living conditions, income, and family circumstances of the poor who were struck with flu. The Mission's screening guidelines continued to be followed during the epidemic, although judging by the number of missing records in the ledger, the process must have been perfunctory and incomplete. As patient records indicated, many were living in dire circumstances, with little income and renting substandard accommodation. The experience of some of these families who were flu sufferers will be described in the following chapter.

¹⁹ PAM, MG10B9, Box 4, MSNM, Annual Reports, 1918 & 1919.

to forty doctors helped the Mission each month at the peak of the epidemic.²⁰ Some of the load was shared by the Victorian Order of Nurses, which provided nursing support for the Metropolitan Life Insurance Company.

These community based nursing services could not on their own address the crisis influenza presented. Believing that public health measures inadequately met the health needs of the poor, and fearing widespread contagion, prominent middle and upper class women reformers and philanthropists responded by organizing an Emergency Nursing Bureau and several food distribution centres. Six hundred and fifty women ultimately volunteered to help in these two efforts.²¹ The Emergency Nursing Bureau operated out of the Medical College on Bannatyne Avenue in central Winnipeg. In charge of the Nursing Bureau were Margaret Cameron, chair of the local Voluntary Aid Detachment, and Nora Hallam, president of the Women Teachers' Club. The Emergency Diet Kitchen organizing committee included: Margaret McWilliams (President of the Local Council of Women); Mrs. Colin Campbell (provincial president of the I.O.D.E., widow of Colin Campbell, Conservative MLA and former Minister of Education); Mrs. A. Code (president of the Women's Canadian Club, and future president of the Board of Management of the Margaret Scott Nursing Mission, daughter of brewery owner E.L. Drewery); Edith Rogers (who in 1920 became Manitoba's first woman MLA, and at the time of the epidemic was active in procuring pensions for soldiers' dependents and widows); and Mrs. John Nairn (chairwoman of the Widows' Committee, Returned

²⁰ PAM, MG10B9, Box 4, MSNM, Monthly Reports, October and November, 1918.

²¹ WT, November 25, 1918, p. 5.

Soldiers' Association). All of the diet kitchen organizers but one were active members of the Local Council of Women. The Council, arguably feminist but not militantly suffragist, was dominated by "middle class women in reasonably prosperous financial circumstances and, for the most part, of British or Ontario origin."²²

Relief organizers were in a position to benefit from the high level of women's volunteer mobilization during wartime, the local nursing Voluntary Aid Detachment (VAD) being particularly important. The Emergency Nursing Bureau was directed by a member of the local VAD. It should not be surprising, then, that influenza relief organization shared much of the philosophy and structure of the VAD movement. Historians Linda Quiney and Anne Summers have both argued that the VAD movement was structured along class, ethnic and racial lines.²³ The Canadian VAD had built-in mechanisms to exclude working class women and non-Anglo-Canadian women from full participation. Coordinators of the Emergency Bureau similarly exercised a gate-keeping

²² Wendy Heads, "Local Council of Women of Winnipeg 1894-1920: Tradition and Transformation" (Unpublished MA thesis, Manitoba, 1997), p. 213. The Council included the wives of prominent Winnipeg men, such as lieutenant-governors, provincial cabinet ministers, and leading capitalists. The Council was not an active proponent of women's right to vote, although the suffragist Political Equality League was affiliated to it from 1914 on. (p. 221) Heads nevertheless concludes that the Council fits Nancy Cott's definition of feminism (p. 215).

²³ Linda Quiney, "Canadian Voluntary Aid Detachment Nurses in the Great War," *Canadian Bulletin for the History of Medicine* 15 (1998); Anne Summers, *Angels and Citizens: British Women as Military Nurses, 1854-1914* (London: Routledge and Kegan Paul, 1988). For further interesting commentary on the VAD movement, see Sharon Ouditt, *Fighting Forces, Writing Women: Identity and Ideology in the First World War* (London: Routledge, 1994), p. 7-46; Sandra Gilbert, "Soldier's Heart: Literary Women, and the Great War," Margaret Higonnet et al, eds., *Behind the Lines: Gender in the Two World Wars* (New Haven: Yale University Press, 1987).

function in influenza relief, making value judgements about what type of woman was most appropriate to fill the volunteer nursing role.

The issue was not whether women had the appropriate training to be of use. Volunteers were not required to have formal nursing training, although obviously trained nurses were highly valued volunteers. As much training as was possible under the circumstances was provided to volunteers by the Bureau, under the leadership of Elizabeth Russell, the recently appointed head of the provincial Public Health Nursing program.²⁴ But the volunteer bureau was careful to stress publicly that certain “qualifications” were needed to make one suited to go out into the community and into the homes of immigrants and the working poor. These informal qualifications were only vaguely articulated. Yet it was clear who was, and who was not, welcome. The most sought-after volunteers, after trained nurses, were teachers, not because they had particularly applicable skills, but because of their educational background and respectability. “An especial appeal is being made to teachers since they are women of training and education,” a women’s columnist for the *Free Press* noted.²⁵ Less welcome were young working class women, as illustrated by the following exclusion of a working girl from the category of ‘nurse’:

[volunteers] include some who are not qualified to nurse but who have offered to assist with housework ... One of the volunteers is a stenographer who after her

²⁴ WT, October 30, 1918, p. 1.

²⁵ MFP, November 2, 1918, p. 10.

day's work will cook and 'tidy' the house and make life more comfortable for the epidemic sufferers.²⁶

A *Free Press* editorial further reinforced the exclusion of working class women:

They cannot, in the majority of cases, undertake the responsibility of upsetting their firm's work, especially at this time when their places cannot be easily filled. They realize that they have no training for the work and their value would be problematical.²⁷

The class basis of the relief effort was also reflected in the absence from the organizing committees of prominent labour women, including Helen Armstrong and Lillias Veitch, both of the Women's Labor League. Middle class women's organizations in the city, with the exception of the suffragist Political Equality League, generally did not welcome working class and immigrant women into their ranks. The Women's Labor League never joined the Local Council of Women, for example, and the North End Women's Council was affiliated for only one year—1917—before 1920.²⁸ Relations between labour and middle-class activists were strained in any case, due to the lack of support from organizations like the Council of Women for the spring 1918 civic workers' strike.²⁹ The failure to attract support from labour women was a reflection of the depth of

²⁶ Ibid.

²⁷ MFP, November 16, 1918, p. 24.

²⁸ Heads, p. 221.

²⁹ *Western Labor News*, October 4, 1918, p 8. The Women's Labor League withdrew its support for an upcoming conference on laws affecting women and children, because of the participation of the Local Council of Women, which the WLL accused of providing "female scab battalions" in the civic workers' strike. For a critique of the class and ethnic biases of feminism in this period, see Carol Lee Bacchi, *Liberation Deferred? The Ideas of the English-Canadian Suffragists, 1877-1919* (Toronto: University of

class tension in Winnipeg. In Vancouver, by contrast, working class women undertook “... the specially arduous task of ministry in the homes of the helpless. This volunteer army recruited from organized labour and other circles has enriched our city’s annals,” according to Rev. Ernest Thomas. This is not to suggest that class identity was not a factor in Vancouver’s relief efforts: middle-class women—“cultured women and University professors who wore the white robes of the hospital”—stayed away from nursing in working class homes.³⁰

There was again a lack of cooperation between the organizers and immigrant groups. The Nursing Bureau and Diet Kitchen volunteers appear to have been virtually ethnically homogeneous. Judging from the names in a published list of volunteers, there were very few non-Anglo-Canadian women involved, with the exception of a small number of Jewish and Scandinavian women.³¹ Charitable relief during the epidemic was, in fact, highly structured along ethnic lines. The Jewish community, for example, operated its own relief agency. At the request of the city’s health department, the Hebrew paper the *Israelite Press* issued a call for volunteers and opened a desk where Jewish girls and women could come forward. “All other nationalities in Winnipeg have organized for this

Toronto Press, 1982) and Mariana Valverde, *The Age of Light, Soap, and Water: Moral Reform in English Canada, 1885-1925* (Toronto: McClelland and Stewart, 1991).

³⁰ These quotes from Rev. Thomas’s sermon are taken from Margaret Andrews, “Epidemic and Public Health: Influenza in Vancouver, 1918-1919,” *BC Studies* 34 (Summer 1977), p. 37, footnote #49. Howard Phillips argues that volunteerism in Cape Town, South Africa crossed “the usual barriers of race, class, and religion,” but also provides evidence in a footnote that white women were reluctant to nurse “Blacks” and “Coloureds.” *Op cit*, p. 18; note #132.

³¹ WT, November 23, 1918, p. 3.

purpose,” the paper stated, noting that other ethnic groups had been approached by city health officials to lend their support to nursing relief work.³² Within days, a Jewish women’s organization called the Red Magen David appealed again to “Jewish Daughters” to help out, particularly among the poor of the north end. President Mrs. S. Stockhammer noted the importance of Jewish efforts in relation to the dominant Anglo-Canadian elite:

Every girl and woman who is not tied down with small children to tend, should join as a nurse. We can’t have the Christian citizens point at us and think that we are negligent and can’t even take care of our own.³³

The success of her argument was indicated in the formation of a Jewish Aid Committee, chaired by S. Hart Green. Based in the Talmud Torah Hebrew School, the committee organized nursing and food relief, but also raised a substantial amount of money - over four thousand dollars by the third week of November.³⁴ The kitchen supplied 150 to 200 families per day with food. Bedding was also provided. Medical relief was delivered by four trained nurses, two doctors, and four medical students, in addition to volunteers.³⁵ No news of this work appeared in the English daily press. The dominant Anglo-Canadian majority was therefore allowed to maintain unchallenged its

³² *Israelite Press*, November 4, 1918, p. 1.

³³ *Ibid.*, November 8, 1918, p. 5.

³⁴ *Ibid.*, November 22, 1918, p. 6.

³⁵ *Ibid.*, November 25, 1918, p. 1. The level of formal relief organization in the Jewish community may have been exceptional. The Icelandic, German, and Ukrainian press made no mention of similar efforts.

views of immigrant communities as dangerously victimized and unable to help themselves.

A final category over which organizers of the Emergency Nursing Bureau attempted to assert control was the age and perceived maturity of volunteers. Although it is impossible to determine the ages of women who volunteered, they were sometimes referred to in the press as “girl volunteers.”³⁶ Nursing coordinators had misgivings about young women being sent to homes where several members of the household were ill, and attempted to assign volunteers so as to minimize the potential risks, according to Nora Hallam:

... we have not half enough volunteers. We need more women with nursing experience to offer their services and also more older women to take the special classes. We can't send young girls out alone to tackle cases where there are five or six persons ill. We send out nurses if we happen to have any, or at least older women to these, and reserve the younger girls for the lighter cases and where household help is needed more than nursing.³⁷

Calls came into the Emergency Bureau at all hours of the day and night, and callers were often desperate to receive help immediately. Sending young women out alone at night to poor neighbourhoods was to be avoided whenever possible, as was assigning them to care for delirious men (although it is not clear how this assessment of patients was made). Delirium was not uncommon among flu victims, likely because of the high fever associated with the disease. Delirious patients were unpredictable and sometimes violent. On November 2, the *Tribune* told of a man who had run five miles through the streets of

³⁶ MFP, November 6, 1918, p. 9.

³⁷ Ibid.

a Winnipeg suburb, in his nightclothes. A police officer and a doctor chased the man, and eventually succeeded in catching him and taking him home.³⁸ And there was the case of the man who threw himself out of the window of his third-story ward in the Winnipeg General Hospital, “mad with delirium.”³⁹ This man lived. Men were generally sent out to care for delirious patients; women were not considered “competent” in these situations.⁴⁰

Organizers’ desire to limit the contact of girls with flu victims fit with contemporary fears and judgements of young female sexuality in the metropolis, as did their concern for girls’ safety from sexual predators, an obvious subtext in anxieties about delirious male patients. As historians Carolyn Strange, Tamara Myers, Diana Pedersen and others have pointed out, while working class and middle class girls and young women enjoyed “unprecedented ... economic and sexual autonomy”⁴¹ in this period, they were also subject to moral regulation. A girl’s decision to exercise her autonomy often meant being labeled as “delinquent”⁴² if her behaviour could be construed as having crossed “the

³⁸ WT, November 2, 1918, p. 1.

³⁹ MFP, October 26, 1918, p. 5.

⁴⁰ Ibid., November 6, 1918, p. 9.

⁴¹ Diana Pedersen, “Providing a Woman’s Conscience: The YWCA, Female Evangelicalism, and the Girl in the City, 1870-1930,” in Wendy Mitchinson et al, eds., *Canadian Women: A Reader* (Toronto: Harcourt Brace, 1996), p. 196.

⁴² Tamara Myers, “The Voluntary Delinquent: Parents, Daughters, and the Montreal Juvenile Delinquents Court in 1918,” *Canadian Historical Review* 80, 2 (June, 1999); Jennifer Stephen, “The ‘Incorrigible,’ the ‘Bad,’ and the ‘Immoral’: Toronto’s ‘Factory Girls’ and the Work of the Toronto Psychiatric Clinic,” in Louis A. Knafla and Susan W.S. Binnie, eds., *Law, Society and the State: Essays in Modern Legal History* (Toronto: University of Toronto Press, 1995); Carolyn Strange, *Toronto’s Girl Problem: The Perils and Pleasures of the City, 1880-1930* (Toronto: University of Toronto Press, 1995), and “From Modern Babylon to a City Upon a Hill: The Toronto Social Survey Commission of 1915 and the Search for Sexual

boundaries of normative femininity, meaning any threat to modesty and chastity.”⁴³ During World War I, an increasing number of alleged delinquents were brought before Manitoba’s Juvenile Court for offences such as trespassing, disorderly conduct, and incorrigibility. Male and female delinquency in Manitoba was structured not only upon categories of gender and class, however; children brought before the court were disproportionately those of European immigrants, rather than of British immigrants or the native-born.⁴⁴

Within the context of social anxieties over young female sexuality, the nursing profession expected young women “to embody the social standards of bourgeois femininity.”⁴⁵ Standards of behaviour on and off the hospital ward were impressed upon young nurses in training, through repetition and ritual, disciplined routine, and symbolic systems such as nursing uniforms. As Kathryn McPherson states, “nurses had to learn their part.”⁴⁶ The epidemic context posed a challenge for the organizers of nursing relief,

Order in the City,” in Roger Hall, William Westfall, and Laurel Sefton MacDowell, eds., *Patterns of the Past: Interpreting Ontario’s History* (Toronto: Dundurn Press, 1988).

⁴³ Myers, p. 255.

⁴⁴ Lorna Hurl, “An Analysis of Social Welfare Policy: A Case Study of the Development of Child Welfare Policies and Programmes in Manitoba, 1870-1924” (Master’s of Social Work thesis, University of Manitoba, 1981), p. 152-154.

⁴⁵ Kathryn McPherson, “‘The Case of the Kissing Nurse’: Femininity, Sexuality, and Canadian Nursing, 1900-1970,” in Kathryn McPherson, Cecilia Morgan, and Nancy M. Forstell, eds., *Gendered Pasts: Historical Essays in Femininity and Masculinity in Canada* (Toronto: Oxford University Press, 1999), p. 182.

⁴⁶ *Ibid.*, p. 181.

because there was neither the time nor the resources for such lessons to be repeated and reinforced. Nursing leaders did make an effort. Elizabeth Russell attempted to implement a four-day training period for nursing volunteers.⁴⁷ This proved to be extremely taxing for her and others responsible for the training. The demand for care quickly overwhelmed the Nursing Bureau, and even minimal training apparently became a luxury.

Nursing leaders also attempted to provide a uniform for volunteers, to give women a visible presence as health care workers, and to distinguish them from other 'working girls' on the streets of the north end. The nursing uniform, McPherson has argued, "located nurses symbolically as workers, as women, as serving society, and as sexually contained."⁴⁸ But the immediacy of the epidemic and the shortage of resources available to volunteer coordinators limited what could be done in this regard. Although it was probably far less than organizers would have preferred, the Red Cross provided white armbands with a green cross.⁴⁹

Emergency relief was characterized by a systematic organization of tasks. Those who needed help could telephone the Nursing Bureau directly, but calls also often came from doctors and clergy. In response to heavy demand from the north end, calls for help from that district were forwarded to a separate phone line from those from the south end of the city. According to reports organizers gave to the press, upon receiving a call from an infected household the bureau sent a city public health nurse out to the home to assess

⁴⁷ WT, October 30, 1918; p. 1.

⁴⁸ McPherson, "'The Case of the Kissing Nurse,'" p. 182.

⁴⁹ MFP, November 14, 1918, p. 7.

what level of nursing care the family required. Volunteer nurses and housekeepers were then assigned accordingly. It is notable that physicians had no apparent role in this triage process. Although nurses were not legally able to prescribe treatment, they apparently acted independently to provide the kind of care influenza patients needed, including measures to control fever, the provision of fluids and nourishment, and physical and emotional comfort and care.

In general, men played a marginal role not only in the coordination of charitable relief, but also in its implementation. Men were drawn into relief work to perform specific tasks for which women were considered unsuited, such as caring for potentially violent male patients. Other masculine responsibilities included driving 'ambulances' (cars temporarily donated for this purpose) and chauffeuring nurses to their assignments. The power of gendered roles remained essentially unchallenged, despite the acute shortage of volunteers. Provincial health officer Gordon Bell did offer separate volunteer classes for men beginning the first week of November. But the number of men who attended appears to have been small.⁵⁰ As with the women, most male volunteers appear to have been middle class, including clergymen, teachers, and social reformers, although the press also reported that some "artisans" came forward as well.⁵¹

A similar order, ritual, and routine were observed in the bureaucratic regime of the diet kitchen. Largely through private donations of food, it managed to feed several thousand families throughout the city. A reporter with the *Free Press* provided an

⁵⁰ MFP, November 6, p. 5.

⁵¹ WT, November 7, 1918, p. 6.

excellent (and comic) illustration of the careful hierarchy of gender, class and ethnicity at work in this effort. The article – entitled “Cheer-O! If You Get the Flu You May Have a Basket” - is worth quoting at length:

... a distinct atmosphere of cheerfulness was apparent ... a resolute spirit of lively energy, due probably to the fact that the work is now so systematized that each individual has her (yes, verily they are all of the feminine persuasion save the Boy Scouts and a young man in khaki whose duties I was unable to ascertain, but who appeared to act as a sort of animated “Keep to the right” sign in the hallway...) As I was saying, each individual has her particular duty for which she is responsible, whether it be receiving contributions, assembling supplies for baskets, packing these, or some other form of usefulness necessary to the desired end which is the nourishing every day of three or four thousand sick people, convalescent people and well kiddies whose parents are too ill to provide for them.... a most capable telephone operator [is] a young lady who, like all the other workers, is giving her services free every day ... she must be, not merely an expert operator but a disciple of Annie Eva Fay, for only mind-reading could be responsible for her understanding of many of the messages which come in broken English over the wire and of the names over which the most acrobatic Anglo-Saxon tongue could not climb. Usually the calls for help come from doctors, nurses, ministers or district visitors and, where this is not so and a request is sent by an unknown person the case is verified ... so that there is no haphazard distribution of food ...⁵²

As calls came in, the operator took down family name, address, the number of ill family members, the number convalescing, and the number who were well, including children. This information was written on a form, which left room for the detailed food orders of the dietician. Reflecting the norms of scientific philanthropy, rather than undisciplined charity, families were expected to pay if possible. Another “business-like young woman enveloped in an apron” took a completed form to be filled at the “receiving depot.” When the box had been filled by a packer, it was ready to be distributed:

⁵² MFP, November 16, 1918, p. 8.

... it passes from her hands to those of an alert superintendent of transport service, who receives the mere men who present themselves as volunteer members of a sort of motor commissariat corps, and directs their attention to the piles of packages ... As each basket or box is carried for delivery the name and address is given to a helper who promptly lists it as sent out. And then the nifty boy scout steps in and busies himself carrying loads to motors, or, if the driver of the car be a woman, a scout accompanies her and delivers the parcel.⁵³

The work of the diet kitchen was scientifically analyzed and divided into discrete tasks in a way that would have pleased Frederick Winslow Taylor. It resembled a highly efficient factory production line. Tasks were strictly categorized by gender. There were no specific skills involved, for example, in packing food, yet men were excluded from this work. Men, however, were responsible for driving and delivering, and if a woman wanted to help with this aspect of the work, she was usually accompanied by a Boy Scout! The reporter's description of the diet kitchen suggested a haven of order in a disordered epidemic moment, yet was strangely dehumanizing both for the volunteers and for the influenza victims who received their aid.

The women who coordinated, shaped and defined volunteerism used their social power to suffuse the project with their gender, class and ethnic biases. The appropriate feminine role in the epidemic context was an umbrella under which class, age, and ethnic boundaries were housed and managed. The careful construction of the volunteer response—who could be a volunteer, in what capacity, and under what rules—was intended to serve more broadly the interests of the dominant classes, working against the threat of social breakdown ever present in epidemic situations. This construction had an additional layer of importance, because women's relief work itself arguably had the

⁵³ Ibid.

potential to become a destabilizing force. The otherness of the north end in the city's imaginary and physical landscape implied a crossing of boundaries when significant numbers of middle class women volunteers ventured out into immigrant and working class Winnipeg to care for the diseased. The volunteer encounter with the diseased poor could impose social order upon chaos. But could it potentially generate new relationships and alliances across class and ethnic lines?

Women's crossing of the north-south divide was not an unprecedented circumstance, of course, because Winnipeg's female philanthropists and nurses had a tradition of home visitation and contact with the poor.⁵⁴ Like their British and American counterparts, female reformers and philanthropists in Winnipeg had a legitimate position as public actors, and a presence on the city's streets.⁵⁵ Although historians such as Mariana Valverde have pointed out that these movements viewed working families as "helpless objects in need of study and reform," not all contact was framed this way. Some women challenged the often condescending and pessimistic middle class view of working families. Influential settlement house activist Jane Addams, for example, argued in a

⁵⁴ For visitation and the work of the Margaret Scott Nursing Mission, see Helena McVicar, "Margaret Scott, A Tribute. The Margaret Scott Nursing Mission (Winnipeg: 1939); Marion McKay, "Caring in Turbulent Times: a Social and Cultural Analysis of the Board of Management of the Margaret Scott Nursing Mission," Unpublished paper. The Children's Home of Winnipeg records indicate that volunteers undertook home visitation. PAM, P5436, Children's Home of Winnipeg, Case File 2298.

⁵⁵ Mariana Valverde, *The Age of Light, Soap and Water: Moral Reform in English Canada, 1885-1925* (Toronto: McClelland and Stewart, 1991), p. 30; Judith Walkowitz, *City of Dreadful Delight: Narratives of Sexual Danger in Late-Victorian London* (Chicago: University of Chicago Press, 1992), p. 57; Martha Vicinus, *Independent Women: Work and Community for Single Women, 1850-1920* (Chicago: University of Chicago Press, 1985).

speech she gave in Toronto in 1897 to the National Conference of Charities and Correction that the privileged had much to learn from their contact with the poor. “It is impossible that you should live in a neighbourhood, and constantly meet people with certain ideas and notions, without modifying your own,” Addams stated.⁵⁶ This view of contact between classes and ethnicities embraced a challenge to social order. Winnipeg was at the centre of radicalism in the social gospel and settlement house movement during the First World War.⁵⁷

In the already unstable epidemic context, the threat posed to social distinctions and hierarchy by a potentially radicalizing encounter, where volunteers confronted and perhaps absorbed the ideas and world views of the afflicted, took on a heightened urgency. These hundreds of volunteer women were sent out, sometimes alone, to homes in poor neighbourhoods, without the accustomed training in appropriate roles and behaviour, and without the protective symbolic barrier of a nursing uniform. The physical and psychological demands placed upon volunteers were extremely high. Whatever the

⁵⁶ Quoted in Cathy James, “Reforming Reform: Toronto’s Settlement House Movement, 1900-1920,” *Canadian Historical Review* 82, 1 (March 2001), p. 74. For further information on the settlement house movement in Canada, of which Winnipeg’s All People’s Mission was an important part, see Richard Allen, *The Social Passion: Religion and Social Reform in Canada 1914-1928* (Toronto: University of Toronto Press, 1971), p. 47; Allan Irving, Harriet Parsons, and Donald Bellamy, *Neighbours: Three Social Settlements in Downtown Toronto* (Toronto: Canadian Scholars’ Press, 1995); Sara Z. Burke, *Seeking the Highest Good: Social Service and Gender at the University of Toronto, 1888-1937* (Toronto: University of Toronto Press, 1993), p. 61-77. The classic study of the American settlement house movement is Allen F. Davis, *Spearheads for Reform: the Social Settlements and the Progressive Movement, 1890-1914* (New York: Oxford University Press, 1967). For a study of Hull House that emphasizes spirituality, see Eleanor J. Stebner, *The Women of Hull House: A Study in Spirituality, Vocation and Friendship* (New York: State University of New York Press, 1997).

⁵⁷ Allen, p. 45-103. Unfortunately, Allen does not discuss women activists.

prescribed rules and boundaries of caring for the diseased poor, relief workers faced not only illness and death, but also the poor conditions in which working families lived. The evidence about what this contact meant to them is fragmented, but there are glimpses into the disruptive quality of the experience, as well as its personal rewards. Eileen Pettigrew, whose study of influenza in Canada is based upon personal interviews and letters from influenza survivors, quotes women stating that volunteer nursing during the flu was the most rewarding experience of their lives.⁵⁸ There are repeated stories of women, sometimes several of them together, working for long hours or days to save one or two lives in working class homes, refusing to leave despite the risk to their own health. Survivors sometimes stayed in touch with these women, expressing their gratitude in a number of ways, from buying chocolates, to erecting memorials.⁵⁹

Some women felt a powerful emotional intensity in relation to their efforts to save lives. A volunteer nurse, for example, harshly criticized the apathy of young bourgeois women who failed to volunteer:

How can women refuse to listen to the cry for help from homes where Spanish influenza is raging? I can't think that they are unwilling to help. I hesitate to say that they are cowards, yet I know women who are in a position to help and are not doing so. If they have small families, that is another matter. One can not expect them to take the risk that other women would. But there are young women who can engage in riding, golfing, and every imaginable outdoor sport, but when a poor woman, sick with influenza, her temperature above 100, her children tossing to and fro in the struggle with the disease, her husband dead, when she calls for help there is no response from the healthy, leisure girl."⁶⁰

⁵⁸ Eileen Pettigrew, *Silent Enemy: Canada and the Deadly Flu of 1918* (Saskatoon: Western Producer Prairie Books, 1983), p. 97.

⁵⁹ Ibid.

⁶⁰ WT, November 9, 1918, p. 2.

Although the identity of the speaker is unknown, she appears to be a middle or upper class woman: "I know women who are in a position to help." Her language suggests that poor women have a right to expect aid from the healthy and the economically secure of Winnipeg society. In the writer's mind, the failure of bourgeois women to respond indicates callousness, fear, and cowardice, qualities that arouse her shame and anger. She is, at least at this moment, more sympathetic to the poor woman with sick children than to members of her own class.

Judith Walkowitz has argued that nineteenth century female charity workers "interpreted the slum as a backdrop for their own personal drama, a place to test their moral fiber or to enjoy the passing show."⁶¹ Some women may have similarly seen the working class and immigrant homes where they attended flu victims as a setting for their personal adventure and valour. Yet this is likely too narrow an interpretation of influenza volunteerism. As recent work by Ellen Ross and Karen Tice suggests, the relationship between professional and volunteer women and their charges was complex and contradictory. Personal relationships were formed, bonds emerged, and middle class women could be "filled with doubts and misgivings" about their role as reformers in the lives of working class and immigrant women.⁶² Spiritual values could be important.

⁶¹ Walkowitz, p. 57.

⁶² Karen Tice, *Tales of Wayward Girls and Immoral Women: Case Records and the Professionalization of Social Work* (Chicago: University of Illinois Press, 1998), p. 129; Ellen Ross, "Good and Bad Mothers: Lady Philanthropists and London Housewives Before the First World War," in Kathleen McCarthy, ed., *Lady Bountiful Revisited: Women, Philanthropy and Power* (New Brunswick: Rutgers University Press, 1990).

Testimony from women influenza volunteers attests to humanitarianism and Christian belief.⁶³ As one woman who volunteered recalled, “It was a time of the Golden Rule. Everyone did something to help.”⁶⁴ Like the indignant volunteer quoted above, this woman’s comments hint at a sense of equality in crisis and of mutual social responsibility.

Challenges to the order and hierarchy central to the relief project also came from the diseased poor themselves. Volunteer coordinators discovered that their interventions were not always welcome. That volunteers and victims had different understandings of the epidemic’s events was fleetingly revealed in a series of exchanges in the pages of the *Free Press* between relief organizers, and the caretaker of a set of apartment blocks called the Thelmo Mansions, which housed many European immigrants. Based upon the testimony of Nora Hallam, nursing relief coordinator, the *Free Press* presented a vivid picture of contagion and suffering in the blocks:

[it] is in a terrible state, practically every household being affected. Many of the suites are small and three and four patients lie in one room. A volunteer teacher who went in there on Monday night to nurse a man and woman and child, found them all in one room, the child very ill. All that night she worked over the baby, and all day on Tuesday. On Tuesday night an assistant was sent in and together they wrestled with death for the life of the little one, the parents knowing the struggle that was going on. The baby died on 2 o’clock yesterday morning and the mother’s condition at least is precarious ... There were more than a score of other cases, most of them in desperate need, on the waiting list.⁶⁵

⁶³ Howard Phillips, p. 233. Phillips has noted the ideals of self-sacrifice exhibited by white middle class English speakers, for whom “‘doing one’s bit’ and helping others ... were deemed to be the highest principles of dutiful humanity.”

⁶⁴ Elizabeth Vaughan, quoted in Pettigrew, p. 107.

⁶⁵ MFP, November 21, 1918, p. 5.

The caretaker, who was subsequently interviewed by the paper, denied overcrowding in his building. He insisted that there were only thirty-six victims in the building – not “practically every household” as the paper had previously reported - and that eighteen of these had already recovered. There had been only one death from influenza, that of an eighteen-month-old baby, who also had measles. Mr. Mitchell went further and stated that the residents of his building did not need or want the help of visiting nurses or of the Emergency Diet Kitchen. According to the reporter:

So far from food being needed by the inmates of the block, Mr. Mitchell insisted that they had the greatest difficulty in disposing of the provisions, only two baskets out of quite a number being accepted by patients.⁶⁶

This was not, however, the end of the controversy. Probably because of press coverage, which explicitly challenged the claims of relief organizers that help was going only to the needy, an inspector was sent out to the Thelmo Mansions by the Diet Kitchen. He discovered that only seven suites were placarded for influenza, and three for measles, thus supporting the caretaker’s version of the situation. The visiting nurse defended herself, and the nursing relief effort in general, by stating that “her patients simply could not have pulled through without the aid of the food sent them by the diet kitchen.”⁶⁷

Relief coordinators continued to believe that their work was essential, and to fear the consequences of unmet health needs. As the intensity of the situation deepened at the

⁶⁶ Ibid., November 22, 1918, p. 4.

⁶⁷ Ibid., November 25, 1918, p. 5.

crest of the epidemic, the highly structured framework of nursing aid and food distribution faced the challenge not of too little, but too much, demand. In the second week of November, the number of new influenza cases approached several hundred per day. The need for nursing care exceeded the capacity of the Nursing Bureau to meet it. There were too few new nursing volunteers to relieve those who were exhausted, and these women were “on the verge of breakdown.” Still, many reportedly refused to leave their cases.⁶⁸ “Who Will Come to the Rescue,” the *Free Press* asked, commenting that “the reports to the [relief] committee Sunday morning made the members feel as if they were in old London in the time of the plague, rather than in a western city in the twentieth century.”⁶⁹ The coordinators began to worry that there were limits to what they could accomplish with only volunteer help. They became increasingly critical of the city government’s lack of intervention:

In an informal discussion ... the feeling was expressed that the civic authorities are not taking the matter with sufficient seriousness, and are not making as much effort as possible to secure a supply of temporary help. Many women and men who would be willing to help cannot afford to drop their means of livelihood at the beginning of winter and take on this work at the risk of their lives, without remuneration. It was suggested that if the city would guarantee reasonably adequate wages to people willing to help but hindered by their circumstances, that it would bring a response.⁷⁰

These comments suggest that the organizers now realized that they had to recruit help from beyond women volunteers of their own class. But their argument that government

⁶⁸ Ibid., November 13, 1918, p. 5.

⁶⁹ Ibid., November 11, 1918, p. 4.

⁷⁰ Ibid.

should provide financial aid to the relief effort, to be used to hire caregivers, went unheeded. As a result, help from working women was difficult to secure.

Popular resistance, alternative meanings, and the need for organizational flexibility all suggest that women's volunteerism in the contact zone, while doing much to meet health needs and therefore stabilizing community order, raised new issues of concern and created new sites of instability within the social hierarchy. The visible leadership role of women in the epidemic formed its own challenge, extending further women's increased occupation of public space in the context of World War I. As Sandra Gilbert has argued for the British case, women were aware of the opportunities that extraordinary wartime demands afforded them. She concludes that "women in the terrible years of 1914-1918 would seem to have had, if not everything, at least something to gain: a place in public history, a chance, even, to make history."⁷¹ Speaking of the feminist potential of the VAD nursing movement, Gilbert argues that the female figure acted as a powerful holder of "the old (matriarchal) formulas for survival" in the wartime context, whereas men were "passive, dependent, immanent medical object[s]."⁷² Relationships between men and women were turned "topsy-turvy" as women released their previously underutilized capabilities, their sexual energies, and, indeed, their anger.⁷³

Perhaps Gilbert downplays the extent to which women's healing role is a traditional, rather than a subversive one. However, it does seem obvious that the power of healing in

⁷¹ Gilbert, p. 203.

⁷² *Ibid.*, p. 211.

⁷³ *Ibid.*, p. 212.

contexts like the influenza epidemic leaked outside the boundaries of the subordinated gender position of nursing relative to medicine, and must have extended the role of some—mostly Anglo-Canadian middle-class—women, who became the keepers of “formulas for survival.” This was not only, as Alfred Crosby has suggested, because sufferers needed “tender loving care” of the kind only nurses (i.e. women) could provide. Although women were acting in roles for which the dominant culture viewed them as naturally suited, the scale of the epidemic revealed women’s foresight and ability to perceive and meet needs in a manner more immediately efficacious than the public health measures of medical officials. The crisis posed by the epidemic was destabilizing to gender hierarchies because women demanded and facilitated an expansion of the roles they played in everyday life. The epidemic posed an opportunity for professional and experienced philanthropic women to apply their considerable organizational and fund raising skills in a particularly dramatic and dangerous historical moment, and for ordinary women to play an active role in this moment.

Thus, the implications of volunteerism were not easily managed. The experiences of women volunteers suggested heightened feminine power, and raised fears that cross-class and cross-ethnic interaction would de-stabilize existing social hierarchies. These tensions were resolved in part through the definition of women volunteers as representational figures.⁷⁴ An important such figure was the nursing heroine, who emerged as the embodiment of bravery, respectable feminine virtue and civic responsibility in the latter

⁷⁴Mary Poovey would suggest that the dominant culture had some “ideological work” in this context. See *Unequal Developments: The Ideological Work of Gender in Mid-Victorian England* (Chicago: University of Chicago Press, 1988), Introduction.

weeks of the epidemic. Toward the end of November, when officials felt the worst was over, the *Tribune* published a list of individuals who had volunteered as a VAD, as both nursing and food relief volunteers were now known. These 650 volunteers, almost all women, became the public heroes of the influenza epidemic. The *Free Press* described volunteer nurses as “heroes of mercy,”⁷⁵ “making by far the greatest sacrifice and ... therefore those to whom the greatest honor should be done.”⁷⁶ J.W. Armstrong, Provincial Secretary responsible for public health, promised that volunteer nurses would be given public recognition for their “anti-flu battle.”⁷⁷ Premier Norris concurred that a medal would be an appropriate gesture:

I consider that a wonderful response has been made to the call for nurses on the part of our women, and undoubtedly the lives of many of our citizens have been saved by their devoted efforts. In no other way could the sick have been taken care of, and although we desire to maintain the volunteer principle actuating these devoted women, I think that some suitable recognition, possibly in the form of a medal, should be made by the province.⁷⁸

Not surprisingly, militaristic discourse was common during the epidemic.⁷⁹ The contribution of volunteer nurses was compared to that of Winnipeg’s young male

⁷⁵ MFP, November 12, 1918, p. 24.

⁷⁶ *Ibid.*, November 16, 1918, p. 24.

⁷⁷ WT, November 16, 1918, p. 3.

⁷⁸ MFP, November 14, 1918, p. 12.

⁷⁹ For a study of military metaphors in the epidemic see Nancy Bristow, “Since the Flu Germs Have Started to ‘Stack Their Arms’”: Military Metaphors and the Influenza Epidemic of 1918-1919,” Paper presented to the American Association of the History of Medicine, April 2002.

soldiers, who had sacrificed their lives and health to secure Allied victory in the Great War. The influenza epidemic was characterized by journalists and politicians as a golden opportunity for local “leisure” women to do voluntary aid work and thereby “emulate [their] sisters overseas.”⁸⁰ Poignant tributes were given those volunteers who lost their lives to influenza. One of these was Mrs. Stanley Maw, who “sacrific[ed] [her] life in helping others.” Mrs. Maw was the ideal influenza volunteer. She was “one of the most popular of the younger set” according to the press, belonged to a prominent family, and was newly married to the son of a local “pioneer” businessman. Her volunteer work in the diet kitchen and delivering food to the poor resulted in her contracting the flu, and led to her death.⁸¹

The discourse of heroism (constructed primarily, though not exclusively, by men) provided only the most limited, clichéd descriptions of women’s experiences as volunteers. It did not explore the emotion or confusion of the epidemic moment, but instead produced images of the ‘rest of the world’—the world of the diseased poor, particularly in the immigrant north end—that were reassuring to Anglo-Canadian upper and middle class Winnipeggers. The encounter between volunteer and afflicted was explained in terms of the devotion to duty and the obligation of the wealthy to assist the poor, thus containing an unprecedented crisis within the boundaries of the status quo. Tributes to women’s sacrifice utilized the feminine to reshape an emergency that

⁸⁰ A *Free Press* editorial pointed out that the shortage of volunteers was understandable given the small number of “leisure women” in the city. Mothers could not be expected to volunteer. Neither could working women. MFP, November 16, 1918, p. 24. See also WT, November 9, 1918, p. 4.

⁸¹ MFP, December 2, 1918, p. 8.

threatened social stability into an opportunity for renewed gender relationships, moral improvement, and social cohesion. Women (and men) were reminded of the ideal of gendered caring and nurturing, relieving anxiety around women's increased occupation of public space. Heroic discourse appropriated potentially destabilizing interaction in the contact zone of disease, ensuring that volunteerism was channeled into a force to preserve, rather than dismantle, "normal" social relations, not only of gender, but just as importantly, of class and ethnicity. The elevated role of the heroic woman volunteer—leisured, respectable, Anglo-Canadian—restated the spatial and social barrier between citizens. That it needed restating points to the instability generated by the epidemic.

The north-south divide, which represented more fundamentally the social distance between wealthy, Anglo-Canadian and working class, immigrant Winnipeg, was not shattered by the movement of middle class Anglo-Canadian women across that divide. The most convincing evidence of the failure of influenza relief to nurture social unity is the Winnipeg General Strike, which arrived immediately on the heels of the epidemic. In that event, middle and upper class women chose their class and ethnic allegiances, and this choice was a blow to hopes of gender solidarity.

Chapter 4 – Influenza and Labour Revolt

In the previous chapter, the gendered nature of volunteerism during the influenza epidemic was shown to be a channel through which social divisions of class and ethnicity were articulated in the epidemic context. Although the relief work of middle class Anglo-Canadian Winnipeg women brought many into contact with working class and immigrant families, this encounter was carefully managed by defining the ideal volunteer as middle class, mature, and Anglo-Canadian, and by introducing a pseudo-scientific division of labour and ordered routine. Yet, beneath an appearance of social order, the influenza epidemic created new tensions in what I have referred to as the “contact zone” between middle and working class Winnipeg. Cross-class and –ethnic encounters, however, appear ultimately to have expanded, rather than contracted, social distance. Both ‘volunteer’ and ‘victim’ became strictly delimited roles.

The following chapters will shift our examination of the impact of influenza upon social relations away from health professionals and middle and upper class Anglo-Canadian volunteers, toward working class communities. The differential impact of influenza upon mortality rates among workers and immigrants in central and north end Winnipeg has already been established. This chapter addresses the reaction of the city’s labour movement to the events of the epidemic, setting their response in the context of years of tension and disagreement between working people and city authorities over health policies and the provision of medical care.

During the epidemic, labour was excluded from making any contribution to disease prevention and management by those who dominated City Council and the Board of Control, the Provincial Board of Health, and voluntary relief agencies. Their cooperation and assistance was not sought, despite the fears of social elites that the unchecked spread of influenza in the north end was a threat to social stability. In this regard, the Winnipeg situation was somewhat unique. By contrast, in cities such as Vancouver the centralized emergency organizations created to coordinate relief and medical care included representation from labour, management, and women's organizations. In that city, labour worked actively with municipal relief authorities to plan more efficient influenza relief measures.¹ This was far from the case in Winnipeg.

From its position on the margins of power, organized labour argued that "Men cannot be allowed to starve in a time of epidemic."² The demand for wage reparations for men put out of work by the government's ban on public gatherings fell on deaf ears. Neither was the state willing to intervene to prevent the predatory pricing practices of the funeral industry, which undermined the financial security of many working families, and prevented some from giving their loved ones a decent burial. The state's lack of responsiveness to workers' needs did little to build unity in the community. Thus, the events of the epidemic became another reminder of workers' lack of economic, social,

¹ Margaret Andrews, "Epidemic and Public Health: Influenza in Vancouver, 1918-1919," *BC Studies* 34 (Summer 1977), p. 38-39. The Metal Trades Council and the Boiler Makers' Union, for example, approached city council with suggestions for improving relief measures. This resulted in a meeting between various sectors of the community to create a centralized organization.

² *Western Labor News*, November 1, 1918, p. 1.

and political power, at a time when frustration with the social order was already extremely high. A historian of the German revolution of 1918-1919 captures the implications of the suffering and frustration of working people when he argues that the influenza epidemic was “one of the many factors which prepared for a far-reaching change and killed all the desire for resisting revolution.”³

Just after the spring wave of influenza had passed, in May and June of 1919, Winnipeg was the site of the historic General Strike, which lasted six weeks, taking two out of every three workers out on strike, organized and unorganized alike. The history of the strike has been well documented by historians.⁴ But it is possible to read this history and have no idea at all that during the winter of 1918-1919, when working class

³ Heinrich Hillermayr, quoted in Manfred Vasold, “The Influenza Pandemic of 1918-1919 in Nuremberg, Germany,” Paper presented to The Spanish Flu After 80 Years Conference, Cape Town, South Africa, 1998, p. 18.

⁴ Eric Angel, “Workers, Picketing, and the Winnipeg General Strike of 1919,” (Master’s thesis, Queen’s University, 1995); David Bercuson, *Confrontation at Winnipeg: Labour, Industrial Relations, and the General Strike* (Montreal: McGill-Queen’s University Press, 1990); J.M. Bumsted, “1919: The Winnipeg General Strike Reconsidered,” *The Beaver* 7, 3 (1994), p. 27-44; Mary Horodyski, “Women and the Winnipeg General Strike of 1919,” *Manitoba History* 11 (Spring, 1986); Gregory Kealey, “1919: The Canadian Labour Revolt,” *Labour/Le Travail* 13 (Spring 1984); Linda Kealey, “No Special Protection – No Sympathy: Women’s Activism in the Canadian Labour Revolt of 1919,” in Deian R. Hopkin, and Gregory S. Kealey, eds., *Class, Community, and the Labour Movement: Wales and Canada, 1850-1930* (Aberystwyth, Wales: Llafur and Canadian Committee on Labour History, 1989); D.C. Masters, *The Winnipeg General Strike* (Toronto: University of Toronto Press, 1950); A. Ross McCormack, *Reformers, Revels, and Revolutionaries: The Western Canadian Radical Movements, 1899-1919* (Toronto: University of Toronto Press, 1977); Tom Mitchell and James Naylor, “The Prairies: In the Eye of the Storm,” in Craig Heron, ed., *The Workers’ Revolt in Canada, 1917-1925* (Toronto: University of Toronto Press, 1998); Chad Reimer, “War, Nationhood and Working-Class Entitlement: The Counterhegemonic Challenge of the 1919 Winnipeg General Strike,” *Prairie Forum* 18, 2 (1993).

Winnipeg was “poised to explode,”⁵ people were ill by the thousands. Many were unable to work to earn wages, and were coping with the illness and death of friends, family, and labour movement colleagues. This historical silence is particularly notable when we consider that it was during the epidemic that workers held their first successful general strike vote (October 1918), and elected to city hall the largest ever contingent of labour councilors (November 1918). These achievements occurred despite widespread illness, and a ban on labour gatherings. Few historians of influenza, or labour historians, have questioned the link between the disease and social unrest.⁶

Other epidemics have been historically linked to class conflict, riot, and revolutionary uprisings, although the nature of the relationship has at times been oblique and difficult to decipher. Cholera’s waves through 19th century Europe, for example, either followed or were followed by significant popular unrest. Britain in 1832 saw both cholera and the Great Reform Bill. In 1848 revolutionary uprisings accompanied cholera through France, and the 1871 epidemic corresponded with the end of the Second Empire. In 1866, the year of another cholera wave, the German Confederation was overthrown.⁷ In Canada, cholera coincided with rebellion and political unrest in Lower and Upper Canada in 1832

⁵ Tom Mitchell and James Naylor, “The Prairies: In the Eye of the Storm,” in Craig Heron, ed., *The Workers’ Revolt in Canada, 1917-1925* (Toronto: University of Toronto Press, 1998), p. 282.

⁶ See Edwina Palmer and Geoffrey Rice, “‘Divine Wind versus Devil Wind’: Popular Responses to Pandemic Influenza in Japan, 1918-1919,” *Japan Forum* 4, 2 (October 1992), p. 319, for mention of a riot by steelworkers in Saha, Japan, against the profiteering of shopkeepers selling patent medicines.

⁷ Richard Evans, “Cholera in 19th Century Europe,” in Terence Ranger and Paul Slack, eds., *Epidemics and Ideas. Essays on the Historical Perception of Pestilence* (Cambridge: Cambridge University Press, 1992), p. 157.

and 1834. As Richard Evans, a historian of cholera in Germany, has concluded, “the general coincidence of cholera epidemics with years of upheaval and revolution has proved too obvious to ignore.”⁸

Cholera is not the only epidemic disease linked with popular resistance. Plague in medieval Europe was likewise associated with riot and social unrest, and has been identified by some historians as a major factor in the transformation of feudal society.⁹ Plague in India at the turn of the twentieth century saw widespread riots, mob attacks on Europeans (particularly doctors), and assassinations of British colonial officials.¹⁰ Smallpox in Montréal in 1885 provoked riots in the working class French Canadian community, resistance to compulsory hospitalization and vaccination, and attacks on public health offices and the homes of provincial Board of Health members. This struggle was cast in terms of ethnic conflict between French and English; it coincided with protests over the execution of Louis Riel.¹¹

Yet the precise relationship between unrest and epidemic disease remains the subject of some debate. The timing of epidemics, for example, sometimes makes it difficult to

⁸ Ibid.

⁹ David Herlihy, *Black Death and the Transformation of the West* (Cambridge, Mass.: Harvard University Press, 1997); Paul Slack, *The Impact of Plague in Tudor and Stuart England* (London: Routledge and Kegan Paul, 1985).

¹⁰ Rajnarayan Chandavarkar, “Plague Panic and Epidemic Politics in India, 1896-1914,” in Ranger and Slack, *op cit*; Ira Klein, “Plague, Policy and Popular Unrest in British India,” *Modern Asian Studies* 22, 4 (1988); David Arnold, “Cholera and Colonialism in British India,” *Past and Present* 113 (1986).

¹¹ Michael Bliss, *Plague: A Story of Smallpox in Montreal* (Toronto: Harper Collins, 1991), Ch. 8.

conclude that epidemics generally provoke revolt. In some cases, as in Russia in 1829, the arrival of cholera preceded popular uprisings.¹² There are other examples, however, in which cholera arrived in the midst of, or after, revolutions. Thus, “in 1848 cholera hit central Europe only in the early summer and did not reach its height until the autumn, while the major revolutionary upheavals had already take place in March and the impact of the disease was generally more severe in 1849.”¹³

In most cases, popular disturbances were multifaceted, with disease itself only one of many causes of the people’s dissatisfaction with ruling authorities. Official responses to disease were often regarded with significant distrust by radicals and by the populace. In Lower Canada in the 1830s, cholera provoked demonstrations and attacks on a proposed isolation hospital in Québec City. This reaction was strengthened by the French Canadians’ belief that the British government—by encouraging massive migration of diseased immigrants into Lower Canada from Europe—was seeking to “destroy the Canadians by unleashing cholera among them.”¹⁴ In a similar conspiracy vein, Upper Canadian radical William Lyon Mackenzie argued (along with Britain’s William Cobbett) that the cholera panic of 1832 was a ruling class plot “to frighten us out of reform.”¹⁵

¹² Roderick McGrew, *Russia and the Cholera 1823-1832* (Madison: University of Wisconsin Press, 1965), p. 17-40.

¹³ Evans, p. 162.

¹⁴ Geoffrey Bilson, *A Darkened House: Cholera in Nineteenth Century Canada* (Toronto: University of Toronto Press, 1980), p. 75.

¹⁵ *Ibid.*, p. 20.

The difficulty of establishing causation is further underlined by quite widely varying historiographical interpretations of the relationship between social organization and disease, and therefore between workers' resistance movements and specific disease episodes. Marxist-influenced perspectives view disease as reflective of crises in class relations and social production, and epidemic moments as arising out of the heightened exploitation of labour.¹⁶ Such an analysis has been influential in the social history of epidemics, particularly in the body of work written in the late 1950s and 1960s, which revealed the linkages between social inequality and mortality. The first major studies of cholera in Europe and Britain concluded that the poor working classes suffered more severely from the disease.¹⁷ Disagreements subsequently emerged about whether the evidence supported a social gradient in cholera mortality.¹⁸ The emphasis on social inequality as a major determinant of epidemic mortality gave way in the late 1970s to a focus upon the social antagonisms raised by epidemic disease, and the capacity of social order to withstand an epidemic crisis. Nevertheless, the controversy over social inequality and epidemic disease has remained front and center in some important works, such as Richard Evans's *Death in Hamburg*, published in 1987.

¹⁶ Evan Stark, "The Epidemic as Social Event," *International Journal of Health Services* 7, 4 (1977).

¹⁷ Richard Evans, *Death in Hamburg: Society and Politics in the Cholera Years, 1830-1910* (London: Penguin Books, 1987), p. 404. For example, see McGrew, p. 6-7; Morris, p. 88-93.

¹⁸ Michael Durey, for example, disputed that class was irrelevant to cholera mortality in England. He argued that the quality of the water supply (unrelated to social class) was a more important factor. See *The Return of the Plague: British Society and the Cholera, 1831-32* (Dublin: Gill and Macmillan, 1979), p. 47-49.

In the 1980s and 1990s, the influence of Foucaultian and post-structuralist perspectives on disease pointed to the significance of discursive formations in epidemic contexts.¹⁹ One fruitful outcome was a furthering of our understanding of the meaning and the interpretation of disease, not just among social elites, but among the masses as well. How were these meanings aligned with previously existing relations, events, and world views through which the society operated? For example, attacks upon doctors were common during the first wave of cholera in Paris in 1832. But how did physicians come to be the target of popular anger, and to be identified as “the agents of the enemy”? Conversely, what views of disease supported middle and upper class beliefs that the working classes were a “threat to public welfare, as both carriers of disease and fomenters of riot”?²⁰

Another important factor in understanding popular reactions to epidemic disease is the exercise of state power. Where the public health actions of the state relied upon force and compulsion, rather than upon persuasion and public confidence, the populace often reacted with violence. Terence Ranger and Paul Slack, in their collection *Epidemics and Ideas*, conclude that “disturbances in time of plague and cholera were reactions to the strict controls and police regulations imposed by apparently insensitive and uncaring

¹⁹ Two examples of monographs in this vein are David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in 19th Century India* (Berkeley: University of California Press, 1993); Nayan Shah, *Contagious Divides: Epidemics and Race in San Francisco's Chinatown* (Berkeley: University of California Press, 2001).

²⁰ Francois Delaporte, *Disease and Civilization. The Cholera in Paris, 1832* (Cambridge, Massachusetts: The MIT Press, 1986), p. 8.

authorities.”²¹ In other words, popular uprising and revolt is predicated on the perception of state public health measures as autocratic, and are not seen as having been precipitated by the disease itself. A more liberal approach to public health, which recognizes limits upon state violations of personal, cultural, and religious freedoms, is less likely to provoke hostile popular responses.²²

Thus, it appears that popular expressions of protest have opposed government action, rather than inaction, based upon the popular right to freedom from state interference. When public health policies moved away from coercion, violent popular protest and resistance subsided. Yet in an age of therapeutic plurality, resistance against hospitalization and vaccination also meant struggling for the right to choose a different course of medical action from that sanctioned by the state. Some resistance movements, such as the opposition to smallpox vaccination in the 19th century, were long-term projects lasting many years and drawing together opponents across the class, gender, and political spectrum. Others were short bursts of popular anger and frustration, usually among the masses. Popular opposition to coercive strategies was a central factor in the turn to a more voluntary approach to fighting epidemic disease, along with the general

²¹ Ranger and Slack, p. 12.

²² For a critique of the Ackernectian thesis that liberal states employ liberal public health policies, and autocratic states employ compulsion against epidemic disease, see Peter Baldwin, *Contagion and the State in Europe, 1830-1930* (Cambridge: Cambridge University Press, 1999). The point here is not to categorize state health policies within or outside of this framework, but merely to address the evidence that coercive state policies provoked popular backlash.

ineffectiveness of coercive measures such as compulsory isolation.²³ Physicians were among those to argue against compulsion. In 1831, after the first wave of cholera, the British medical profession denounced the use of forced confinement of cholera victims in pest houses. This it viewed as “folly” which raised the threat of riot and popular uprising.²⁴

This does not mean, however, that coercion disappeared, or that quarantinist state intervention was a relic of the nineteenth century. Richard Evans has argued that state involvement in the “policing of epidemics” waned after the first cholera epidemic of 1832, but then picked up again after Robert Koch’s discovery of the cholera bacillus in 1884, which gave renewed strength to the contagionist (versus sanitationist) view of disease. After this point, “massive preventive campaigns” of quarantine, isolation and disinfection were again undertaken, and the strength of modern state apparatuses made these measures much more effective.²⁵ Compulsory isolation of cholera victims and the destruction of their personal property was employed by the Italian government in Barletta in 1910. In colonial settings, compulsion was used in implementing public health measures into the twentieth century.²⁶

²³ Frank M. Snowden, “Cholera in Barletta, 1910,” *Past and Present* 132 (1991); Richard Evans, “Cholera in 19th Century Europe,” p. 167.

²⁴ Snowden, p. 84.

²⁵ Evans, “Cholera in 19th Century Europe,” p. 171.

²⁶ David Arnold, ed., *Imperial Medicine and Indigenous Societies* (Delhi: Oxford University Press, 1989), p. 12; Ira Klein, p. 739; David Arnold, “Cholera and Colonialism in British India,” p. 145-148. Klein argues that the Indian authorities had largely abandoned compulsion by the early 1900s.

Organized protest against state health policies during epidemics, nevertheless, has been all but non-existent. Historians of epidemics and revolt have generally concluded that radical labour and political leaders did not take an active part in fomenting popular unrest and riot during epidemics. Citing examples from Britain, France, and Germany in the mid- to late-nineteenth century, Richard Evans argues that “cholera riots were generally free from any encouragement by political radicals,”²⁷ who tended to be afraid of mass sentiment, and who believed that popular fears of disease were instigated by government to discredit their movements or to reverse political reforms. Left ideological perspectives did not generally view epidemic disease as a rallying point for popular movements. The apparent disconnection between epidemic unrest and radicalism in Canada is encapsulated in the following quote, taken from Michael Bliss’s study of smallpox in Montreal. A Québec tradesman, a veteran of the Paris Commune, stated when asked to comment upon riots occurring in Montréal during the 1885 smallpox epidemic:

Lay the riot to the Communists? ... Not at all ... Whenever anything is smashed here you cry ‘Communist’, but you forget that we Communists are reasoning people; if we wanted to raise an insurrection we should go to work differently; we might make a barricade, but to start an anti-vaccination riot composed of little boys is a business that a Communist laughs at.²⁸

Judging by the failure of union and socialist leaders to consolidate popular unrest during the 1910 cholera epidemic in Barletta, Italy, such views persisted into the

²⁷ Evans, “Cholera in Nineteenth-century Europe,” p. 166.

²⁸ Bliss, p. 180.

twentieth century. Frank Snowden's study of this epidemic explores why workers rioted "instead of taking more organized and disciplined political action."²⁹ In particular, he asks why a general strike was not called in the face of popular opposition to state health policies. There was by 1910 a long history of general strikes in this part of Italy. The general strike, he argues, had superseded the bread riot as the weapon of choice in workers' attempts to defend their interests. A general strike failed to emerge in response to cholera partly because the agricultural workers lacked leverage due to poor crops and economic crisis, and because the leaders of the socialist movement, largely middle class, were "mesmerized by the authority of science ... [and] had no independent health policy."³⁰ The socialist press and union organizers supported the health ministry, and denounced the fears and resistance of the population as rooted in superstition and ignorance. "On the issue of public health," Snowden concludes, "the workers found themselves leaderless."³¹

There is little in the unfolding of events of winter 1918-1919 to suggest that the Winnipeg General Strike was a direct response to the influenza epidemic. But, the coincidence of the two events warrants our attention for two important reasons. First, the level of support for the General Strike at the community level—in the streets and in households—is considered by historians to be fundamental to the depth of resistance shown by workers. It is at this level that working families evolved their strategies for

²⁹ Snowden, p. 98.

³⁰ *Ibid.*, p. 99.

³¹ *Ibid.*, p. 100.

coping with influenza, and where they confronted the social injustices of the epidemic. In the following chapter, we will see that the community solidarity of the General Strike was prefigured in the epidemic, when families had to survive without wages, and mutual aid and assistance were fundamental to survival. Out of this mutual reliance, strong bonds of class and community were formed.

Second, health had become a politicized issue in Winnipeg, on which working people were not “leaderless.” Unlike the socialist movement in Barletta, Winnipeg’s radical community cannot be criticized for failing to take advantage of popular unrest against state authority during the epidemic. Mass reaction to influenza in Winnipeg did not include rioting, destruction of property, or overt expressions of mistrust toward public health officials and physicians. There were no particularly notable instances of mass opposition to state disease control measures, and thus little unrest to control and channel. However, there were several points of tension. Labour’s history of openly criticizing hospitals and physicians gave political articulation to popular dissatisfaction with medical care. Although labour leaders did not openly oppose the hospitalization of influenza victims, their longstanding disagreements with Winnipeg hospitals and physicians over the quality of health care provided to public patients formed an important backdrop to informal resistance to hospitalization during the epidemic. On other issues, criticism of the authorities was much more direct. The epidemic galvanized working class leadership in Winnipeg to directly confront the provincial and city governments on questions related to workers’ economic security. Labour’s demand that “men cannot be allowed to starve”

was aimed not just at the capitalist bosses, but also at a state oblivious to the needs of the people.

The events of the influenza epidemic should be considered within the context of class and ethnic tensions surrounding medical professionalization and public health in the first decades of the twentieth century. This was a period of transition in public attitudes toward medicine and public health measures, and in popular health practices. While many traditions of 'self-help' persisted, such as the reliance upon wise women and midwives, and the use of patent medicines and herbal remedies of various types,³² these co-existed with the increasing influence of physicians, public health experts, and nurses. The power of the state to take interventionist measures that violated individual freedoms increased in most Western countries in the latter half of the nineteenth century, partly as a result of a renewed faith in isolation as a means of combating infectious diseases, based upon the science of bacteriology and the 'germ theory' of disease.³³

³² Diana Gittins, *Fair Sex: Family Size and Structure, 1900-1939* (London: Hutchinson, 1982), p. 51; Elizabeth Roberts, *A Woman's Place: An Oral History of Working-Class Women, 1890-1940* (Oxford: Basil Blackwell, 1984), p. 189 – 191.

³³ Dorothy Porter, *Health, Civilization and the State: A History of Public Health From Ancient to Modern Times* (London: Routledge, 1999), p. 134. For a Canadian perspective on developments in public health in this period see Jay Cassel, "Public Health in Canada," in Dorothy Porter, ed., *The History of Public Health and the State* (Amsterdam: Clio Medica, 1994), p. 290-296; Heather MacDougall, *Activists and Advocates: Toronto's Health Department, 1883-1983* (Toronto: Dundurn Press, 1990), p. 10-13.

Working class and immigrant women and men responded to public health campaigns and medical professionalization along a continuum from resistance to accommodation.³⁴ Notable oppositional movements in the late nineteenth century included anti-vaccinationism, and the campaign against the Contagious Diseases Act in Britain.³⁵ Anti-vaccinationism had a presence in Canada and in Winnipeg as well, as we shall see. These movements, however, were waning in the first decades of the twentieth century. No organized opposition emerged against the “powerfully interventionist” infectious diseases laws passed in the late nineteenth and early twentieth centuries.³⁶ The public appears to have adapted in this period to the authority of the state and medical officials to regulate individual behaviour in the name of public health. Dorothy Porter has commented that: “By the last quarter of the nineteenth century, the British public was becoming

³⁴ Nancy Tomes, *The Gospel of Germs: Men, Women, and the Microbe in American Life* (Cambridge, Massachusetts: Harvard University Press, 1998), p. 188; Cassel, p. 287. The literature on mothers’ responses to maternal health and child welfare campaigns is voluminous. Canadian studies include Andrée Lévesque, *Making and Breaking the Rules: Women in Québec 1919-1930* (Toronto: McClelland and Stewart, 1994); Cynthia R. Comacchio, “Nations Are Built of Babies”: *Saving Ontario’s Mothers and Children, 1900-1940* (Montreal: McGill-Queen’s University Press, 1993); Katherine Arnup, Andrée Lévesque and Ruth Roach Pierson, eds., *Delivering Motherhood: Maternal Ideologies and Practices in the 19th and 20th Centuries* (London: Routledge, 1990). Women’s agency in determining their medical care is explored in Wendy Mitchinson, “Problematic Bodies and Agency: Women Patients in Canada, 1900-1950,” in Franca Iacovetta and Wendy Mitchinson, eds., *On the Case: Explorations in Social History* (Toronto: University of Toronto Press, 1998). A particularly useful examination of British working class attitudes to social and medical reform in this period is Caroline Rowan, “Child Welfare and the Working-Class Family,” in Mary Langan and Bill Schwartz, eds., *Crises in the British State 1880-1930* (London: Hutchinson, 1985).

³⁵ For the latter, see Judith Walkowitz, *Prostitution and Victorian Society; Women, Class and the State* (Cambridge: Cambridge University Press, 1980); Frank Mort, *Dangerous Sexualities: Medico-Moral Politics in England Since 1830* (London: Routledge and Kegan Paul, 1987).

³⁶ Dorothy Porter, p. 134.

acclimatized to a new medical rationality which might involve the trimming of its liberties.”³⁷ Similar changes occurred in the Canadian context.

The public was growing acclimatized as well to the “gospel of germs”, as Nancy Tomes has referred to the popularization of bacteriology in America.³⁸ As she notes, the new belief in microbes and germs as a source of disease was not an inevitable outcome of improvements in medical knowledge, but the result of “educational crusades” undertaken by health reformers, particularly the anti-tuberculosis, consumer, and domestic science movements.³⁹ The acceptance of germ theory progressed more quickly among the middle class than among workers and immigrants. This was not necessarily because the latter were resistant to the idea that germs existed and caused ill health. Tomes makes the astute observation that middle class health reformers made little attempt to explain the theory of germs and disease transmission to the targets of their campaigns. Rather they focused upon simplified rules for sanitary living, without providing any scientific justification. If these rules were resisted, perhaps it was because the realities of working people’s lives made it all but impossible for them to respond to the implications of germ theory in day to day living. Nevertheless, the evidence shows that many immigrant and working class women did their best to adopt the sanitary ideals pushed by doctors, social workers,

³⁷ Ibid., p. 137.

³⁸ Tomes.

³⁹ Ibid., p. 9.

visiting nurses, and consumer advertising, applying standards of household cleanliness to themselves and each other.⁴⁰

Tomes's research is particularly important because it examines not only the response of women to educational campaigns targeted at the domestic sphere, but also the attitudes of organized labour toward germ theory when it was applied to the workplace. American unionists, although generally mistrustful of middle class reformers, were willing to embrace germ theory, if it could be used to buttress their own arguments in favor of safer and healthier workplaces, and better worker health. But their 'gospel of germs' had significant differences from that of mainstream health reformers. The American Federation of Labor, for instance, in its 1906 anti-tuberculosis literature, accepted the view that tuberculosis was caused by germs. Protection from the disease, however, came not from sanitation, but from solidarity. "Join a Labor Union and Help Stamp Out Consumption," a leaflet stated, arguing that the union movement would fight tuberculosis first by achieving a shorter working day and higher pay. As Tomes concludes, "the AFL saw the link between disease and economic justice in even more expansive terms than did the most zealous middle-class anti TB workers."⁴¹

Labour's analysis of the causes of disease focused not upon germs, but upon the role of unsafe and unhealthy workplace conditions—the "fearful tribute which labour pays to

⁴⁰ Ibid., p. 183 – 195.

⁴¹ Ibid., p. 211. Unfortunately, there are no studies of attitudes toward germ theory in Canada's labour movement.

capital.”⁴² The rate of occupational disease and injury during the Second Industrial Revolution was extremely high in North America. Eric Tucker’s research on Ontario shows sharply escalating numbers of serious industrial accidents, including those causing death, after 1900.⁴³ David Rosner and Gerald Markowitz draw similar conclusions for the United States, where workers had rates of injury and death on the job two to three times higher than Europeans.⁴⁴ In 1894, Manitoba adopted the *Workmen’s Compensation for Injury Act*, which increased employers’ responsibilities, but required workers to use the civil courts to win financial awards. In 1900, the province passed its first *Factories Act*, pushed to do so after the death of Gudrun Johansson, whose skirts had become tangled in an unprotected revolving shaft in her workplace. This act was rarely enforced, however; it took sixteen years for a full time factory inspector to be appointed.⁴⁵ During the first two decades of the twentieth century, workers and their unions consistently pressured government to reform factories laws and improve enforcement. Doug Smith argues that this struggle was an important factor in the coalescing of labour organizations into a movement in this period.⁴⁶

⁴² *The Voice*, July 20, 1906, quoted in Doug Smith, *Consulted to Death: How Canada’s Workplace Health and Safety System Fails Workers* (Winnipeg: Arbeiter Ring Publishing, 2000), p. 24.

⁴³ Eric Tucker, *Administering Danger in the Workplace: The Law and Politics of Occupational Health and Safety Regulation in Ontario, 1850 – 1914* (Toronto: University of Toronto Press, 1990), p. 180.

⁴⁴ David Rosner and Gerald Markowitz, “Safety and Health on the Job as a Class Issue: The Workers’ Health Bureau of America in the 1920s,” *Science and Society* 48, 4 (Winter 1984-85), p. 466.

⁴⁵ Smith, p. 24-26.

⁴⁶ *Ibid.*, p. 25.

Boundaries between the health of home, community and workplace were often blurred. Arguing that the solution to health problems would come not only by winning reforms from employers and governments, workers created their own health care institutions. At the turn of the twentieth century, for example, the Western Federation of Miners (WFM) established twenty-five workers' hospitals in Canada and the US, including six in British Columbia. The last of these was opened in 1918 in Silverton, B.C. Indeed, as Alan Derickson argues in *Workers' Health, Workers' Democracy*:

Beginning with the railroad brotherhoods and other craft organizations in the mid-nineteenth century, most unions administered disability and death benefit programs. In addition, around the turn of the century a number of organizations began to deliver health and welfare services, establishing old-age homes, sanitariums, clinics, and hospitals. Unionists of all stripes understood not only the humanitarian value of such endeavors but also their instrumental value in recruiting and retaining members.⁴⁷

While the WFM was certainly located at the more activist end of mutual aid and benevolent fraternalism, many other unions were involved in the health of their members and their members' families, taking a proactive role in shaping health care institutions and services. The involvement of union locals in assisting influenza victims will be discussed in the following chapter.

In his study of health coverage in the weekly labour newspaper, *The Voice*, between 1894 and 1914, Desmond Fitz-Gibbon reaffirms that Winnipeg workers articulated a different vision of public health from that of middle class reformers.⁴⁸ In the early

⁴⁷ Alan Derickson, *Workers' Health, Workers' Democracy: The Western Miners' Struggle, 1891-1925* (Ithaca: Cornell University Press, 1988), p. xi.

⁴⁸ Desmond Fitz-Gibbon, "The People's Health and The Peoples Voice: Working-class reaction to public health in Winnipeg, 1894-1914," Paper presented at the 2002 Annual Meeting of the Canadian Society for

twentieth century, working class spokesmen and -women tended to be anti-medical establishment and anti-compulsory vaccination, and to support an analysis of disease that prioritized the role of poverty, wages, and working and living conditions in determining the people's health. Workers' demands for public health revolved around the right to a living wage, to quality housing, and to "control over their own and their children's bodies."⁴⁹

Health issues received considerable coverage in *The Voice*. Although it was officially published by the Trades and Labour Council (TLC), the paper represented an eclectic mix of working class opinion (albeit, only of Anglo-Canadian working class opinion) including the views of working class feminists, socialists, trade unionists, social democrats, and single taxers.⁵⁰ Health was often a topic of debate, particularly in the weekly women's columns written by Ada Muir between 1906 and 1912. Ada Muir was born in Britain, and trained as a nurse there before emigrating to Canada. She was the mother of six. Muir was an active feminist, and a founding member of the Women's Labor League.⁵¹ This overlapping of commitments was not uncommon in health

the History of Medicine. For another supporting view, see Michael Sigsworth and Michael Worboys, "The Public's View of Public Health in Mid-Victorian Britain," *Urban History* 21, 2 (October 1994).

⁴⁹ Nadja Durbach, "Class, Gender, and the Conscientious Objector to Vaccination," *Journal of British Studies* 41 (January, 2002), p. 60. See also her "'They Might As Well Brand Us': Working-Class Resistance to Compulsory Vaccination in Victorian England," *Social History of Medicine* 13, 1 (2000), p. 45, where she argues that "anti-vaccinationism ... helped to reorganize working-class identities around the site of the vulnerable body."

⁵⁰ Fitz-Gibbon, p. 4.

⁵¹ Anne Molgat, "'The Voice' and the Women of Winnipeg" (Master's thesis, University of Ottawa, 1988), p. 89.

movements of the era.⁵² She was a proponent of natural health, an anti-vaccinationist, and explicitly rejected the germ theory of disease. “The germ scare is only a medical scare craze”⁵³ she bluntly argued in 1911. Illnesses like tuberculosis were caused not by *bacilli* in her view, but by “nervous depletion of the chest from worry, poverty, strain, or restraint. It is caused by dirty and unwholesome conditions, and is purely an economic and social disease.”⁵⁴ Thus, the solution was not medical science or public health measures, but rather to “improve working conditions and remove the cause of the workman’s fear that when old and unfit for employment he will starve, and many a consumptive case will be prevented.”⁵⁵

Muir was consistently hostile to the medical profession, and to the medical inspection of school children. She considered inspection and the compulsory vaccination of school children to be violations of working class freedom without demonstrable cause, as neither would improve the health of working families. Public health measures failed to address the fundamental cause of illness: “How will medical inspection provide a remedy for the thousands of poor who must live on less than a living wage during eight months of the

⁵² Durbach, p. 61. Durbach notes the links between female antivaccinationism, the movement for the female franchise, opposition to the Contagious Diseases Acts, vegetarianism, and antivivisection in late nineteenth century England.

⁵³ *The Voice*, February 24, 1911.

⁵⁴ *The Voice*, April 2, 1909.

⁵⁵ *The Voice*, May 24, 1907.

year and on nothing at all the remaining four?" she queried.⁵⁶ Working class opposition to compulsory vaccination was consistently expressed in the pages of *The Voice* from 1897 on. The paper noted the establishment of a short-lived Anti-Vaccination League in 1902.⁵⁷ The reasons for the relative lack of success of this group, compared for example with Ontario's Anti-Vaccination League—a much more stable and forceful organization—are unclear.⁵⁸ Muir became the central working class voice for anti-vaccination after the inauguration of her column in 1906. She and her family left Winnipeg for Vancouver in 1912, where she and her husband Alan continued to be active on health issues, becoming vocal opponents of the sterilization of the feeble-minded and the mentally ill.⁵⁹

Muir's ideas were not always shared by others in the labour and socialist community, particularly the Independent Labour Party, which tended to give greater support to the development of state medicine and public health.⁶⁰ She was not alone, however, in

⁵⁶ *The Voice*, August 27, 1909.

⁵⁷ Fitz-Gibbon.

⁵⁸ The Ontario League had a strong middle class presence, which appears to have been lacking in Winnipeg. See Paul Adolphus Bator, "The Health Reformers Versus the Common Canadian: The Controversy Over Compulsory Vaccination Against Smallpox in Toronto and Ontario, 1900-1920," *Ontario History* 75, 4 (1983), p. 353.

⁵⁹ Molgat, p. 92.

⁶⁰ Muir disagreed with the Independent Labor Party's support for compulsory education, since this would require the vaccination of all school-age children. Fitz-Gibbon, note #38. She also criticized a physician giving a lecture to the Canadian Labour Party in February 1908, who supported the germ theory of disease and compulsory notification and medical home inspections.

arguing for a class analysis of disease causation and in opposing state intrusion into the health and medical care of the people. Her advocacy in *The Voice* was a factor in the establishment of the Winnipeg Health League, in 1907. Its president was Alan Muir and the vice-president Fred Dixon, an advocate of the single tax, and a labour member of the provincial legislature.⁶¹ Dixon would (with J.S. Woodsworth) assume the editorship of the *Western Labor News* after the arrest of William Ivens during the Winnipeg General Strike. The Health League was active for almost a year, publishing articles critical of the city's health policy, opposing compulsory vaccination, and holding public lectures and meetings on a variety of health questions. Although the level of interest in the League's activities appears to have been fairly high, the group discontinued its lectures in spring 1908. It was followed a few years later by the Manitoba Medical Freedom League, formed in 1914.⁶² This organization was short-lived. Dixon himself continued to advocate for improved health conditions for workers through higher wages. In 1911, he criticized the health department for missing the true cause of overcrowding and disease in the city's north end: poverty.⁶³

⁶¹ Fred Dixon first ran for the provincial legislature as a Labor Party candidate in 1910, but was narrowly defeated as a result of a split in the left vote when a Socialist Party candidate entered the race. In 1914, Dixon ran again with the endorsement of the Labour Representation Committee, a joint venture of the Labor Party and the Social Democratic Party. This time his bid was successful. Doug Smith, *Let Us Rise!: An Illustrated History of the Manitoba Labour Movement* (Vancouver: New Star Books, 1985), p. 29-30.

⁶² Fitz-Gibbon.

⁶³ *The Voice*, June 2, 1911.

Certainly, *The Voice* was only narrowly representative. Its Anglo-Canadian audience and authorship did not necessarily reflect the views of European immigrant workers, and its writers were among the labour movement's skilled elite, not its rank and file. Nevertheless, coverage of health issues in its pages suggests some of the significant points of tension between working people and the public health and medical establishment in Winnipeg before 1918. Within such a context, measures taken by health authorities to contain influenza in the fall of 1918 were likely to generate criticism. There was no violence directed at hospitals and physicians during the influenza epidemic in Winnipeg such as occurred, for example, in Montréal during the smallpox epidemic in 1885. Hospital isolation of flu victims was nevertheless controversial. In the first days and weeks of the epidemic, health authorities in the city scrambled to find beds to care for the infected. The hospitalization and isolation of victims was believed to be essential to fighting the spread of the disease, more so than quarantining and placarding homes, which Douglas and other medical officials initially opposed. Every hospital in the city contributed space for beds, the role of the King George V Hospital for infectious diseases and the Winnipeg General Hospital being particularly important. The available space in these facilities was quickly filled in the first days of heavy infection rates, and the lack of space led to the refitting of the Old Coffee House, on Main Street, by municipal health authorities. City Council authorized modest expenditures to fight influenza, including the transfer of \$400 from the crematory operating account into a new Spanish Influenza account, and an appropriation of \$2000 to the Municipal Hospital Commission for the cost of equipment to outfit the new facility at the Old Coffee House. Capital expenditures

by the city for this facility, two smaller emergency hospitals in the north end, and an additional 50 beds in the King George were to eventually mount to \$15,000. "Much of it can be applied to furnishing the new Nurses' Home," the hospital commission argued.⁶⁴

Although the press reported that 2000 influenza patients were in hospital on any given day, the figure seems improbable. According to the records of the Winnipeg General Hospital and the King George Hospital, only 2957 influenza cases were treated in isolation wards in 1918, including at the Logan Annex.⁶⁵ These facilities together had approximately 500 beds.⁶⁶ The press estimated that at the peak of the epidemic 6000 Winnipeggers had the flu on any given day. The majority of flu victims probably never saw an influenza ward. The irony is that at some point near the peak of the epidemic, the hospital wards stopped filling. As we saw in Chapter 2, officials quickly became alarmed in the second week of November when fifty influenza beds remained empty and daily infections and deaths climbed precipitously. Hospitalization as a disease control strategy appeared ineffective. There were probably several factors contributing to underutilized hospital beds, including the failure of the public health system to promptly locate flu

⁶⁴ CWA, Council Minutes, October 28, 1918; November 14, 1918; December 23, 1918.

⁶⁵ Mary Shepherd, *Our Hospitals Through the Years* (Winnipeg: Comet Press, 1958), p. 33; PAM, MG10 B11, Box 2, Winnipeg General Hospital Annual Report, 1918.

⁶⁶ The Logan Annex accommodated 200 at its peak. The WGH ward initially held only fifty. (see MFP, October 12, 1918, p. 1) An additional 60 – 70 beds were made available by the end of October. See PAM, MG10 B11, Box 18, Winnipeg General Hospital, House Committee Minutes, October 23, 1918, October 30, 1918. The King George Hospital had 190 beds, and an additional 50 were added. The North Winnipeg Hospital took 76 flu patients in total over the course of the epidemic. The number of beds in this hospital (a converted house on Burrows Ave. in the north end) is unknown, but it could not have been large. See Shepherd, p. 27, 33.

victims and see to their isolation. Hospitalization was not forced upon the sick. Physicians were notoriously slow to report cases to the authorities. It may also be that the work of women volunteer nurses convinced people that it was possible to get care at home, thereby avoiding hospitalization. But there were also likely less circumstantial and more deeply rooted explanations as well.

There is evidence that in early twentieth century Canada there was a generally chilly relationship between hospitals and working people, despite the fact that perceptions of hospital care were generally improving in this period. David Gagan and Rosemary Gagan have found that working people did not have a positive view of the care they might expect to receive at the Vancouver General Hospital in the years leading up to the First World War. Complaints from public ward patients about lack of quality care, poor nourishment, and dirt had contributed to a public inquiry into mismanagement of the Vancouver General in 1912. These historians describe the institution (and indeed argue that Vancouver's was probably not an exceptional experience) as "impersonal, elitist, overcrowded, imperious, discriminatory, judgemental, success-oriented, unaffordable, and costly."⁶⁷

The provision of care to the sick poor had long been an issue in Winnipeg as well. Beginning around 1908, *The Voice* gave extensive coverage to the lack of adequate medical and hospital services available to the residents of the north end. As the 1908

⁶⁷ Discriminatory because Asian patients were segregated in Ward H, located in the basement. David Gagan and Rosemary Gagan, "'Evil Reports' for 'Ignorant Minds'? Patient Experience and Public Confidence in the Emerging Modern Hospital: Vancouver General Hospital, 1912," *Canadian Bulletin for the History of Medicine* 18 (2001), p. 364.

Hospital Commission (referred to in Chapter 1) made its deliberations, *The Voice*, the *North-Ender* (a community newspaper), and physicians who practiced in the area argued that the north end should have its own general hospital. They argued that the Winnipeg General was not meeting the needs of the people, particularly those of poor immigrants and workers. Dr. Sharpe testified that “the foreign element ... didn’t understand the doctors,” and reported one case where the police had handcuffed an immigrant mother to her bedpost in order to remove her child with diphtheria to the hospital.⁶⁸ In his opinion, an institution based in the community would help to overcome immigrant fears of doctors and hospitalization. The physicians and *The Voice* endorsed a municipally operated facility, and suggested the old women’s college grounds on Aberdeen as a potential site. Their arguments failed to convince the Hospital Commission. The hospital eventually built on that site was the Winnipeg Children’s Hospital; an institution not publicly managed, but built and operated very much according to a traditional philanthropic model, with the financial support of the city. The North End Hospital, originally called the Peoples Dispensary, was established in 1908 with the support of the Women’s Baptist Union. The following year it became non-denominational, and moved into a house converted for the purpose on Burrows Avenue.⁶⁹ The facility remained small and was received only \$500 per year from the city.⁷⁰

⁶⁸ Ibid., November 20, 1908, p. 7.

⁶⁹ Mary Shepherd, *Our Hospitals Through the Years* (Winnipeg: Comet Press, 1958), p. 32-33.

⁷⁰ *The Voice*, December 5, 1918, p. 4.

At the same time, the Winnipeg General was receiving large sums of money in order to finance its expansion. In 1911, when the City Council granted a request from the General for \$400,000, Ada Muir's wrath was bitterly expressed.

When the city granted \$400,000 to the General Hospital it, in so doing, created an emporium for surgical and disease grafting fanatics who should be practically free of public opinion and public control, and yet have practically a free hand at the public purse to carry on their barbarous and grotesque systems.⁷¹

Two years later, the General was again before council seeking another \$400,000. The Trades and Labor Council argued that this would virtually ensure that the North End Hospital would receive little support, and that the General intended this result. "For fears that the North Winnipeg or other hospital shall get some share the General's board asks often and for large sums," a *Voice* editorial claimed.⁷² The TLC demanded that the General be brought under municipal control, arguing that the facility was inaccessible to working people, while providing publicly-subsidized care for the wealthy:

Proof enough had been produced on the floor of the council that the working class could not get even into the pauper ward of the hospital if it was suspected he [sic] would be unable to produce considerable coin. Another delegate argued that the owning class in Winnipeg had found that by means of the hospital they could get the best in medical service at a lower cost and load a lot of the cost on the city.⁷³

Perhaps in response to public criticism, the city council lowered the proposed grant to \$275,000, and scheduled a plebiscite for October 1, 1913. Despite the property

⁷¹ Ibid., September 29, 1911, p. 3.

⁷² Ibid., September 13, 1913, p. 4.

⁷³ Ibid., August 22, 1918, p. 1.

qualification, the bylaw was defeated. To the outrage of the labour movement, the bylaw was then resubmitted by city council. The Trades and Labor Council carried out a public campaign to defeat the bylaw a second time and formed a Citizens' Committee. One of the Citizen Committee's more ingenious strategies was to send ballots to all physicians in the city asking whether they were satisfied with the process for staff appointments at the General. Sixty physicians responded, and 75 percent were in favour of changes to appointment procedures.⁷⁴ The Trades and Labor Council proposed that the General be made a municipal hospital by vesting the hospital's property with the City, and ensuring that a majority of the hospital board was appointed "by elected representatives of the people."⁷⁵ The bylaw was again defeated.

Despite this labour victory, the North End Hospital never received significant support from city council, and was unable to expand. The General continued to receive sizable grants, although much smaller than previously. With the establishment of the King Edward and King George municipal hospitals, some of the strength of the labour movement's arguments against the "monopoly" held by the General was dissipated.⁷⁶ Nevertheless, *The Voice* continued to argue in favour of democratic control of all hospitals. Its editorials consistently took the labourist stance that medical care should be provided to workers through publicly owned and operated hospitals, not autonomous and

⁷⁴ Ibid., December 19, 1913, p. 1

⁷⁵ Ibid., November 7, 1913, p. 1.

⁷⁶ "Hospital monopoly" was used by Arthur Puttee, among others. Ibid, December 5, 1913, p. 4.

(they argued) unaccountable institutions like the Winnipeg General.⁷⁷ By the end of the war, suggestions were coming forward for a full socialization of medical care. Mrs. John Dick of the Women's Civic League, *The Voice* reported, "spoke for free hospitals, not only for the needy, but for all the sick. The after-war sentiment would be that the state should take care of the children, the old and the sick."⁷⁸

The Winnipeg General made every attempt to improve its public image. "The Winnipeg General is largely a poor man's hospital," the directors proclaimed in 1918; fifty percent of the facility's beds were used by "those unable to pay."⁷⁹ The municipal and provincial governments granted funds to WGH for the care of these patients, but funding appears to have been inadequate; at the end of the war the hospital was carrying deficits in excess of ten percent of annual expenditures. While expressing pride in its 'public' mandate, the General was critical of certain aspects of public provision as well. Like other public hospitals, the WGH rigorously screened patients for financial eligibility, believing as the dominant classes did that the poor must be taught self-respect and independence.⁸⁰ The public obligation to care for the poor sat uneasily with some

⁷⁷ The major study of labourism in Canada at the turn of the 20th century is Craig Heron, "Labourism and the Canadian Working Class," *op cit*. This paper unfortunately does not address the health and social welfare platforms of labourism in detail. Heron does argue that labourists favoured only modest social welfare measures, and continued to prefer self-reliance and mutual assistance to state intervention in social life, until wartime conditions and the increasing influence of socialists in the workers' movement pushed labourists into a more radical rhetoric of public service and ownership.

⁷⁸ *The Voice*, March 8, 1918, p. 4.

⁷⁹ PAM, MG10, B11, Box 2, Winnipeg General Hospital Annual Report, November 30, 1918.

⁸⁰ Gagan and Gagan, p. 349: "The commodification of hospital-based health care reproduced in the hospital environment the social attitudes, controls, and structures of the wider community. This

medical practitioners at the hospital. Interns, for instance, to whom was delegated a great deal of the work, resented being required to provide care in the outdoor clinic. In May 1918, the Advisory Committee of the medical staff submitted an internal report criticizing the “abuse” of free medical care in the dispensary and outpatient clinics.⁸¹ A major re-organization of hospital beds undertaken by the medical superintendent, Dr. Collins, in September 1918 suggested closing 42 public beds, and opening a further 31 private and semi-private beds, perhaps to increase the hospital’s revenues.

These attitudes and policies generated some tension with the poor who turned to the General for medical treatment. Labour city councilors often advocated for patients who were in conflict with the medical staff at the facility. In August 1918, A.A. Heaps presented two patient complaints to the WGH.⁸² The details of the first case are unclear, but the second remained outstanding in October, when Heaps appeared again before the General Hospital’s House Committee. The complaint came from the husband of a mentally ill woman. He had arranged to have his wife seen by a doctor at the General, and had brought her to Winnipeg from the Selkirk Mental Hospital for this consultation. When they arrived, the husband testified, the doctor was not available at the hospital. The husband was angry about this, and complained to the hospital and to Heaps. When asked about the situation by the medical superintendent, the doctor simply replied that nothing

development appeared to contradict the hospital’s promise of undifferentiated, scientifically-mediated, medical efficiency and efficacy for all, and its reputation as a human and caring institution.”

⁸¹ PAM, MG10 B11, Box 18, Winnipeg General Hospital, House Committee Minutes, May 22, 1918.

⁸² PAM, MG 10 B11, Box 18, Winnipeg General Hospital, House Committee Minutes, August 14, 1918.

could be done for the woman, and that therefore he had refused to see her. His explanation was supported by the medical superintendent of the General, who had contacted the Selkirk Mental Hospital superintendent to verify that the women's case was hopeless. The doctor was not criticized for his failure to meet his commitment to her husband.⁸³

On April 1, 1919, Alderman Robinson (who was also Secretary of the Trades and Labor Council) presented to City Council a complaint from Joseph Fly, a worker at the CPR, on behalf of his co-worker Dirks Vanderlick. Mr. Vanderlick had been seriously injured on the job, and been taken to the emergency room at the General for treatment. Fly claimed that there was considerable delay in receiving treatment while the hospital staff questioned Vanderlick to ascertain his ability to pay. This delay concerned Fly a great deal, as he believed his colleague was going to bleed to death. In a written response to Robinson the following morning, hospital superintendent Herbert Collins denied that there was ever any danger to Vanderlick's life, and indicated that the house surgeons considered his condition to be good.⁸⁴ There was a notable lack of process for resolving these patient concerns. The House Committee invariably defended the conduct of the General's physicians, and this was the end of the matter in most cases.

During the influenza epidemic, the quality of care at the General Hospital was problematic. As was noted in the previous chapter, the south wards at the General were not ideal for delivering quality care. There was a shortage of trained personnel. In the

⁸³ PAM, MG 10 B11, Box 18, Winnipeg General Hospital, House Committee Minutes, October 9, 1918.

⁸⁴ CWA, Council Correspondence, 1919, 11802.

third week of November, Dr. Collins reported that the female patients in the influenza wards were receiving virtually no medical attention from the Visiting Staff. There is no record in the minutes of any formal patient complaints having been laid, so the source of this criticism is unclear. Collins's report may have been a result of his own observations, patients may have verbally complained (family were not allowed to visit flu victims, so no complaints were likely from that quarter), or perhaps the nursing staff had expressed concern. Whatever the root of the issue, little was done to deal with it at the time, and the matter remained unresolved until December 11, well past the peak of the epidemic. While the members of the House Committee defended their colleagues, arguing that they were extremely busy in their own practices, Dr. Collins was nevertheless asked to interview the Chief of the medical staff, Dr. Montgomery. A week later, Collins reported that the issue had been satisfactorily resolved, with a temporary associate physician, A.J. Burrige, made responsible for the women in S.II ward. Conditions at other facilities could hardly have been better. Miss Elsie Robertson, the nurse placed in charge of the Logan Annex, recalled that she "encountered great difficulties in procuring medical men and nurses."⁸⁵ These were not ideal patient care conditions.

In the midst of the controversy over the care of female ward patients at WGH, three of fourteen intern members of the resident staff resigned. One of their colleagues, Fred Orok, had recently died after being infected with influenza. Two more interns resigned later that month. The reasons for their resignations are unclear. According to Collins, the interns wanted "to put in more time at their studies which were behind on account of the

⁸⁵ Mary Shepherd, p. 33.

flu ban.” Perhaps more at issue was the ‘outside’ work interns were required to do; services to the Ninette tuberculosis sanatorium and the City Hospitals were specifically mentioned. Yet the interns were clearly taking advantage of the high demand for their services at the time to negotiate better working and studying conditions. The hospital gave Collins the authority to stop compelling interns to do outside work in early January 1919. Around this time, the facility also had to deal with the resignation of Dr. Ross, an anaesthetist, who left in frustration over the hospital’s refusal to purchase a nitrous oxide dispenser. This must have been Dr. Edith Ross, granddaughter of Dr. Charlotte Whitehead Ross, Manitoba’s pioneering rural woman doctor. The House Committee was sufficiently moved by her resignation to agree to the purchase, but noted that it would carefully monitor its use for public ward patients. Presumably the best available technology for dispensing anaesthesia was considered unnecessary to the care of the poor.⁸⁶

Organizational tensions were not limited to the professional staff. A letter was received from a notary public on behalf of the family of Walter Saddler, who had worked briefly as an orderly on the influenza wards. Mr. Saddler had contracted the flu and died. His relatives, unable to meet the expense of burying him, requested that the hospital contribute to the cost. The House Committee “did not feel the hospital would be justified in paying these expenses, the man being employed for the specific purpose of caring for flu patients, and knew the risk he was taking when he took on the work.”⁸⁷ The hospital

⁸⁶ PAM, MG10, B11, Box 18, Winnipeg General Hospital, House Committee Minutes, November 7, 1918.

⁸⁷ PAM, MG10, B11, Box 18, Winnipeg General Hospital, House Committee Minutes, December 18, 1918.

was unwilling to acknowledge any workplace hazard in the work Mr. Saddler had performed. No mention is made of any condolences coming from the hospital to the bereaved family. His death while caring for flu victims would not have been noted at all had the family not demanded some compensation. By contrast, the parents of Fred Orok and nurse Florence Smith were sent letters of sympathy, and this was noted in institutional records.⁸⁸

Another recorded dispute with an employee came in early January 1919, with the resignation of Mr. Saunders, an office clerk. Mr. Saunders had resigned, his dignity and sense of fairness offended, after he was disciplined for being away from work “for two days without permission” in late December. Although the hospital learned that he was at home nursing his sick wife, he was deducted two days’ pay. “To this he had taken great exception,” the House Committee was told. After “free discussion” it was agreed that the action had been “rather drastic” and that Mr. Saunders should receive his pay. The House Committee believed that he would subsequently withdraw his resignation. Mr. Saunders, however, did resign.⁸⁹

With poor staff relations and questionable quality of care for working class patients before and during the epidemic, empty influenza beds should come as no surprise. Although health officials stressed that the hospital, not the home, was the best place for flu victims, they did have some insight into why hospital beds were not being utilized:

⁸⁸ PAM, MG10, B11, Box 18, Winnipeg General Hospital, House Committee Minutes, November 27, 1918.

⁸⁹ PAM, MG10, B11, Box 18, Winnipeg General Hospital, House Committee Minutes, January 2, 1919; January 8, 1919.

"Perhaps citizens do not know how to get a patient to the hospital. There is no red tape at all. ... Extra beds have been prepared at considerable expense and volunteer workers are installed ... to meet the need," officials stated.⁹⁰ "Red tape" was a euphemism for the invasive questionnaires regarding income and family status to which public ward patients were normally subjected at the Winnipeg General. Working class patients were expected to pay if, in the opinion of hospital staff, they could afford it. The desire to avoid degrading bureaucratic questioning was likely to have discouraged many from seeking out hospital care, particularly in situations where the illness was believed to be mild and manageable. Dr. Alexander, of the King George, reported being distressed by the condition of patients who had delayed seeking medical attention: "A very large number of cases were brought to hospital at later stage of disease with history of acute symptoms for 5 to 10 days before admission. Many of these cases were moribund on admission, dying in periods varying from 5 minutes to 8 hours."⁹¹

To what degree normal hospital procedures were waived during the epidemic is unclear. The claim that there was no "red tape" suggests that flu patients may have been admitted to hospital without questions and without charge. WGH records indicate that the cost of providing care for poor patients in that facility was covered by the city, and that the usual investigations of patients' ability to pay were waived. The poor, however, had no way of knowing that care would be provided without cost, and may have feared

⁹⁰ WT, November 16, 1918, Society Section, p. 3.

⁹¹ CWA, City Correspondence 12020, Report from Dr. Alexander to the Hospital Commission, December 10, 1919.

receiving hefty medical bills. Health officials avoided clearly stating that patients would be provided with free treatment—if the policy amounted to that, it was never openly acknowledged. If there was confusion and if financial constraints kept the sick away from hospitals, the authorities had only themselves to blame.

The implications of the lack of accessible medical care were severe for working families. However great the threats to order and the push to reform health and welfare in the period, the availability of health care to the poor declined in Winnipeg after the epidemic, at least in the short term. The following year, the outdoor clinic saw few poor patients because medical staff could not be found to provide services. The clinic was essentially not functioning. While the hospital was clearly concerned about this, little was done. There does not appear to have been a solid mechanism in place at public hospitals for ensuring consistency of care to patients who could not pay: this despite the fact that the municipal government had considerable representation on the boards of public hospitals.⁹² As we will see in the following chapter, some working class mothers questioned whether public patients were in fact treated equally, and made difficult sacrifices in order to be able to pay for physician services. The commodification of medical care is depressingly clear. These dynamics are further illustrated in the physicians' strike which took place in 1933 when doctors refused to provide health care

⁹² At the WGH, City Council was represented on the 30 person Board of Trustees by 8 city councilors, and the provincial government by the Minister of Agriculture. See PAM, MG10B11, Box 2, Winnipeg General Hospital Annual Report, 1918.

to those on relief unless they were paid by the government to perform the service, and bargained to ensure payment according to fee-for-service, not salary.⁹³

Labour made no open criticisms of quarantine and isolation measures during the influenza epidemic. On a related issue, however—the cost of burying the dead—labour was vocal, and successful in having its concerns heard by City Council. Members of the TLC raised “the matter of exorbitant funeral charges” at a meeting in December:

Funeral expenses were detailed in several cases – one from Oak Point being charged \$900. The usual city charges were from \$135 to \$165 and up. Where the people were poor the charges were painfully excessive. It was also reported that pauper burials cost the city only \$15. The spread between this and the cheapest private funeral was far too great.⁹⁴

The matter was referred to the TLC executive. The Women’s Labour League also discussed the cost of funerals, and criticized the burden this placed upon widows. In one case a bereaved widow was left with a \$570 undertakers’ bill.⁹⁵

These concerns resurfaced in the new year in the work of the Social Welfare Commission (SWC), which reported directly, on a monthly basis, to City Council. According to the SWC’s February report, the Winnipeg Mothers’ Allowance committee had drawn attention to the high cost of funerals, and requested the Secretary of the SWC to investigate. The connection between labour, the SWC, and the local Mothers’ Allowance committee was via two key individuals: Alderman Simpson, a printer and

⁹³ Ian Carr and Robert Beamish, *Manitoba Medicine* (Winnipeg: University of Manitoba Press, 1999), p. 120.

⁹⁴ *Western Labor News*, December 20, 1918.

⁹⁵ MFP, December 4, 1918, p. 8.

member of Council for Ward 6, also chair in 1919 of the SWC, and member of the Mothers' Allowance committee; and Helen Armstrong, the Women's Labour League representative on the Mothers' Allowance Winnipeg committee, appointed in January 1919.⁹⁶

In its report, the SWC noted that there had been "considerable publicity given to the action of the Commission," despite the fact that Clarke, the SWC's secretary, had requested that news of the Commission's investigation remain out of the papers. The coverage "aroused a good deal of resentment in some quarters," the SWC noted. "The undertakers felt that they had been condemned of overcharging without any basis of fact."⁹⁷ The SWC's investigation did, however, reveal a certain degree of predatory pricing on the part of local undertakers, though the report attempted to downplay this. It revealed some pertinent facts about the price structure of the funeral industry during the epidemic, and documented funeral and burial practices in the community.

Hypothetically, a relatively inexpensive funeral and burial were possible, although when one considers the costs relative to workers' wages, even the cheapest funeral could cost the equivalent of several months' rent or food for a family. Plain wooden coffins could be had for \$25 to \$30, but more elaborate caskets ranged in price from \$40 to \$125 and upward. Cemetery charges then had to be paid; these varied according to cemetery from \$17 for an adult at Brookside Cemetery, where many of the working class were buried, to \$32 at Elmwood Cemetery. There was a military plot at Brookside, so veterans

⁹⁶ Armstrong was likely appointed as a result of the increased strength of labour on city council after the November 1918 election. CWA, City Council Minutes, January 7, 1919; January 20, 1919.

⁹⁷ CWA, Council Correspondence 11788, Social Welfare Commission Report, February 1919.

and their dependents could be buried without charge, except for a grave digging fee. Brookside also had a special section devoted to infants, both still births and those characterized as “premature.” Babies who died before three months of age were buried there. In 1918, there were 1239 burials at Brookside, and one-quarter of them were in this special infants’ section.

Additional charges abounded. Cemeteries charged extra for a death during winter. If the ground was too frozen for the grave to be dug, the body had to be stored in a vault until spring. (Many influenza victims must not have been interred until spring 1919.) Embalming (described as a “luxury” in the SWC report) cost \$25. Washing, shaving and dressing the body were extra. Fifty percent of funeral accounts showed expenses for burial clothes, a reflection of how important was observance of the proper burial rituals, as well as, perhaps, the lack of good clothing among workers. A significant and unavoidable expense was transporting the body. A hearse to the funeral service cost \$10 to \$15; an additional \$6 per car was charged for mourners. The cars only held four people, so often two were needed. Some families paid for black gloves to be worn by the pallbearers, at a cost of \$1.50 - \$3.00. Finally, there were the death notices to go in the papers. Seventy-five percent of families paid to have one, and they cost from \$1 to \$5.

Thus, it is not difficult to imagine why, as the report concluded, funerals during the epidemic cost at least \$100. “Nearly every individual stated their inability to secure cheaper service,” the Commissioners noted, before assuring the Mothers’ Allowance committee members and City Council that the conditions of the epidemic were “abnormal.” Certainly, they were. Undertakers made most of their profit on caskets, they

concluded, but this conclusion ignored all the 'frills' that led to mounting costs. While the SWC was quick to argue that undertakers had done nothing to influence their customers' choice of caskets, or other decisions, choice hardly seems to have entered into the matter. There was also price gouging by the suppliers of caskets. The report noted that the local factory was behind 1200 orders during the epidemic, and that "undertakers were forced to take coffins and caskets at prices which cut their profits ..."

The city, through the SWC, provided relief for those who could not pay; at least 120 families received free graves and burials. Many poor families, however, resisted turning to municipal aid. The Salvation Army helped one family "who were loath to have their daughter buried at the city's expense."⁹⁸ Every one of the family's seven members became ill with the flu, and were cared for by the fourteen year old son. The family was poor, the father "crippled with rheumatism," and the mother working. The eldest daughter, who cared for the family while her mother worked, died of influenza. With the aid of a Salvation Army truck, the family was able to convey her body to be buried in a family plot about fifteen miles outside of the city.

There were good reasons why those with an alternative would have avoided the 'pauper's burial,' and that explain the generosity of unions, mutual aid groups, and churches in contributing to funeral costs. As opposed to a service at the funeral chapel, a hearse, and mourning cars, the poor flu victim was summarily disposed of, with little ritual observed:

⁹⁸ WT, November 28, 1918, p. 6.

The body is placed in a plain box and taken direct from the house to the cemetery in the "body car." Services are held by arrangement at the vault in the winter, and at the grave side in spring and summer. The permits for graves are issued by the Commission after investigation.⁹⁹

Under normal circumstances, the poor could not bury their dead before the SWC determined whether they legitimately required municipal aid. During the peak of the epidemic, however, investigations were set aside, probably to facilitate the prompt burial (or cold storage) of diseased bodies. The poor suffered the denial of accustomed rituals, but worse fears were realized in March 1919, when it was discovered that four bodies of influenza victims had been "lost." One woman and three infants, whose undertakers' bills were paid by the SWC, were not actually buried, according to records at Brookside Cemetery.¹⁰⁰ No one would admit to any knowledge of what had happened to these bodies. The controversy hints at older terrors among the poor that their bodies would end up dissected,¹⁰¹ not buried, and that underpinned social conflict over the right to bodily integrity after death.¹⁰²

The inquiry into funeral costs seems not to have yielded any particular results, although the conduct of the funeral business was held up to public scrutiny. This was a period of some strength for labour representation on city council. It is most interesting, in fact, that the municipal election held in December saw labour well organized and able to

⁹⁹ CWA, Council Correspondence 11674, Social Welfare Commission Report, November 1918.

¹⁰⁰ WT, March 8, 1919.

¹⁰¹ In Manitoba, unclaimed bodies were used by the hospitals for teaching and research purposes.

¹⁰² For the Burke and Hare body-snatching scandal, the British 1832 Anatomy Act, and popular opposition to dissection, see Ruth Richardson, *Death, Dissection and the Destitute* (London: Routledge, 1987).

increase its impact at city hall. Early in November, the Dominion Labor Party was mobilizing election workers, and urging that the public meeting ban not prevent the necessary political work in preparation for the November 29th vote. "The flu ban makes it impossible to hold meetings, and as a consequence the flu ban will put us up the flue unless we throw off the mask and get down to business," the *Western Labor News* noted, partly tongue in cheek.¹⁰³ Election issues were the main topic of news in the labour press in November and December.

In a heavy voter turnout, labour candidates had a good showing in the November 29 civic election. Two new labour aldermen were elected, giving labour a significant voice on council.¹⁰⁴ Ernest Robinson, secretary of the TLC, won unexpectedly in Ward 4, and W.B. Simpson, printer, was elected in Ward 6. A.A. Heaps was re-elected by acclamation in Ward 5, and W.L. Wiginton returned in Ward 7. Labour was pleased with the results:

The result of the election in Ward 4 is a clear indication that the workers of the city of Winnipeg are not prepared to dance to the tune that the board of trade calls. Too long they have been dominated by the financial interests. Today they are awakening to a realization of their power, and have given unmistakable evidence that they are going to have a say in the civic government ... Today workers say, 'Working class candidates and working class policy is the only thing for us.'¹⁰⁵

¹⁰³ *Western Labor News*, November 8, 1918, p. 1.

¹⁰⁴ Labour now controlled seven votes of fourteen on Council. No analysis has been done on the results of this election and the record of labour councilors in the year 1918-1919. For municipal politics in Winnipeg after the General Strike see J.E. Rea, "The Politics of Class: Winnipeg City Council, 1919-1945," in Carl Berger and Ramsay Cook, eds., *The West and the Nation: Essays in Honour of W.L. Morton* (Toronto: McClelland and Stewart, 1976); Paul Phillips, "'Power Politics': Municipal Affairs and Seymour James Farmer, 1909-1924," in A.R. McCormack and Ian MacPherson, eds., *Cities in the West* (Ottawa: National Museums of Canada, 1975).

¹⁰⁵ MFP, November 30, 1918, p. 10.

Reflecting their continuing dissatisfaction with medical care in the north end, voters in Ward 5 failed to return the necessary three-fifths majority in support of a new hospital bylaw to raise \$400,000 for expansion to existing city hospitals.¹⁰⁶ The bylaw did receive the overall necessary support elsewhere. This election also saw the defeat of the property qualification for aldermen, a reform for which labour had long fought.

The incumbent mayor, F.H. Davidson, was defeated by controller Charles Gray by a large majority. The *Winnipeg Tribune* attributed Davidson's loss to the strength of labour, and to his lack of leadership during the epidemic.¹⁰⁷ The two were not isolated factors. The TLC and labour members of city council had been vocally opposed to the lay-off of 300 to 400 theatre, bowling alley and billiard parlour employees as a result of the ban on public gatherings. The TLC executive promised to take action to address the needs of the men out of work. "Men cannot be allowed to starve in a time of epidemic," it was argued in the *Western Labor News*.¹⁰⁸ Theatre owners initially supported the theatre closure. The reasons for this were clearly articulated in the press:

... the film industry would prefer an imperative order closing all the houses rather than any half-way measure. The picture houses are taxed four different ways: they are under heavy expense to the exchanges, have highly paid employees, particularly in the operating room and in the orchestra, and if the theatres remain open and are poorly attended, as was the case last evening, it meant a loss so severe that none of them dared to contemplate it.¹⁰⁹

¹⁰⁶ WT, November 30, 1918, p. 2.

¹⁰⁷ Ibid., p. 4.

¹⁰⁸ *Western Labor News*, November 1, 1918, p. 1.

¹⁰⁹ MFP, October 11, p. 3.

For theatre owners, staying open might be worse than being forced to close, since workers' wages would still have to be paid if the theatres were operating. However, the state, not the employer, became the target of labour's anger. Its position was that men put out of work by state decisions had a right to support. Alongside the controversy over funeral costs, the demand for compensation was another indication of workers' belief in the state's obligation to protect the health and financial security of workers' families. Further evidence of this perspective can be seen in labour's commitment to secure state support for influenza widows.¹¹⁰

The public meeting ban had been declared under the authority of the provincial government's *Public Health Act*. After hearing the complaints of labour representatives the Provincial Secretary, Dr. J.S. Armstrong, evaded any responsibility, as the *Free Press* reported:

Some hardships much be encountered in carrying out any such provision. The board of health had no authority regarding the matter of wages, this being entirely within the province of the employers and employees. At such a time the whole community had to suffer a certain measure of inconvenience.¹¹¹

Despite the provincial government's flippant response, the right to a family wage was the center of the TLC's appeal on October 16 to the city's Board of Control for the reimbursement of theatre employees' lost wages. The workers' case was presented by T.J. Murray, the Dominion Labour Party solicitor. He argued that employees could not

¹¹⁰ This is discussed in greater detail in the following chapter.

¹¹¹ MFP, October 12, p. 4.

find work by leaving the city, because theatres were also closed in other nearby cities, such as Minneapolis. Five days later, a deputation of proprietors appeared before the Board in support of the employees.¹¹² As a result, the Board agreed to appoint a committee to take up the issue with the provincial government. The Mayor and Board of Control were careful to “repudiate any legal liability.” Frank Kerr, the relief commissioner, was asked to help the men find temporary work, and it was suggested that families could be provided with cheap firewood.¹¹³

But working families resented the refusal of the city to offer any solution apart from relief. On October 26, the Board of Control received a letter from Mrs. Lamoreaux, the wife of a theatre employee, outlining her family’s struggle to make ends meet as a result of the ban on theatres.

As my husband was operated on three months ago at St. Boniface Hospital I must tell you that we are in need, we were just getting on with little money, when the theatre closed. Really I don’t know how I am going to meet my rent, and buy wood. He can’t work hard after the operation he had, and he is looking for work since, without any luck. Are we going to be long without work. If I was alone, it will be alright, but with my two littles [sic] boy, I am really discouraged. The first of the month is coming due and no money to pay rent. What are we going to do, can you do something, for the sake of my little children. You know the high cost of living.¹¹⁴

Rather than reply directly to her, the Board referred Mrs. Lamoreaux’s letter to Frank Kerr. The relief commission apparently arranged some work for Mr. Lamoreaux, which

¹¹² CWA, Board of Control Minutes, October 16, October 21, 1918.

¹¹³ WT, October 16, 1918, p. 1.

¹¹⁴ CWA, Board of Control Correspondence 014403, October 26, 1918.

he refused, perhaps resisting the inference that he could not provide for his family, or perhaps because the work was unsuitable for a man in frail health. Mrs. Lamoreaux was entirely dissatisfied with the city's response to her plea, and wrote another anguished and angry letter on November 6.

I am surprised to see that there is no answer to my letter, as I can't believe that there will be nothing at all, the City Hall must help out the family who is in need. If the theatres is closed longer what are we going to do? If you don't believe what I write, send somebody over. I must get fuel, its take big money to buy fuel, and nobody's will advance you, on account the theatres closed up. Won't you really help out for my little ones. I am worrying so much. Eaton's employes [sic] my husband for three days a week, that will give us money to buy things to eat, but I can't buy fuel, send me some wood or coal over, you will surely help a mother in need. I hope this letter won't be without any answer.¹¹⁵

The Board of Control did respond to her second letter, chastising her and her husband for his failure to show up for relief work, and denying their family any further assistance. "The stand taken by the Relief Department is that in cases where the family is able to work and work can be had, the City is not justified in giving material relief," the Board lectured.¹¹⁶

Adding to the pressure upon the Board was a December 7 letter from the Provincial Exhibitors Association in support of the Winnipeg Musicians' Association (a union affiliated to the TLC). It forwarded to the Board documentation of the financial impact of the ban upon over eighty Winnipeg musicians, the majority of whom were married. These men alone had lost over \$15,000 in wages.¹¹⁷

¹¹⁵ Ibid., November 6, 1918.

¹¹⁶ Ibid., November 8, 1918.

¹¹⁷ CWA, Board of Control Correspondence 014426, December 7, 1918.

The Mayor and his controllers, at this point not having to answer to full council meetings, did not meet the workers' demands for "compensation for loss of time."¹¹⁸ They furthermore refused to recognize the unfairness and humiliation workers perceived in their predicament. The Board of Control committee, which met only twice, declined to appeal to the provincial government on the workers' behalf. Since employees had already made their case directly to the Province, the Board argued that it "could not add anything further to the representation of the case" and such a meeting was therefore unnecessary.¹¹⁹ The Board referred the issue of compensation to the City Solicitor for a legal opinion, and he reassured them that "the City has no authority to grant any such compensation."¹²⁰

T.J. Murray had committed to raise the issue again after the meeting ban was lifted. In December, he and newly elected alderman Ernest Robinson led a delegation to meet with Premier Norris and Edward Brown. Rather than demands for the family wage and financial need, however, the delegation this time focused its argument around concepts of 'British' justice and the public good, common to the discourse of Winnipeg's labour movement in the period leading up to the General Strike:¹²¹

¹¹⁸ WT, October 16, 1918, p. 1.

¹¹⁹ CWA, Board of Control Correspondence 014426, November 13, 1918.

¹²⁰ Ibid., December 13, 1918.

¹²¹ For a discussion of demands for British law and justice in Winnipeg's labour movement in this period see Chad Reimer, "War, Nationhood and Working-Class Entitlement: The Counterhegemonic Challenge of the 1919 Winnipeg General Strike," *Prairie Forum* 18, 2 (1993), p. 228-233

... owing to the imposition of the ban on theatres, the men represented lost an aggregate of \$23,000 in wages. It was urged by spokesmen that this loss was incurred in behalf of the public generally, and that injustice would be done if working men were compelled to suffer for the public good, without at least a portion of the cost being met by the people generally.¹²²

A similar appeal was made to city council on December 11. At the same time, the industry was petitioning for compensation for financial losses.¹²³ Neither group was successful.

In the months and weeks leading up to the General Strike, then, flu altered the context within which labour radicalism flourished. Two further examples bear directly upon labour's increasing determination to confront capital. First, the coincidence of orders-in-council limiting the civil liberties of immigrant and radical organizations and media with the ban on public gatherings, which lasted an extraordinary six weeks in 1918. Second, the tactics labour employed to achieve a vote in favour of a general strike in sympathy with striking freighthandlers in October 1918, just as the epidemic was breaking in Winnipeg.

September and October 1918 witnessed a wave of state crackdowns against immigrant and radical organizations and media.¹²⁴ On September 25th, the federal government through Order-in-Council PC 2381 banned all "publications" in an "enemy

¹²² WT, December 13, 1918, p. 2.

¹²³ CWA, City Council Minutes, December 9, 1918.

¹²⁴ See Gregory Kealey, "State Repression of Labour and the Left In Canada, 1914-1920," *Canadian Historical Review* 73, 3 (1992); Peter Melnycky, "The Internment of Ukrainians in Canada," in Francis Swyrypa and John Herd Thompson, eds., *Loyalties in Conflict: Ukrainians in Canada during the Great War* (Edmonton, Canadian Institute of Ukrainian Studies, 1983).

language.” In addition to Ukrainian papers (which were considered Austrian and therefore “enemy”), the order-in-council banned Russian and Finnish publications. As Gregory Kealey has noted, “the debate that followed PC 2381 and its subsequent amendments made painfully clear that the intended target was socialism and had little to do with the war.”¹²⁵ Punishments could be severe: fines of up to \$5000 and five years in prison. The “enemy” language press was eventually allowed to publish with English translations appearing in the papers. PC 2384, a second order-in-council, “effectively banned freedom of association, assembly, and speech for a select group of Canadians, most of whom were foreign immigrants.”¹²⁶ Among the banned were the Finnish Socialist Party of Canada and the Social Democratic Party. The Socialist Party was spared. The scope of this legislation extended beyond the banned organizations themselves, into the lives of their members, who were forbidden from speaking, writing, publishing, or possessing the literature of banned organizations, and even from wearing a badge or insignia indicating membership. Within such a repressive context, Linda Kealey has argued, freedom of speech and association became central demands in working class and immigrant struggles.¹²⁷ The orders-in-council, rather than isolating ‘foreign’ radicals, appear to have contributed to cross-ethnic solidarity among labour and socialist activists.

¹²⁵ Gregory Kealey, “State Repression of Labour and the Left In Canada, 1914-1920,” p. 294.

¹²⁶ Ibid.

¹²⁷ Linda Kealey, *Enlisting Women For the Cause: Women, Labour and the Left in Canada, 1890-1920* (Toronto: University of Toronto Press, 1998), p. 221-223.

These federal orders-in-council were introduced just as influenza was arriving upon Canadian shores. A few weeks later, the ban on public meetings in Winnipeg imposed further restrictions on a mobilized and threatening workers' movement. Of course, the ban was not restricted to radical organizations: everyone was expected to curtail their public activities, including churches. But the ban did not close other obvious locations of potential infection, including workplaces, stores, restaurants, and hotels. The ban had the advantage of putting a stop to meetings among workers, and applied not only to immigrants but also to the Anglo-Canadian leaders of Winnipeg's labour and socialist movement. Whether or not the government intended to further restrict working class organizations via its actions to curb the flu, few among the city's elites could have been sorry to see another barrier placed in their way. And, given the context, it also seems likely that few working class and immigrant leaders took at face value the claim that the ban on public gatherings were strictly a public health measure. Groups such as the TLC did not publicly oppose the meeting ban, although A.A. Heaps, labour alderman, was arguing for the ban to be lifted in mid-November, after one month. His opposition may have been solidified by the spectacle of Armistice celebrations, which glorified the war effort, but did little to contain disease. William Ivens, editor of the *Western Labor News* and leader of the Labour Church, from the outset opposed church closures, unlike the mainstream churches.¹²⁸

Labour's response was remorselessly disciplined. Not only labour leaders, but workers themselves were careful to avoid provocative defiance of the meeting ban, which

¹²⁸ WT, October 12, 1918, p. 9.

might have invited fines, arrests, and further state repression. The TLC executive continued to meet, but regional council meetings were cancelled. Early on some union members did ignore the ban. According to the *Free Press*, on October 14 striking freight handlers gathered in the corridors of the Labour Temple, after discovering the meeting rooms were locked. The paper strongly criticized this alleged infraction of the law, but apparently no arrests were made.¹²⁹ After this, labour's strategy was to respectfully observe the letter of the law, and if possible to find loopholes. On October 17, the strikers held an open-air meeting just outside the city limits.¹³⁰

A couple of days later, the TLC was preparing to hold a general strike vote in support of the freighthandlers who were on strike across the prairies. Two hundred men were out in Winnipeg.¹³¹ Five leaders of their union had been arrested in Calgary, charged with violating the Borden government's prohibition on strikes and lockouts. Unrest throughout the prairie region was high, as a general strike seemed likely in Calgary, and CPR workers in Saskatchewan struck in solidarity.¹³² It was decided to conduct the vote by ballot distribution, rather than at large meetings, to avoid transgressing the influenza regulation prohibiting public gatherings. The vote took place over five days, and ballots were counted on Wednesday, October 23. The results of the vote were announced the

¹²⁹ MFP, October 15, 1918, p. 5.

¹³⁰ WT, October 18, 1918., p. 7.

¹³¹ MFP, October 4, 1918, p. 10.

¹³² Tom Mitchell and James Naylor, "The Prairies: In the Eye of the Storm," p. 181-182.

following day: 92 percent in favour of a general strike.¹³³ On October 25, the Calgary prosecutions were withdrawn, and the general strike was called off.

The October strike vote and the November election, when juxtaposed with the consistent images of devastation and helplessness appearing in the mainstream daily papers, give two quite different pictures of the impact of the epidemic upon working people. The capacity of the workers' movement to mobilize throughout the epidemic does not suggest a community incapacitated by disease. Neither does the General Strike itself, which came immediately on the heels of a less intense but significant spring wave of influenza. Rather, it appears that the epidemic had an important role in galvanizing labour's determination to push its agenda of entitlement and social justice, and in increasing workers' militancy and confidence in their potential for success. Labour's key demands during the epidemic were: that "men" should be treated justly by the state, not allowed to starve without wages; that the state had an obligation to prevent business from profiting from workers' misfortune; and, that families were entitled to protection by the state from destitution when their breadwinners were ill or dead. These were consistent with broader demands driving organization at the workplace and in politics, and with the demands for a "living wage" and legal recognition of the right to organize central to the General Strike.

A belief that social relations were central to the disease experience continued to inform workers' activism, based as it was upon the assumption that the epidemic affected workers and their families differently from how it affected those with greater means. As

¹³³ Western Labor News, October 25, 1918.

we shall see in the following chapter, the scale of the influenza epidemic, if it did nothing else, drove thousands of working families together to this common point of understanding. The implications of their efforts at community solidarity during the epidemic were firmly felt in May 1919.

Chapter Five – Working Class Neighbourhoods and the Collective Struggle for Survival

Evan Stark, in his 1977 article “The Epidemic as Social Event, ” argues that the coincidence of epidemics and revolt in the nineteenth century was a reflection of a failure in social and political authority, and arose out of workers’ awareness of the social nature of disease. “Victims of epidemics now cried of injustice, not simply from pain,” he states.¹ Stark contends that epidemics heighten class consciousness, sharpening workers’ perception of social power and hierarchy. While the suffering of the people is traumatic, this trauma itself serves to challenge the seeming naturalness of the social order. Workers’ relations with one another are also strengthened. Out of the disruption of daily routines of work and exploitation, caused by the illness and death of thousands of workers, emerges a carnivalesque, saturnalian world where the suffering of people becomes as well an opportunity, a theatre or stage for

... collective self-recognition and for the reconstruction of collective identities ... where the sacredness of the body and the state, ‘the body politic’, is thrown to the wind ... [epidemics are] instruments with which masses attempt to transform their objectification, their victimization, into ‘biological reasons,’ the assertion and redistribution of meaning according to need.

... This almost Brechtian theatre of crisis quickly fills the apparent vacuum created by the dissolution of traditional authority and work relations. The suppressed world of the bohemian, the ‘quack’ cures of traditional healers and gypsies, the fraternity of gangs, the language of passion, dreams, conspiracy, and crime – all surface as the cash nexus gives way. And definitions of health and safety shift as well. Heretofore defined as individual survival in an anarchic market, now health appears to depend wholly on the mutual support of the individual and his immediate community.²

¹ Evan Stark, “The Epidemic as Social Event,” *International Journal of Health Services* 7, 4 (1977), p. 687.

² *Ibid.*, p. 692.

Stark draws our attention to the social and political significance of mutual interdependence in the epidemic context. It is not only that people reach out to one another out of necessity, in order to survive. It is that acts of mutual reliance build bonds, release a “suppressed world” of workers’ culture, and suggest new forms of social relations. Stark is describing the re-emergence during an epidemic of pre-capitalist social organization. He suggests glimpses of an alternative to the existing order. The epidemic is, then, the world turned upside down, and upside down, the possibility of living differently emerges. Thus, “when work ceases during a riot, mass strike, or epidemic, bourgeois history dissolves. But without capital, labour reaches out to become itself, beyond bourgeois history, toward ‘society.’”³ Thus, it is not only expressions of overt resistance to state policies that can tell us something about the relationship between epidemics and social unrest. Clues to this link lay also in the experiences and responses of working and immigrant families as they addressed the epidemic.

To argue that the influenza epidemic held significant emancipatory potential appears at first glance to be a distortion. It is, in fact, difficult to find sources that portray working families as anything other than passive victims of a ravaging disease. Reports in the mainstream press certainly presented this picture. Accounts of the progress of the disease in the north end, above all, tended toward the lurid. Stories of horrific events in the households of poor families were not necessarily untrue (although some were, as we have

³ Ibid.

seen), but they may not have been representative. It may at first escape our attention that, although the mainstream press almost never made any mention of working people organizing their own relief measures, or even assisting one another, these efforts did in fact occur. The dominant Anglo-Canadian community publicized its own role in organizing voluntary medical and support services, but never acknowledged those of other ethnic or workers' groups in the city.

This oversight was consistent with prevailing attitudes that emphasized the ignorance and unhealthy living habits of working class and immigrant families, and blamed mothers, in particular, for the ill health of their families.⁴ Although some public health commentators recognized that income and social factors had a role to play in health, most still argued that even the poor could enjoy good health if only they were better educated on health matters, and improved their level of hygiene and healthy living.⁵ Public health reformers and medical professionals did not perceive poor and immigrant communities as capable of taking the initiative in maintaining health. They tended to view their own roles as experts as pivotal to any health improvements, and derided traditional health therapies.⁶ The First World War heightened concern over the health of the population.

⁴ See Cynthia Commachio, *Nations Are Built of Babies: Saving Ontario's Mothers and Children, 1900-1940* (Montreal: McGill-Queens University Press); Katherine Arnup, Andrée Lévesque, and Ruth Roach Pierson, eds. *Delivering Motherhood: Maternal Ideologies and Practices in the 19th and 20th Centuries* (London: Routledge, 1990); Alan Kraut, *Silent Travelers: Germs, Genes, and the "Immigrant Menace"* (New York: Basic Books, 1994).

⁵ See Chapter 1, p. 44.

⁶ See in particular Katherine Arnup, *Education for Motherhood: Advice for Mothers in Twentieth Century Canada* (Toronto: University of Toronto Press, 1994).

The poor physical condition of many young working class recruits, and their susceptibility to diseases such as tuberculosis and venereal disease, reinforced claims that Canada's racial stock was threatened.⁷

The narrative of the epidemic from the perspective of the dominant culture stressed the heroism of middle class Anglo-Canadian women who organized relief efforts to 'save' essentially demoralized and incapacitated working class and immigrant communities, particularly in the north end of the city. The middle class and bourgeoisie associated the moral failings of the poor with a susceptibility to epidemic disease. During Hamburg's 1892 cholera epidemic, for example, immorality was viewed as the cause not only of poor living conditions, dirt, and damp, but also of fear and "psychological disturbance."⁸ Fear was itself believed to be an important predisposing condition among cholera victims, particularly when it led to consumption of alcohol. Furthermore:

[Fear and panic] were portrayed as natural elements in the psychology of poverty, the last and most fatal products of a downward spiral of moral and physical integrity and self-respect that could only end in death ... the middle classes [believed] that 'in our social milieu, if one is only careful, there is nothing to worry about,' while proletarians were suffering heavily because they 'are unfortunately still very foolish, in part are not *able* to be on their guard as our sort are ...'⁹

⁷ McCuaig, Katherine. *The Weariness, the Fever and the Fret: the Campaign Against Tuberculosis in Canada, 1900-1950* (Montreal: McGill-Queen's University Press, 1999), p. 37; Cynthia Comacchio, "Bringing Up Father: Defining a Modern Canadian Fatherhood, 1900-1940," in Lori Chambers and Edgar-André Montigny, eds., *Family Matters: Papers in Post-Confederation Canadian Family History* (Toronto: Canadian Scholars' Press, 1998), p. 292. For the impact of the Boer War in the British context see Anna Davin, "Imperialism and Motherhood," *History Workshop Journal* 5 (Spring 1978), p. 15-17.

⁸ Richard Evans, *Death in Hamburg: Society and Politics in the Cholera Years, 1830-1910* (London: Penguin Books, 1987), p. 235.

⁹ *Ibid.*, p. 247-248; p. 355-56. Italics in the original.

Similar references to the prevalence of fear among the masses appeared in the press during Winnipeg's influenza epidemic.¹⁰

Public health authorities argued that influenza could be avoided, if only people took the proper precautions and avoided panic. Information circulated by the board of health early in the epidemic warned the public not to ignore the early symptoms of the disease: "If you should be attacked by the disease, go to bed at once. Rest and warmth are very important factors in its cure. Take warm drinks, live on fluids and send for your physician. Having done these things promptly, there is usually little danger."¹¹ Of course, the well-off could heed this advice more easily. Little sensitivity was shown to the fact that the material conditions of life for working families in Winnipeg made it difficult to take preventive health measures. As we have seen, living conditions probably deteriorated for many in the later years of the war. Households lost considerable purchasing power relative to wages. Nutritional levels may have suffered as a result of the significant increases in the cost of food. Housing was often overcrowded, of poor quality, and lacking in adequate ventilation.¹² These were ideal conditions for the spread of an extremely infectious disease like influenza.

Among immigrants and workers, the family (especially its female members) was the basic unit of health care provision, and the first line of defense against disease. In the

¹⁰ See, for example, WT editorial, October 30, 1918, p. 4.

¹¹ MFP, October 11, 1918, p. 3.

¹² For a summary of living conditions see Chapter 1.

absence of any proven medical therapy, care and attention, hygiene, hydration, rest, and nourishment were the most important components of recovery from influenza. Because working class households were heavily afflicted, these were difficult to provide within the immediate or extended family. In cases where the wife and/or mother became ill the necessary work of home maintenance—cooking meals, laundry, shopping, household cleaning, and the care of the ill and young children—was interrupted.¹³

There were also basic logistical problems to dealing with disease. Keeping the sick clean, dry, and comfortable could be impossible for working families. The majority of homes in the north end had no baths.¹⁴ Very likely, people had few clothes, and may have been unable to frequently change soiled items; spare linens were probably few or non-existent. Doing extra laundry was an enormous task in poor homes that lacked hot running water. And so the sick, who were probably perspiring very heavily and perhaps vomiting, may have been lying in very unclean and damp beds. Linens were among the donations called for during the epidemic, as middle class volunteers came to realize that poor families had few extra resources on hand. In an epidemic disease context, even more

¹³ For a summary of women's labour in home maintenance see Veronica Strong-Boag, *The New Day Recalled: Lives of Girls and Women in English Canada, 1919-1939* (Toronto: Copp Clark Pitman, 1988), p. 113- 144. Mary Kinnear, *A Female Economy: Women's Work in a Prairie Province, 1870-1970* (Montreal: McGill-Queen's University Press, 1999) and Meg Luxton, *More Than a Labour of Love: Three Generations of Women's Work in the Home* (Toronto: Women's Press, 1980) demonstrate the challenges of women's household work in Manitoba in this period, particularly among working class and rural women.

¹⁴ In 1921, fewer than 33 percent of north end homes had baths. City of Winnipeg, "Report on a Housing Survey" (1921), p. 51-83 as cited in Orest Martynowych, *Ukrainians in Canada, The Formative Period, 1891-1924* (Edmonton: Canadian Institute of Ukrainian Studies Press, 1991), p. 142.

than in ordinary life, hygiene was a luxury that the well-off could afford, and for which the poor struggled.¹⁵

Warmth, too, was a luxury. Poor families probably lacked adequate heating fuel for their homes. Influenza struck during the prairie winter, when it was difficult to keep homes warm. Coal prices had escalated during the war, and there were fuel shortages. The ill tried to convalesce in freezing cold houses, apartments, and rented rooms. Renters were forced to sit in their kitchens near the stove in order to stay warm and avoid becoming chilled.¹⁶ Under such conditions, the disease spread rapidly and took a heavy toll.

The availability of food became more of a pressing issue than ever during the epidemic. The loss of wages due to illness, even if this was only short-term, meant no money to purchase food. As working class family historians have noted, wives stretched food budgets as far as they could go by buying only what was absolutely needed, when it was needed, often on credit.¹⁷ Food was bought in small quantities as resources became available, often daily. When disease struck a family, there may not have been food in the

¹⁵ For a discussion of the relevance of social inequality to hygiene and the prevention of cholera, see Evans, p. 409-412. The well-off had domestic servants to boil all water and maintain strict hygiene in their households. The poor lacked running water, had to carry water long distances, and lacked the fuel and person-power to boil all of their water. They were therefore more likely to contract cholera.

¹⁶ WT, October 12, 1918, p. 5.

¹⁷ Bettina Bradbury, *Working Families: Daily Survival in Industrializing Montreal* (Toronto: McClelland and Stewart, 1993), p. 152-181; Peter Baskerville and Eric W. Sager, *Unwilling Idlers: The Urban Unemployed and Their Families in Late Victorian Canada* (Toronto: University of Toronto Press, 1998), p. 149; Ellen Ross, *Love and Toil: Motherhood in Outcast London* (New York: Oxford University Press, 1993), p. 27-55.

house. Shopping could be done by a healthy family member, friend, relative or neighbour, if this support was available, and likewise the preparation of meals. But some were trapped in their homes without food, and this certainly hampered recoveries. The Emergency Diet Kitchen tried to provide food for as many families as possible. Working class families were urged to pay a small amount for this assistance, and those who could were probably happy to do so.

To the difficulties of attaining warmth, cleanliness and nourishment should be added rest. William Beveridge argued in his 1977 study of influenza:

The cardinal rules for dealing with uncomplicated influenza [are] (1) confinement to bed at least during the duration of the fever, and (2) rest during convalescence. If either of these rules is broken the risk of developing complications and prolonging the ill effects of the disease is much increased.¹⁸

But wage earners could not afford to lose wages, and many would have continued to work even after they developed symptoms of influenza, and returned to work before they were truly well. The need for wages to sustain the household was pressing at this time, given the high cost of living. Choosing rest over a wage packet, even if rest alone might ensure recovery from the flu, was a difficult choice to make. Working class women were engaged in work in the home that was generally physically strenuous and exhausting.

Fear of losing income kept many at work, and turned workplaces into sites of disease. Although meeting bans and quarantines were enforced by the authorities, workers still went to their places of employment, where they would come into contact with carriers of the virus, or would infect others themselves. Certain categories of workers appear to have

¹⁸ W.I.B. Beveridge, *Influenza: The Last Great Plague* (New York: Prodist, 1977) p. 14.

been particularly vulnerable to contracting influenza. Those in public service and professional occupations—doctors, nurses, social workers, child welfare workers—were certainly at high risk.¹⁹ But there were others who regularly came into contact with the infected public and who also appear to have been hard hit, including police and firemen. The work of the city health department was hampered by the illness of seventeen of its fifty emergency drivers.²⁰ Railway workers were also heavily stricken. The CPR reported on November 6 that 2270 of its employees on western lines were ill, including trainmen, switchmen, station agents, dispatchers and ‘newsies’.²¹

Evidence suggests that factory workers were also severely affected, probably because of the poor ventilation and close quarters of their workplaces. One example was the Winnipeg garment industry. Victory Loan canvassers reported to the press that many of the workers at Northland Knitting Company were victims of the flu. “That is only one illustration of the ravages made by the disease,” a canvasser reported; “I happen to know that a large number of firms with indoor help, particularly in the knitting and sewing trades, are badly hit.”²² Another factory-like setting was the phone company. Seventy-five ‘phone girls’ (twenty-five percent of the workforce) were off work by the Armistice,

¹⁹ See Chapter 3 for information on the health of volunteer and professional nurses.

²⁰ WT, November 6, 1918, p. 5.

²¹ MFP, November 6, 1918, p. 5. See also Janice Dicken McGinnis, “The Impact of Epidemic Influenza: Canada, 1918-1919,” in S.E.D. Shortt, ed., *Medicine in Canadian Society* (Montreal: McGill-Queen's University Press, 1981), p. 464-465.

²² MFP, November 4, 1918, p. 5.

causing a serious interruption in phone service. The public was urged to make only essential calls.²³ The overall economic cost as a result of lost wages, lower consumption, and reduced productivity is impossible to determine. It is evident, however, that the business class in the city became increasingly restive through late November and early December, as the epidemic lingered and public closures remained in place. Ultimately, business leaders would take public health officials to task for their management of the epidemic, and its impact upon the financial health of the city.

Sojourning workers faced considerable disadvantages during the epidemic. The Ukrainian immigrant community in Winnipeg, for example, included a significant proportion of unattached young men who lived in room and board accommodations, and worked at manual labour jobs. As many as 70 percent of the nearly 70,000 Ukrainian subjects of the Austro-Hungarian empire who had emigrated to Canada between 1910 and 1914 fit this description. Most had not become naturalized, and thus were subject to registration and internment laws in the earlier years of the war, before the labour shortage led to their release.²⁴ As 'enemy aliens' these men endured the hostility of the host society during and immediately after the war.²⁵ Ukrainian-Canadian historian Orest Martynowych argues that these single migrant labourers had greater difficulties adjusting

²³ MFP, November 11, 1918, p. 5; WT November 11, 1918, p. 2. Note that the garment factories and the telephone company were centres of militance among women workers during the General Strike. See Mary Horodyski, "Women and the Winnipeg General Strike of 1919," *Manitoba History* 11 (Spring, 1986).

²⁴ Martynowych, p. 323.

²⁵ Frances Swyripa and John Herd Thompson, eds., *Loyalties in Conflict: Ukrainians in Canada During the Great War* (Edmonton: Canadian Institute of Ukrainian Studies, 1983).

to Canadian life than permanent settlers who had established family and neighbourhood ties. He describes them as a “large floating population ... with little emotional solace and material support...”²⁶

During the influenza epidemic, the more fortunate among them would have been boarding with a single family or perhaps a widow who might have been able to nurse them through illness if she remained well herself. Others, however, were squeezed in large numbers into unhealthy living quarters,²⁷ perfect conditions for infection to spread. Single men would not only have been particularly vulnerable to contracting the disease under such conditions, but recovery would have been more difficult without the basic health care given by family or friends. It is difficult to establish how sojourning men coped, since their stories were less appealing to the press than those of families with young children. The records of the Margaret Scott Nursing Mission document a visit to a boarding house on Stella Avenue on November 2, where a Polish widow, herself ill, with three young children, boarded several Polish men who were all down with the flu. They were married men, in their early forties, who worked as labourers for the CPR. One man’s record indicated that his wife was “in the old country,” although he had been in Canada for over five years. The assistance from the Mission nurse may have saved these men’s lives.²⁸

²⁶ Martynowych, p. 142-43.

²⁷ Martynowych, p. 140-141. Conditions were improving by the end of the war, but a 1921 housing survey still found 20 percent of north end houses dirty or overcrowded. 45 percent of families (4.5 persons) lived in three rooms or less.

²⁸ PAM, MSNM, MG10B9, Boxes 7-10, Applications for Nursing, Attendance and Relief, 1908-1921, 8238 – 8241.

Pregnant working class women infected with influenza were among the most distressing cases these nurses attended to. They were called to care for sick women who went into labour prematurely and 'miscarried', and others who gave birth while infected with influenza, some of whom died. A 32 year old Finnish woman, pregnant with her third child (her other children were one and two years of age) was suffering from influenza, and delivered a stillborn child on November 1.²⁹ On November 12 a young Jewish mother aged 20 died. She had two children, ages two and four, and had been pregnant with her third when she developed influenza. She was sick for a week, before she miscarried at seven months. Two physicians who worked with the MSNM tried to save this woman's life. The surviving children and the husband, a pedlar, also had the flu, and were cared for by the Mission nurses.³⁰

The Mission's records unfortunately give very little commentary about their patients. One of the nurses, however, a Miss Hughes, sometimes wrote short notes on her patient ledger that give some insight into her own emotions and those of her patients. Miss Hughes gave her notice at the end of November 1918, perhaps because of the strain of caring for flu victims that month, when the Mission made nearly 900 visits to flu sufferers. She had attended a 23 year-old English woman, probably a war bride, whose husband worked as a railway mechanic, earning \$22 per week. The woman had a

²⁹ PAM, MSNM, MG10B9, Boxes 7-10, Applications for Nursing, Attendance and Relief, 1908-1921, 8235.

³⁰ PAM, MSNM, MG10B9, Boxes 7-10, Applications for Nursing, Attendance and Relief, 1908-1921, 8277.

miscarriage on November 22: "Mrs. Smith³¹ been seven months out from England. Came home from King Edward hospital Sunday. Seems very ill this p.m." Then, "miscarriage at three p.m. Seven months. Volunteer nurse in house all [the] time."³² In another case, that of a woman who appears to have been a European immigrant, whose husband earned only 38 cents per hour as a labourer with the CPR, the nurse described the patient as suffering from the flu and an "abortion" rather than miscarriage. Her husband and sixteen-month old child had both been hospitalized.³³ Not all pregnancies and confinements attended by the Mission's nurses ended tragically. Some women were able to deliver their babies safely, particularly if they were past the worst of the illness, as in the case of a mother who delivered her fourth child on November 25. This must have been a very poor family, with the husband earning only \$16 per week working at the CPR freight sheds, and five mouths to feed. One of their other children was in the King George Hospital suffering, not from influenza, but diphtheria.³⁴

Single mothers, who often experienced a lack of social support, faced difficult circumstances.³⁵ Most had limited childcare options, which made finding and keeping

³¹ A pseudonym.

³² PAM, MSNM, MG10B9, Boxes 7-10, Applications for Nursing, Attendance and Relief, 1908-1921, 8322.

³³ PAM, MSNM, MG10B9, Boxes 7-10, Applications for Nursing, Attendance and Relief, 1908-1921, 8324.

³⁴ PAM, MSNM, MG10B9, Boxes 7-10, Applications for Nursing, Attendance and Relief, 1908-1921, 8333.

³⁵ The Mothers' Allowance program, introduced in 1916 in Manitoba, denied benefits to unwed mothers, forcing them into poverty. For background on Mothers' Allowance programs in Canada see Margaret

employment difficult. Working in domestic service, which in 1918 constituted approximately one-fifth of women's jobs,³⁶ may have forced some women to find live-in childcare, as few employers welcomed servants' children in their homes. Childcare that involved separate living arrangements could prevent mothers from caring for their children during illness. For example, in early November, the Margaret Scott Mission nurses were called upon to help a six year old girl on Logan Avenue, whose mother lived at another address downtown. It appears that the single mother, aged 35, worked as a live-in domestic, and paid to leave her two young girls to be cared for by others. (The younger child, aged three, lived at a third address.) She earned \$30 per month at her job doing housework, and received no financial assistance from public or private agencies. The person responsible for the daily care of this young girl needed help from the Mission because the girl's mother was unavailable.³⁷

Rare insight into how a working class woman felt about and lived through this time can be found in letters written to her daughter Jessie by Annie Ambrose. Jessie had been living with Annie's sister in England, since her parents, brother, and sister had emigrated

Little, *No Car, No Radio, No Liquor Permit: the Moral Regulation of Single Mothers in Ontario, 1920-1997* (Toronto: Oxford University Press, 1998); and "Claiming a Unique Place: The Introduction of Mothers' Pensions in British Columbia," in Veronica Strong-Boag and Anita Clair Fellman, eds., *Rethinking Canada: The Promise of Women's History*, 3rd ed. (Toronto: Oxford University Press, 1997), p. 285-303.

³⁶ Paul and Erin Phillips, *Women and Work* (Toronto: James Lorimer, 1983), p. 12. Domestic service as a percentage of women's employment was falling in 1918. In 1891 domestics made up 41 percent of the female labour force; by 1921 this had fallen to 18 percent.

³⁷ PAM, MSNM, MG10B9, Boxes 7-10, Applications for Nursing, Attendance and Relief, 1908-1921, 8247.

to Canada in 1908, where her father found semi-stable employment as a freight agent with the Canadian Northern Railway. The family had lived in St. Anne de Bellevue, Québec until 1911, when they moved to Brandon, Manitoba. Annie never liked Brandon, and was trying to make a move back to Québec in fall 1918. Her daughter Cecilia was hoping to go to secretarial school in Montréal. Mrs. Ambrose's letters to her daughter Jessie describe the family's circumstances and the epidemic.

In answer to your letter of this morning do not write to this address again. I am starting for Montréal on the 16th tomorrow for the winter months perhaps for good. Dad is going to stay here for a while ... We have a very bad attack of Spanish Influenza here. Day Schools and Sunday Schools also Churches are closed or any Big Places of any Importance. There [has] been a lot of preparation made for the Harvest Thanksgiving here but it had to be postponed. Also we had news on Saturday that the war was ended. I said it was too good to be true it was too quick ...

You see I started this letter in Brandon but I am finishing it here in Montreal. Got here on Saturday afternoon and today Sunday is raining hard all day. The Spanish Influenza in [sic] very bad here. People are dying [in] hundreds. I have come down here in a very bad time. Willie is not up to the mark as [sic] been in bed all day been riding in the train since Wednesday. So I hope he will be alright tomorrow.³⁸

Ten days later, things were worse for Mrs. Ambrose:

I came across the pictures I promised you. They are not very good but I reckon you will know them. I have had both of them very sick with the Grippe. I have got Willie [9 years] up and out of danger but Cecilia is still very sick. The doctor is coming tomorrow. There has been a lot of sickness here and the deaths as much as two hundred a day with the Spanish Flu. It is something awful and raining the whole time I have been here. If we live here we shall be in a flat staying with Frank's sister for a time till we decide what we will do. Everything is shut down here none of them can go to school or a private school till the sickness is over. How are you all over there. Write and let me know I hope you are well I feel alright myself up till now. I brought a lot of my best china here with me I have got

³⁸ PAM, MG14C96, Jessie Ambrose Fonds, Letter October 15, 1918.

it all broke even my Cheese Dish I had in England kept it all this time and got it broke I did feel upset over it. Willie send his love.³⁹

Cecilia became very ill, developing pneumonia, but did eventually recover. The move to Montréal seemed ill fated:

What with her sickness and her new clothes and coming back here besides Willie to get ready for school. It [has] made me rather short. So now I am going back to Brandon to start afresh and come down next year. I am disappointed but it can't be help [sic] so I must make the best of it. It would make all the difference if Papa was with us there is lots of places being shut down and Mrs. Harrison is out of her position now and I don't do any work at all and I think Papa is getting a raise where he is ... It [has] turned very cold here, it will be colder still going West. I dread going there.⁴⁰

By the New Year, the family was back in Brandon and influenza was again raging in the community, "six houses all in a row nearby" affected, as Annie wrote to Jessie. Mrs. Ambrose read in the newspaper about the epidemic's second wave in Australia, and sent the clipping to her daughter, hoping that she and her friends in England were all well.⁴¹

Annie Ambrose's letters illustrate that transiency and family separation made coping with the epidemic more difficult for women. In some unfortunate cases, mothers had to face the death of a child without the support of their spouse. One 33-year-old Hungarian mother of seven children, ages eleven months to 12 years, was alone with her family in a home on Alfred Avenue in the north end, while her husband worked as a cook for a CNR

³⁹ PAM, MG14C96, Jessie Ambrose Fonds, Letter October 27, 1918.

⁴⁰ PAM, MG14C96, Jessie Ambrose Fonds, Letter November 29, 1918.

⁴¹ Annie Ambrose's son Willie would later lose his life in a mill accident. Cecilia and her husband would deny Annie a room in their home during the Great Depression. See Veronica Strong-Boag, *The New Day Recalled*, p. 186.

gang in Ontario. Three of her children, including the youngest, an eleven month-old girl, had had whooping cough since September. When the Mission nurses attended the family in the third week of November, six of the children and their mother had been ill with influenza for a week. Incredibly, two of the boys with whooping cough were improving. The baby, however, was very ill and died the day the nurses arrived, after being transferred to hospital.⁴²

Because of the war, of course, many more women than usual were managing their households without men. The loss of wages to soldiers' dependents was partially compensated for by allowances from the Canadian Patriotic Fund. Women who were in common-law relationships with soldiers were potentially in a slightly better financial situation than were other unmarried women heading households, because the Canada Patriotic Fund (unlike the Manitoba Mothers' Allowance) did support common-law wives. However, financial support for soldiers' wives was grossly inadequate, at a maximum of \$40 per month, but often not more than \$18 per month. The benefit was based upon the number of children women had. According to Nancy Christie, the families of unemployed or unskilled workers may have benefited from a more stable income than that to which they were accustomed; however, "the standard of living of thousands of skilled-working-class families fell to that of unskilled workers."⁴³ Some of

⁴² PAM, MSNM, MG10B9, Boxes 7-10, Applications for Nursing, Attendance and Relief, 1908-1921, 8307.

⁴³ Nancy Christie, *Engendering the State: Family, Work, and Welfare In Canada* (Toronto: University of Toronto Press, 2000), p. 52.

the mothers treated by the Mission for influenza were soldiers' wives who were supporting several children. When they became ill, one of the pressing difficulties confronting these women was child care. Those with friends or family were perhaps fortunate enough to get help. Others had no support.

Some of the children whose fathers were overseas were sent to the Children's Home of Winnipeg, the largest Protestant orphanage in the city, with the financial support of the Patriotic Fund. This is what happened to two of the three children of a soldier's wife from a more prosperous area of the north end. In December 1918, she wrote to the Children's Home requesting that her children be temporarily admitted, while she recovered from the flu:

Dear Madam,

I wish to apply for the admission of two children age seven and five years to the childrens home the circumstances [sic] are as follows. My husband is overseas for the four years six weeks ago myself and the children were all stricken with Flu and as we had no person to care for us, the children or at least two of them went to the children aid and I was sent to hospital myself I am now convalescing at the YWCA but I feel that I am unable to resume the care of the children and my doctor tells me that I may require further treatment (see enclosed certificate) there is a third child in the childrens Hospital but she will probably remain there for some time in view of fact the childrens aid are very anxious to have children removed would you please deal with this as early as convenient?⁴⁴

The children were admitted, and happily were discharged to their mother about a month later.

Other families were not as fortunate. One example is that of a mother suffering from tuberculosis, who had used the Home for several years as a source of respite care when

⁴⁴ PAM, P5436, Children's Home of Winnipeg, Case File 2272.

her health became too poor to care for her three children. In winter 1918, her husband was overseas. Her children were aged two, five, and six. The two eldest had been in the Children's Home since January 1918, while the baby was cared for by friends. This arrangement faltered, and the young boy was also admitted to the Home some time that year. A letter to the Home explains the circumstances, and the mother's anxiety:

The Drs examined me and I am sorry to say the report is worse than I expected but Im [sic] my Fathers child and have young ones to fight for so will fight it out with Gods help ... I want to know if you could take another little burden that is I trust they are not too much of a burden but my baby is to find a new home and I do not wish him changing too often I want him with Melanie if you will take him they are just crasy over each other and are as like as peas in a pod only he is of Henrys build. I am hoping if you will have him that the pleasure of seeing the others will take the strangeness off he has been made much of where he was and Im real annoyed that they should have had him if they could not keep him for me for I wished him sent with the others but perhaps it will be allright I do not know if you can take this added responsibility but will be relieved if you will he is running around and pretty near as active as Melanie they were running races at home...

A letter also survives from this mother to her older children, written when the baby was being admitted to the Home:

Henry and Melanie will you do something for Mama our Dear little baby has got to find another home after all and I want my big son and daughter to keep an eye on him will you oh you poor Darlings what a lot Mummie has to leave to you and they tell me if I love you I must do it so try and be good a little longer it can not be for always every one is good to you are they not tell Mrs McDougal or whoever comes to see you if you want anything. do you have all you want and is it nice at school Henry you will know if you are doing wrong by whether you care if you are seen if you ever feel afraid anyone will see you just stop right there laddie for it must be wrong – be a good boy and tell Melanie all about Jesus and remember he is looking after you – Oh my Dear little son pray for your old Mummy like you did the night Robbie came to us you remembers I sent word if you prayed for me you would hear some thing in the morning and you did didn't you. Well now you pray for Mummie every night and perhaps soon I'll see you

won't that be nice good bye my darlings Melanie will be a little Mother to Robbie will you sweetheart and Henry look after you both..."

Both of the boys contracted influenza, and were sent to the King George Hospital in early December. The youngest died there on December 6, 1918. Despite her own ill health, the mother had her eldest son discharged directly to her from the King George at the beginning of January, and then took her daughter home on January 22, 1919.⁴⁵ The effect of a child's death in a situation compounded by the grief, and perhaps guilt, of separation must have been devastating.

Such stories illustrate that working class experience during the influenza epidemic was in many cases harsh and traumatic. The material context of working class life posed a considerable challenge to disease prevention and cure. Some individuals and families had little choice but to turn to social agencies for help when informal networks of kin and neighbourhood failed or were non-existent. In addition to privately run charitable institutions, a significant number of families applied for aid from the municipal relief agency (the Social Welfare Council) or from the provincial Mothers' Allowance program.⁴⁶ But it is nevertheless essential to recognize that charitable and state support were often the choice of last resort for workers, although they did use "considerable ingenuity" in accessing these resources.⁴⁷ Self-help was preferred to charity.⁴⁸

⁴⁵ PAM, P5436, Children's Home of Winnipeg, Case File 2198. The names of children and families have been changed to ensure confidentiality.

⁴⁶ The circumstances of widows applying for Mothers' Allowance because their husband died of influenza are discussed in Chapter 6.

⁴⁷ Baskerville and Sager, p. 150.

Some unions provided sickness and death benefits, linking their activism in the workplace to benevolence in the broader community. Alan Derickson has argued that unlike fraternal organizations, which “sealed fraternal impulses in exotic compartments removed from their members’ working lives, [and] reinforced values and practices of individualism,” unions nurtured an “ethos of mutualism.”⁴⁹ This ethos could be an essential source of aid during an epidemic.⁵⁰ Skilled, unionized workers in Winnipeg affected by influenza took advantage of union health and welfare plans, and death and funeral insurance. Over fifty members of the Winnipeg Typographical Union Local 191 applied for its sick benefit, which basically provided wage replacement for ill workers. The benefit was a very modest \$5 per week. Most claims were for at least two weeks off work, some as many as five. On November 30, a record twenty-three members made claims, totaling \$300. According to union records, all claims were honoured. Until January 1919, although many of the union’s members had become ill, “not one member to date had died,” it was proudly noted.⁵¹ This, unfortunately, did not last past the New Year; early in January “the Charter was to be draped on account of the death of three of

⁴⁸ Ibid., p. 155.

⁴⁹ Derickson, p. 57.

⁵⁰ Ibid., p. 65. “When epidemics or other catastrophes drained the treasury, some locals generated revenue from nonmembers through fund-raising social events. Most, however, managed to build a large enough surplus during good times to survive periods of increased claims or decreased revenue.”

⁵¹ PAM, MG10 A29 Box 2, Winnipeg Typographical Union, Minutes, November 30, 1918.

our members” of the flu. The union also wrote a letter of sympathy to one member who had lost his wife to influenza.

The Typographical Union was relatively large and prosperous, with five hundred members and finances that remained in the black even after paying out sick benefits throughout the winter of 1918-1919. More financially taxing was death insurance. In January and February of 1919, the union paid out \$1675 in mortuary benefits.⁵² It appears to have received financial aid from the international union to cover these costs. Other union locals had difficulty managing to pay out death benefits. The International Union of Bricklayers and Allied Craftsmen Local 1, a much smaller union with a limited budget, had to impose a death levy on its membership in the second quarter of 1919. This was to cover the \$350 paid out to two members whose wives had died.⁵³

Even where formal sick benefit schemes did not exist, unions supported their members and families financially and emotionally. Records suggest a sense of moral obligation among male unionists not only to assist male breadwinners financially, but also to play a psychological caregiver role, a role normally ascribed to women in the broader culture.⁵⁴ The International Brotherhood of Carpenters and Joiners Local 343, for example, reported regularly at their monthly membership meetings on the well being and progress toward recovery of their ill brothers in the union. This was called the “Sick”

⁵² PAM, MG10 A29 Box 2, Winnipeg Typographical Union, Minutes, January 25, 1919; February 22, 1919.

⁵³ PAM, P3562, International Union of Bricklayers and Allied Craftsmen Local 1, Minutes, October 7, 1918; December 2, 1918.

⁵⁴ Alan Derickson notes that “friendly visiting was a hardy union tradition” and argues that this psychosocial support “prevented mental illness and hastened recovery in some cases.” *Op cit.*, p. 69.

report, or sometimes the “Sick and Death” report or the “Sick and Accident” report. In this small local, the welfare of members was ritually noted in meeting minutes, in a matter-of-fact manner, with statements such as “Brother Jackson said he was not improving much,” or, “Brother H Barnard was reported improving some.” Members were encouraged to visit the sick and offer them encouragement in their period of recovery.⁵⁵

Until early January 1919, the carpenters’ union members appear to have escaped the worst of the epidemic, with the possible exception of the illness (and subsequent resignation) of their vice-president.⁵⁶ Meetings of the local union were suspended due to the public meeting ban, although executive meetings were still held to deal with necessary business, such as the initiation of new members and paying bills. At a full membership meeting on January 17 the first serious influenza case was noted:

A. Chumley was reported sick and ... [illegible] was nearly over the whole family and that they had buried one child and that he was in strand circumstances financially. It was regular moved and second that we donate Bro. Chumley Fifty Dollars. Carried unanimous. [sic]⁵⁷

⁵⁵ PAM, P3351, United Brotherhood of Carpenters and Joiners of American Local 343, Minutes, February – April 1919.

⁵⁶ PAM, P3351, United Brotherhood of Carpenters and Joiners of American Local 343, Minutes, October 18 – November 22, 1918. The union minutes do not indicate the nature of his illness, but the timing suggests influenza.

⁵⁷ PAM, P3351, United Brotherhood of Carpenters and Joiners of America Local 343, Minutes, January 17, 1919.

This brother returned to work at the end of January, and thanked the union for its support. Brother Woodcock, however, died of influenza in early February 1919, leaving his family in troubling circumstances:

Bro. Woodcock was reported as having died on Tuesday noon and that he was buried Thursday at four in Brookside Cemetery and that the family was in quite a muddle as it leave [sic] his wife with two small children and expect another in the near future. When it was moved and second that we apoint [sic] a committee to look after the widows...⁵⁸

Four members of the local union were appointed to this committee. They had the assistance of a member from another local in helping Brother Woodcock's widow and her family. Brother McClement, of Local 2655, reported that the Assiniboia Council was looking after the widow, and assured Local 343 that he would see that the city council did just that.⁵⁹ This was not, however, the end of the union's involvement with the Woodcock widow. In April 1919, the union received a bill of \$125 from Gardiner and Sons Funeral Chapel. The local decided to contact the widow to see what portion of this bill she could pay. When they did so, they discovered that, "she was not getting the proper compensation ... and it should be investigated." The union members then moved to pay the total funeral costs. What eventually happened to this woman and her family is not known. In another case, the union donated \$50 to help a widow who had lost both husband and a child to the epidemic and was herself ill. At least three more union

⁵⁸ PAM, P3351, United Brotherhood of Carpenters and Joiners of America Local 343, Minutes, February 14, 1919.

⁵⁹ PAM, P3351, United Brotherhood of Carpenters and Joiners of America Local 343, Minutes, February 21, 1919.

members died during the epidemic but there is no record of financial aid given to their families. It is possible that these men were bachelors or that their families had other sources of support.

Labour movement women also helped to organize relief. The Machinists' *Bulletin*, edited by R.B. Russell, printed a report from the Vancouver Ladies' Auxiliary in April 1919, explaining their growing health and welfare network:

We have had so much sickness during the past few months, and with the New Year, we had to increase our sick committee. We have a committee of two in every district now, which helps to lighten the work ... The Brothers of 777 have also been helping financially in relief work.

On March 8 we got up a bright concert for the wife and family of a brother of 777 Lodge, who died recently. The wife and two babies being left without any support whatever, excepting for the gigantic sum of \$4.00 a week from the charitable and sympathizing city. We are pleased to report the concert realized \$263 after expenses were paid, this money is being sent to the widow, so much a month, at her request.⁶⁰

Not surprisingly, Helen Armstrong, leader of the Women's Labor League, was involved in finding financial support for families stricken by the flu. At the December 13 meeting of the Trades and Labour Council (TLC) in Winnipeg, she requested help from the body for Mrs. Webb of Weston: "who has lost her husband, her son, and her daughter. She is left entirely alone and needs financial help." An offering was taken.⁶¹

⁶⁰ PAM, P3038, International Association of Machinists and Aerospace Workers Lodge 2, International Association of Machinists, Specialists and Helpers, District Lodge 2, *Bulletin*, April 1919.

⁶¹ *Western Labor News*, December 13, 1918, p. 1. Given her connection with Helen Armstrong, this may very well be (despite the different spelling of her name) the Mrs. Webbs who chaired the Women's Labor League Relief Committee, which distributed money toward rent to women strikers during the Winnipeg General Strike. See Mary Horodyski, "Women and the Winnipeg General Strike of 1919," *Manitoba History* 11 (Spring, 1986), p. 30.

Unfortunately, the Women's Labor League left no written records, and the full extent of their relief work among working class families will never be known. Armstrong, however, is remembered by her surviving family members as a woman who constantly reached out to those in need, utilizing her formidable organizing skills not only to help women in the workplace, but also in private life.⁶² At the time of the epidemic, the Armstrongs were living on Inkster Ave., in the heart of north end Winnipeg. It is probable that Helen and other working class women created an informal support network to help each other in a time of distress, as they were to do in a few short months during the General Strike.

The epidemic came with its costly setbacks for labour activists, such as the death of the President of the Metal Trades Council, Ray Calhoun, a friend of R.B. Russell's. No doubt he would have been a key figure in the General Strike had he lived. The deaths of two prominent women activists were also noted in the *Western Labor News*. Mrs. Lillias Veitch, involved in the TLC, the Women's Labour League, and the choir at William Ivens' Labour Church, died December 27. Ivens himself performed her service. The death from influenza of Miss Isabella Duncan, leader of the Winnipeg Housemaids' Union, was noted on the front page of the November 15 issue of the *Western Labour News*.

⁶² Interviews with Helen's grandchildren appear in "The Notorious Mrs. Armstrong," directed by Paula Kelley, Buffalo Gals Productions, Winnipeg, 2000.

There were a few employers who saw it was in their own best interests to offer support when their workers were affected. A.W. McLimont,⁶³ general manager at the Winnipeg Electric Railway Company (a unionized workplace), organized a relief committee for his employees. Whether this committee covered any lost wages due to illness is unknown, but it is likely that a workplace-based relief operation may have been more welcome among working families than municipal relief and may have carried less stigma.

Formal mutual benefit organizations played an essential role in times of unemployment, injury, or illness. Helping members deal with the impact of disease through sickness and death benefits was a core function of working class and immigrant mutual aid organizations in North America in this period. Fraternal and benevolent associations often paid benefits to members unable to work due to illness. Although these organizations did not cover all workers and immigrants, sources suggest that as many as one-third of adult male workers in Canada belonged to some sort of fraternal organization in the first decades of the twentieth century.⁶⁴ Unskilled workers, however, were much less likely to belong, probably because they could not afford the membership fees.⁶⁵ The

⁶³ McLimont was among those “local luminaries” who petitioned the federal government in May 1918 to outlaw strikes during the duration of the war, in the midst of a bitter civic workers’ strike. David Bercuson, *Confrontation at Winnipeg: Labour, Industrial Relations, and the General Strike* (Montreal: McGill-Queen’s University Press, 1990), p. 63.

⁶⁴ Baskerville and Sager, p. 158. The figures are: 37% of adult males in Ontario in 1901; a “similar number” in British Columbia in 1921.

⁶⁵ *Ibid.*, p. 159.

poorest and most vulnerable of the working class, many of them in Winnipeg's case likely to have been unskilled European immigrants, were therefore lacking a valuable source of support.

Provincial government records show that Winnipeg had approximately forty functioning mutual benefit organizations, including Jewish, Italian, German, English, Chinese, Bohemian, Polish, Ruthenian, and Hungarian groups.⁶⁶ Some of them had a relatively large membership. The St. Nicholas Mutual Benefit Association, a Ruthenian group, had over eight hundred members. Italian immigrants formed the Roma Mutual Benevolent Society in 1911, with a more modest enrollment of one hundred and twenty members at its founding.⁶⁷ British immigrants could belong to one of the lodges of the Sons of England, a stable and successful organization.⁶⁸ The German immigrant community had several clubs (organized by country of origin – e.g. the German-Hungarian Club) which offered sickness and death insurance to their members. These organizations had some experience offering relief in a time of crisis. They had worked together to provide relief to their compatriots during the 1913 depression in Winnipeg,

⁶⁶ PAM, GR 7406, Government of Manitoba, Health and Welfare, Board of Welfare Supervision/Public Welfare Commission, Institution, Society and Subject Files, 1916-1945, File 27, Charters Under the Charitable Association Act.

⁶⁷ Stanislao Carbone, *The Streets Were Not Paved With Gold: A Social History of Italians in Winnipeg* (Winnipeg: Manitoba Italian Heritage Committee, 1993), p. 38-41. The Italians were a fairly small group of approximately one thousand immigrants at the end of the war.

⁶⁸ A. Ross McCormack, "Networks Among British Immigrants and Accommodation to Canadian Society: Winnipeg, 1900-1914," *Histoire sociale/Social History* 17, 34 (November 1984), p. 371-372. By 1929, the Sons of England had 2500 members in Manitoba.

and in the period immediately following the declaration of war against Germany when many local Germans were fired from their jobs.⁶⁹ Winnipeg's Jewish community, which by 1921 numbered nearly 15,000, had a well-developed social welfare network, including such institutions as an orphanage and an old-people's home. It comes as no surprise, then, that the Jewish community organized relief efforts very similar to those of the Anglo-Canadian middle class.⁷⁰ Jewish immigrants could also turn to mutual aid organizations such as *landsmanshaften* (organizations of Jews coming from the same village in Europe) or free loan associations, which flourished in Winnipeg in this period.⁷¹ All mutual benefit organizations must have been very active during the influenza epidemic.

Networks for mutual aid were often informal. Eric Sager and Peter Baskerville have argued that it was workers themselves who provide assistance to the unemployed in their communities. "Though the press rarely made much ado about it, it was often the employed workers who responded with the greatest generosity to the calls for donations and aid in times of crisis."⁷² Gunter Baureiss and Julia Kwong, in their history of Chinese

⁶⁹ Arthur Grenke, *The German Community in Winnipeg, 1872-1919* (New York: AMS Press, 1991), p. 66-89.

⁷⁰ See Chapter 3. For inter-ethnic relief and mutual aid among Jewish immigrant during epidemics in New York at the turn of the 20th century see Howard Markel, *Quarantine! East European Jewish Immigrants and the New York City Epidemics of 1892* (Baltimore; The Johns Hopkins University Press, 1997), p. 64-65.

⁷¹ Gerald Tulchinsky, *Branching Out: The Transformation of the Canadian Jewish Community* (Toronto: Stoddart, 1998) p. 8.

⁷² Baskerville and Sager, p. 155; Derickson, p. 61.

immigrants in Winnipeg, note the role of family associations based upon clan.⁷³ Some networks among working class immigrants, however, may have crossed ethnic lines to a greater degree than formal aid organizations. In the north end's polyglot neighbourhoods, financial help could be found in the form of credit from local shopkeepers, already a common practice and an essential method for getting by among working class wives. Joseph Zuken, who grew up in Winnipeg's radical Jewish community recalled his parents' efforts to help neighbourhood families by extending credit:

They never employed anybody. They kept few books, the accounts were marked on the walls, and when there were people who couldn't afford to pay, my parents simply rubbed out the accounts and extended new credit.⁷⁴

Jewish merchants provided services beyond their own ethnic group; they lived in multi-ethnic areas, and were able to speak European languages including Polish, Russian, and Ukrainian. As Artibise has noted, European immigrants dealt with Jewish merchants because they had credit practices similar to those migrants were accustomed to in the small villages of their homelands.⁷⁵

A fascinating community event that occurred during the worst days of the epidemic revealed that the influenza experience could bring together members of different ethnic and religious groups in shared rituals of mourning and hope. On November 10, in the

⁷³ Gunter Baureiss and Julia Kwong, *The History of the Chinese Community in Winnipeg* (Winnipeg: The Chinese Community Committee, 1979), p. 44-45.

⁷⁴ Doug Smith, *Joe Zuken, Citizen and Socialist* (Toronto: James Lorimer, 1990), p. 23. Zuken was elected to City Council as a Communist in 1961.

⁷⁵ Alan Artibise, p. 162

Shaarey Zedek Jewish cemetery in East Kildonan, rabbis Khanovitch and Gorodsky performed a “sacrificial wedding”⁷⁶ intended to ward off disease. In this simultaneous wedding and funeral, the rabbis addressed the suffering of the people, and called upon God for assistance. Over one thousand people, “Jew and Gentiles alike,”⁷⁷ witnessed the wedding of Harry Fleckman and Dora Wiseman, while at the other end of the cemetery, ten Jews buried an influenza victim. According to the *Tribune*:

The ancient Jewish “Song of Life” was played. On the west side of the cemetery, at the same time, Jews were chanting the wail of death, as a body was committed to the grave. Ancient Jewish chapters reserved for these ceremonies were chanted by the rabbis, and so repeated by all Jews present as the wedding procession marched out of the cemetery.⁷⁸

The *Israelite Press* reported that “many shed tears for the victims of the influenza.” A collection was held which raised \$450 for “charity.”⁷⁹

This moving ceremony did not meet the approval of all in the Jewish community, particularly because it violated guidelines put down by the health authorities that funerals should be small and without unnecessary ceremony. An article in the *Israelite Press* criticized rabbis Khanovitch and Gorodsky for showing poor judgement, and for encouraging superstition.

It is a misdeed of our religious leaders to undertake performing a wedding at a cemetery and bring together such a large crowd. If the sick will use medicine and

⁷⁶ MFP, November 12, 1918, p. 5.

⁷⁷ WT, November 11, 1918, p. 5.

⁷⁸ Ibid.

⁷⁹ *Israelite Press*, November 15, 1918, p. 1.

doctors and not wait for miracles and wonders to cure them that is allright. [sic] But if they rely entirely on such miracles, many of them will surely die. It is therefore the duty of the Rabbis to warn everybody not to neglect the medical attention necessary to end the epidemic.⁸⁰

The ethnic press was a crucial source of information about influenza. Many of Winnipeg's immigrant groups had their own newspapers, mostly weekly publications. Some were short-lived and insubstantial, yet they may have been the only source of information for those who did not read English. Although the municipal authorities did print handbills in some languages other than English in order to provide immigrant communities with information about measures being taken to prevent and treat the disease, this was a limited method of communicating with the city's immigrants.

The Ukrainian, Jewish, Icelandic, and German papers devoted varying degrees of attention to the epidemic. The main Ukrainian language paper in publication at the time of the epidemic, *Ukrains'kyi Holos*, was preoccupied with events in Europe – particularly the ending of the war and the revolution in Russia. In any case, it rarely offered extensive local news. Relatively little was said about the epidemic in its columns, but the paper did print information regarding the public meeting ban and other orders from public health officials.

To a certain degree, the ethnic papers echoed the official interpretation of the disease and how to combat it. For example, the Icelandic paper *Heimskringla* reported on October 3, 1918 upon the arrival of infected soldiers in Winnipeg, and repeated the cautions of public health officials to avoid crowds, and to report all suspected cases to

⁸⁰ Ibid., November 22, 1918, p. 2.

health authorities. On the 24th of that month, the paper stressed that the main preventative measures against the disease were isolating the sick, avoiding contact with sputum or spit, and disinfection. Contacting a physician was considered important.⁸¹

Such commentaries do not suggest a radically different view of the disease than that of the Anglo-Canadian mainstream. However, in some ways the ethnic and labour press represented diverse interpretations of the causation and disease process of influenza. The Icelandic *Vorold* argued that medical science was unnecessary to see the obvious connection between the war and the epidemic:

All great wars have been accompanied by plagues which is not very surprising if considered that it does not take more than one beast to die and rot in the field to poison the air around it. One can imagine how it will be where thousands and even millions of people and horses are massed together. ... We talked to a soldier that was back from the war and was just coming from Saskatchewan and he told us all kinds of things that shed a light on the origin of the plague. After a big battle the dead are buried in [mass graves] as best can be done. It is obvious when dozens and even hundreds of thousands fall in one day, what a big job it is to bury them. When the burying is finally over, another battle starts shortly after; shells tear and rip the earth in big areas where the bodies were buried and then they are ripped apart in shreds and scatter in all directions. No special health knowledge is needed to understand what kind of danger there is of air poisoning and plagues as a result of that. To understand that, one only needs common sense and a little bit of thinking.⁸²

In its only lengthy discussion of influenza, the *Western Labour News* offered a view of the disease out of keeping with contemporary germ theory:

Influenza may be described as a most typical example of epidemic disease. It literally comes upon the people, and does not appear to be conveyed by infection so much as it is produced by a peculiar atmospheric condition, due evidently to

⁸¹ *Heimskringla*, October 3, 1918; October 24, 1918.

⁸² *Vorold*, December 3, 1918.

the fact of the atmosphere being loaded with the germs of this disease at the time being.⁸³

Not only did the paper doubt theories of contagion, it also argued that prevention depended upon attention to the individual's overall health and vitality:

It is not a little remarkable how some people escape from its ravages. It would appear that only those whose health is at the time in an unsatisfactory condition are affected; especially are these liable to it whose blood is contaminated by faecal absorption from the lower bowel, due to that commonest of all evils and predisposer of disease, constipation.⁸⁴

The piece went on to suggest that the most important aspect of treatment was to lower the fever by using a drug called phenacetin, the daily use of enemas, and proper nourishment. The advice to use enemas probably harmed more than it helped, as it would have further depleted already dehydrated sufferers.

The *Western Labor News* was not alone in its questioning of germ theory and mainstream medical approaches to influenza. Popular perceptions of the disease seemed to have rejected germ theory in favor of a miasmatic causation. Perhaps because strategies such as public meeting bans and isolation of the sick were unsuccessful in preventing the spread of influenza, some people began to question whether the disease was spread only through person-to-person contact. Public health authorities were called upon to defend germ theory against public skepticism:

A widespread rumour that the ban on public meetings had been found a failure, that the flu germ was air-borne and not disseminated by contact, was exploded

⁸³ *Western Labor News*, November 8, 1918, p. 5.

⁸⁴ *Ibid.*

yesterday by Dr. Gordon Bell, who declared that the germ's only vehicle was moisture disseminated by patients.⁸⁵

Although mainstream allopathic medical practitioners had gained a firm hold over health care provision by this period, this did not necessarily mean the end of older traditions, such as self-medication, herbal healing and other forms of folk medicine.⁸⁶ One woman healer from the Ukraine, a herbalist practicing in the north end of the city named Dyna Lublynsca, claimed to have cured more than one hundred cases of influenza. She would not divulge the secret of her therapy, but stated that it worked by lowering fever.⁸⁷ Since high fever and dehydration were among the more dangerous symptoms of influenza, it is possible that her interventions did help some patients, no less so than conventional therapies.

Ukrainian immigrants may have turned to the Winnipeg-published almanac *Kalendar Ukrain's'koho Holosu* for treatment advice. Influenza was not a new disease, and therapies used in the past continued to be considered effective. This particular almanac argued that all infectious diseases, including influenza, were caused by "microbes ... [also known as] bacteria, bachilli, or microorganisms."⁸⁸ The almanac listed the main

⁸⁵ MFP, November 5, 1918, p. 5.

⁸⁶ See Virginia Berridge, "Health and Medicine," in F.M.L. Thompson, ed., *The Cambridge Social History of Britain 1750-1950*, vol. 3 (Cambridge: Cambridge University Press, 1990), p. 186-188.

⁸⁷ WT, November 27, 1918, p. 10.

⁸⁸ *Kalendar Ukrain's'koho Holosu*, (Winnipeg, 1918), p. xxii – xxx.

symptoms of a range of infectious diseases: measles, diphtheria, chickenpox and smallpox, typhoid, dysentery, and tuberculosis. Regarding influenza it noted:

Influenza comes from being chilled in the spring and in the fall and appears as nasal congestion, congested throat, wheezing, headaches, unnoticed fever, and a general weakening. This is a disease of the whole body, even though one part of the body may seem more touched by it than another. ... The important thing is to cleanse the stomach, lie down in bed and eat liquid foods such as broths, etc.⁸⁹

Popular health materials reflected a significant demand for information to facilitate self-prescribing and self-treatment. Popular therapies to combat influenza were extremely common and numerous, many of them inexpensive traditional methods made from materials easily at hand in the working class household. "Every household had its own trusted preventative and remedy," Eileen Pettigrew has noted.⁹⁰ Preventatives included "cotton bags holding a lump of camphor and worn on a cord around the neck," "hot coals sprinkled with sulphur or brown sugar and carried through the house accompanied by clouds of billowing smoke," handkerchiefs soaked in eucalyptus oil, or powdered sulphur sprinkled in one's shoes.⁹¹ Others wore and ate raw garlic. Poultices were used on the chests of flu victims, made of bran as hot as possible; lard mixed with camphor and chloroform, or turpentine; and goose-grease. An elaborate but cheap poultice recipe was used by an Alberta woman:

⁸⁹ Ibid.

⁹⁰ Eileen Pettigrew, p. 110. For the use of traditional therapies by First Nations in Canada see Mary Ellen Keln, "British Columbia First Nations and the Influenza Pandemic of 1918-1919," *BC Studies* 122 (1999), p. 40-41. For traditional remedies in Japan see Edwina Palmer and Geoffrey Rice, *op cit*, p. 320-321.

⁹¹ Pettigrew, p. 114.

Peel ten pounds of onions (for an adult), run them through a meat-chopper with the finest cutter available, put the ground onions into a large dish-pan; add about six or seven pounds of fine salt, stir together on the stove until it is too hot to hold in the hand. Add enough flour to thicken, just so the juice will not run. ... The poultice should be kept on ... not to exceed ten hours; then remove the poultice and rub with soft, dry towels, then with sweet oil and alcohol.⁹²

Sore throats could be treated with a sip of oil of cinnamon, or a drink made of warm milk, ginger, sugar, pepper and soda. There were infinite permutations of such home remedies.

Inexpensive traditional therapies became more valued as the cost of patent medicines escalated. Eucalyptus oil, for example, was in high demand, and its price increased by one hundred percent in some stores.⁹³ Manufacturers and salesmen of patent medicines were quick to seize the commercial opportunities afforded by the epidemic. Advertisements for commercial flu remedies were common in the newspapers of the day, with many patent medicine manufacturers claiming the efficacy of their products, like “Fruit-a-Tives – The Wonderful Fruit Medicine Gives the Power to Resist this Disease” and “Spanflu” Preventative Tablets.⁹⁴ Many of these were all-purpose sorts of remedies, not preparations specific to influenza treatment.

Door-to-door salesmen also got into the influenza marketplace.⁹⁵ This excitement in the market extended far beyond health products. If an influenza angle could be found to sell products, it was exploited. Disinfectants claimed to “Kill the Flu.” The Edison

⁹² Pettigrew, p. 112.

⁹³ WT, October 14, 1918, p. 10.

⁹⁴ MFP, October 12, 1918, p. 30; October 19, 1918, p. 2.

⁹⁵ Pettigrew, p. 112.

Phonograph Store marketed its product as “Flu Proof Entertainment.” Soon after the disease arrived in Winnipeg, a local insurance company promoted itself by committing to insure citizens against the flu.⁹⁶ Advertising during the flu epidemic illustrates the spectacular growing capitalist consumer culture, and its efforts to bring consumerism into the heart of the epidemic experience. Many of the ads were amusing in their almost incongruous, clever, and innovative claims.

But this spectacle of consumption did not extend to the sale of one traditionally important prophylactic—alcohol.⁹⁷ Prohibition was a point of tension between workers and prohibition forces from the start of the epidemic. There were early appeals to ease prohibition laws, given that alcohol was a medically recognized treatment for flu sufferers. Legislators, Protestant church leaders, and prominent physicians were vehemently opposed to allowing the sale of liquor.⁹⁸ On November 1, employees of an unidentified Winnipeg company sent a petition to the Attorney General asking not for a lifting of prohibition, but rather that the government procure alcohol and allow afflicted workers to freely purchase it:

We, the undersigned employees of [left blank] request you to use your good offices to procure a supply of whisky and quinine to help combat the epidemic of Spanish influenza now raging. We appear to be practically the only victims of the disease to date, and as the nature of our work exposes us to infection to a greater degree than the average citizen, we respectfully make this appeal. We would

⁹⁶ MFP, October 19, 1918, p. 21, 22; October 15, 1918, p. 2.

⁹⁷ Class conflict with regard to alcohol consumption during epidemics had a long history. For cholera, see Geoffrey Bilson, p. 36-37; Richard Evans, *Death in Hamburg*, p. 353-355.

⁹⁸ WT, October 12, 1918, p. 1.

further request that the liquor be sold in reasonable quantities without a doctor's prescription while the epidemic lasts.⁹⁹

This letter was ridiculed in the *Free Press* under the headline, "Failed to Get Their Whisky."¹⁰⁰ The Attorney-General replied that he did not have the power to grant the workers' request. Three weeks later, the Commercial Travelers' Association formally appealed to the provincial government to ease the liquor ban, and accused pharmacists of price gouging on their sale of prescription medicines containing alcohol. Premier Norris's cabinet debated the issue, but rejected the request. Implicitly denying (or ignoring) the claim that physicians were prescribing liquor, the government stated that alcohol was not necessary to treatment.¹⁰¹

The suffering of working class and immigrant families during the epidemic can best be understood as a reflection of the daily material hardships of their lives. To recognize the relevance of material factors is not, however, to accept the determinist bourgeois view of working class and immigrant districts, which acknowledged little and knew less of the networks sustaining these diverse communities. Far from being passive victims, the 'others' of Winnipeg's influenza epidemic responded to the disease by drawing upon longstanding ties of family, ethnic, gender, and class bonds, and neighbourhood loyalties. When these indigenous networks failed, they sought out aid from agencies such as the Margaret Scott Nursing Mission, the Emergency Nursing Bureau, and other social

⁹⁹ MFP, November 6, 1918, p. 5.

¹⁰⁰ Ibid.

¹⁰¹ WT, November 20, 1918, p. 3.

welfare agencies. Despite bourgeois fears of moral incapacity and degeneracy, a few rare insights into the personal responses of working class mothers show not only how resilient their circumstances taught them to be, but also how optimistic and determined they often remained. Women like Mrs. Ambrose and the anonymous mothers who were separated from their children by illness illustrate fully the emotional strength of working class and immigrant mothers. As has been suggested by historian Ellen Ross and critic Carolyn Steedman, our histories must learn to pay attention to the rich emotional and psychological landscape of working class family life.¹⁰²

It seems clear that, for a time, the demands of coping with influenza disrupted the functioning of workers' everyday lives, and called upon informal and formal networks of communal solidarity in an extraordinary way. As Stark suggests, quack healers and fraternal relationships asserted their place in the life of the community, and the exploitative relationships of the cash nexus faded in importance. And the preservation of life and health became a social issue, dependent upon bonds between people and social justice, rather than individual behaviour and effort, as the dominant society would have workers believe. This alternative view of the meaning of disease and the appropriate social response to an epidemic had a lasting impact on solidarity in workers' households and communities.

¹⁰² Ellen Ross, *Love and Toil: Motherhood in Outcast London* (New York: Oxford University Press, 1993); Caroline Steedman, *Landscape for a Good Woman: A Story of Two Lives* (New Brunswick, NJ: Rutgers University Press, 1986). Steedman cautions historians against "a refusal of a complicated psychology to those living in conditions of material distress." p. 12.

The effect may have been particularly powerful among women. Temma Kaplan, analyzing the roots of female collective action in working class communities in the early twentieth century, has argued that “the bedrock of women’s consciousness is the need to preserve life.”¹⁰³ Women’s collective demands that the state should guarantee them their rights as nurturers grew out of threats to daily routines of survival and social disorder, and often focused upon issues such as food supply and health.¹⁰⁴ “Networks devoted to preserving life by providing food, clothing, and medical care to households became instruments used to transform social life,” Kaplan argues. “Experiencing reciprocity among themselves and competence in preserving life instills women with a sense of their collective right to administer everyday life, even if they must confront authority to do so.”¹⁰⁵

The epidemic was experienced by working class women as a moment of social disorder and as a threat to the life and well-being of their families and neighbours. It also demonstrated the power of women’s networks to sustain life, and thus as Kaplan argues, strengthened their confidence to confront power. The politicization of women’s role as nurturers was revealed most fully not during the epidemic, but in their participation in the General Strike in May; in their crowd actions against strike-breakers, and in their support

¹⁰³ Temma Kaplan, “Female Consciousness and Collective Action: The Case of Barcelona, 1910-1918,” *Signs* 7, 3 (1982), p. 546.

¹⁰⁴ *Ibid.*, p. 549.

¹⁰⁵ *Ibid.*, p. 551, 560.

organizations for women strikers.¹⁰⁶ Tom Mitchell and James Naylor have emphasized the role of women in sustaining the General Strike in working class neighbourhoods:

It was clearly not just solidarity at the point of production that drew Winnipeg workers out: the workforce that struck was simply too diverse. No doubt debates about the appropriate response to the crisis raged in working-class neighbourhoods. Here lived women who had shared the pains of war – absent loved ones, maintaining families in the midst of rising prices, and an unsure future. And it would be they who would bear the brunt of responsibility for supporting their families on non-existent wages until the strike was solved, drawing not only on their own resources but on those of neighbours and kin.¹⁰⁷

Women had shared not only the pains of war, but those of the influenza epidemic as well. The resourcefulness and commitment that sustained workers' families during the strike was precisely that which had just a short while earlier carried them through the epidemic. For them, the influenza epidemic was a devastating trial run and a painful lesson in their own capacity for survival. Perhaps it was also the final in a long series of hardships that demanded recognition beyond what the existing social order was prepared to grant.

¹⁰⁶ Women in working class districts attacked and intimidated those who continued working through the strike. The Women's Labour League organized a food kitchen and cash assistance for women strikers. See Linda Kealey, "No Special Protection – No Sympathy: Women's Activism in the Canadian Labour Revolt of 1919," in Deian R. Hopkin and Gregory S. Kealey, eds., *Class, Community, and the Labour Movement: Wales and Canada, 1850-1930* (Aberystwyth, Wales: Llafur and Canadian Committee on Labour History, 1989), p. 134-159; Eric Angel, "Workers, Picketing, and the Winnipeg General Strike of 1919," (Master's thesis, Queen's University, 1995), p. 98-104; Mary Horodyski, "Women and the Winnipeg General Strike of 1919," *Manitoba History* 11 (Spring, 1986), p. 30-31.

¹⁰⁷ Tom Mitchell and James Naylor, "The Prairies: In the Eye of the Storm," in Craig Heron, ed., *The Workers' Revolt in Canada, 1917-1925* (Toronto: University of Toronto Press, 1998), p. 185. Another useful treatment of the role of women in "community mobilization" in support of strike action is Steven Penfold, "'Have You No Manhood in You?': Gender and Class in the Cape Breton Coal Towns, 1920-1926," *Acadiensis* 23, 2 (Spring 1994), p. 21-44.

Chapter Six –Working Class Widow(er)s and Orphans

Just as the influenza crisis lessened, a successful grocer named James Stanley died, leaving behind a wife and eighteen-month old daughter. He was thirty-two, a member of the Emmanuel Church, and former master of the Loyal Orange Lodge No. 2483. Stanley's death and his wife's attempt to ease his suffering were dramatized in the local press, in a narrative of "thoughtfulness and love ... [of] how a wife, ill with influenza, pretended she did not know her husband was dying, and how the husband tried to hide the tragedy from his wife."¹ Suffering from pneumonia after contracting the flu, Stanley had been hospitalized, and his wife told that he could not recover. She and her baby were too ill to visit her husband to say goodbye, and so she sent him a letter via a volunteer nurse, Mrs. Caton, who was deeply touched by their final communication:

As Mrs. Caton was opening the letter, Mr. Stanley forced a smile. Knowing that he was dying, but unaware that Mrs. Stanley had been informed of this fact, he whispered: "Tell Lily that I've had a close shave, but I'll be home Sunday." With a quiver in her voice Mrs. Caton began reading the letter to the dying man. To her surprise she discovered that there was no "good-bye" in the missive. Instead, the sick wife poured out the story of her love for her husband and expressed the hope that he would be better soon. Though fully aware that he would not recover, Mrs. Stanley hid this knowledge from her husband in a final effort to comfort him in his dying hours ... in that chamber of death, with a nurse administering to the doomed man's needs, Mrs. Caton alone knew that the letter was a message of farewell.²

The press also told the pathetic story of six year old Charlie Leonard, "alone in the world" after the death of his mother. Charlie's "daddy," a sergeant, was recovering from war wounds in an English hospital. His mother, Francis, had been working at a

¹ WT, November 29, 1918, p. 20.

²Ibid.

department store lunch counter until she became ill with influenza. Two weeks later, her manager found her dead in her home, but not until her young son had been alone with her body for a day and a half. The child was described as “weeping silently” when he was found. Francis’s boss, Mike Economy, took over the care of the child. Charlie was not taken to attend his mother’s funeral.³

Most families who lost loved ones to influenza did not have their stories told in the press. Yet, there is ample evidence that, as historian Geoffrey Rice has simply stated, “the 1918 flu struck hardest at young families.”⁴ The majority of flu victims were young men and women in the prime of life; sixty percent of deaths in Winnipeg were of adults between the ages of 20 and 39. Four out of every ten flu victims, perhaps as many as five hundred men and women, may have been parents of dependent children.⁵ As a result, the epidemic left widows and widowers, single-parent led families, ‘half-orphans’, and some children without any living parents.⁶

Although there are strong indications that the epidemic altered family configurations and relationships for many parents and children, the long-term impact of the disease has not been given a great deal of attention by historians. In part, this is

³ WT, November 21, p. 2.

⁴ Geoffrey Rice, *Black November: The 1918 Influenza Epidemic in New Zealand* (Wellington, New Zealand: Allen and Unwin, Historical Branch, Department of Internal Affairs, New Zealand, 1988), p. 171. See also David Killingray, “The Influenza Pandemic of 1918-1919 in the British Caribbean,” *Social History of Medicine* 7, 1 (April, 1994), p. 63.

⁵ Using death certificates (which are not publicly accessible to researchers in Manitoba) Geoffrey Rice has calculated that over forty percent of non-aboriginal flu victims in New Zealand were married with children. Rice, p. 171. The figure of five hundred is rounded up from 486, which is 40% of the 1216 official flu deaths in the city of Winnipeg.

⁶ It was relatively rare for a child to lose both parents. Rice, p. 171-172. In the New Zealand case, 6415 children lost one parent; 135 both.

because epidemics are thought of as discrete moments in time; revealing episodes in the life of a community. Epidemics are interesting for their “shock effect,”⁷ and provide a historical snapshot that exposes the resilience and weakness of a society, the inner workings of its politics, the breakages in its cohesion. This conceptualization of epidemic disease, while analytically powerful in many respects, has pointed historians away from considering impacts of epidemic disease that might not be episodic in nature. Questions remain with regard to how families coped with spousal illness and death, whether they were able to return to a stable existence, and what strategies they might have used to do so. How did social inequality or the presence or absence of social supports affect outcomes? What might have been the emotional and psychological impact of loss upon so many adults and children?

The challenges to family life posed by the epidemic should be integrated into our knowledge of post-World War One reconstruction and Canadian family history.⁸ As historian Cynthia Comacchio has argued, as a result of the crisis of the First World War,

‘the family’ acquired new significance in view of the depleted ‘human stock’ of an underpopulated young nation. The much-heralded return to ‘normalcy’ at war’s end, consequently, would hinge upon a regenerated family that, for all its modern trappings, preserved intact its ‘traditional’ hierarchy defined by gender and age.⁹

⁷ Terence Ranger and Paul Slack, eds., *Epidemics and Ideas: Essays on the Historical Perception of Pestilence* (Cambridge: Cambridge University Press, 1992), p. 3.

⁸ Two recent reviews of family history in Canada are Bettina Bradbury, “Feminist Historians and Family History in Canada in the 1990s,” *Journal of Family History* 25, 3 (July 2000), p. 362-384; Cynthia Comacchio, “‘The History of Us’: Social Science, History, and the Relations of Family in Canada,” *Labour/Le Travail* 46 (Fall 2000), p. 167-220.

⁹ Cynthia Comacchio, *The Infinite Bonds of Family* (Toronto: University of Toronto Press, 1999), p. 66. Nancy Christie similarly argues that the ‘household’ was the focal point of social dislocation arising out of the war. Paul Kellogg of the Canadian Patriotic Fund decried the “unraveling fabric of

The influenza epidemic made the “regenerated family” that much more difficult to achieve, and had important implications for state development and social welfare reform. Fledgling public programs such as the Mothers’ Allowance were suddenly burdened with hundreds of single mothers demanding support. Child welfare reforms, particularly the drive toward de-institutionalization,¹⁰ were complicated if not stymied by the numbers of orphaned children for which to care. The ‘abnormal post-war conditions’ around which conflicts of gender, race and class were focused included, to a much greater degree than has been generally understood, the ramifications of a devastating epidemic upon working class family life.

Historical evidence about working class family life is often difficult to uncover. This chapter relies heavily upon material found in two sets of case files: those of the Manitoba Mothers’ Allowance program, and the Winnipeg Children’s Home (the city’s main Protestant orphanage). These case files are not entirely representative, particularly of the experience of European immigrants, but they do provide rich

family life at home.” Christie, *Engendering the State: Family, Work, and Welfare In Canada* (Toronto: University of Toronto Press, 2000), p. 47. See also Veronica Strong-Boag, *The New Day Recalled: Lives of Girls and Women in English Canada, 1919-1939* (Toronto: Copp Clark Pitman, 1988), p. 81-106.

¹⁰ For the move away from the institutionalization of dependent and delinquent children, see John Bullen, “J.J. Kelso and the ‘New’ Child-savers: The Genesis of the Children’s Aid Movement in Ontario,” in Russell Smandych, Gordon Dodds and Alvin Esau, eds., *Dimensions of Childhood: Essays on the History of Children and Youth in Canada* (Manitoba: Legal Research Institute, 1991), p. 135-138; Tannis Peikoff and Stephen Brickey, “Creating Precious Children and Glorified Mothers: A Theoretical Assessment of the Transformation of Childhood,” in the same volume; P.T. Rooke and R.L. Schnell, “The Rise and Decline of British North American Protestant Orphans’ Homes as Women’s Domain, 1850-1930,” *Atlantis* 7, 2 (1982), and *Discarding the Asylum: From Child Rescue to the Welfare State in English Canada, 1800-1950* (Lanham, MD: University Press of America, 1983), p. 337-387.

evidence documenting the disease experience of working class families.¹¹ Case files are increasingly recognized as a valuable source for uncovering the lives of ordinary people.¹² These records, usually employed to research the history of the welfare state and relations of social power, can also be used slightly differently to investigate historical events like the influenza epidemic. Mothers' Allowance and Children's Home records allow us to follow two broad categories of families affected by the flu. The first is those headed by widows who succeeded in keeping their families together with the financial aid of the state. The second is families in which children had lost one or both parents and had to be institutionalized because of the lack of childcare alternatives. The latter records are particularly interesting for the rare opportunity to learn how widowers coped after the loss of a wife and mother.¹³

The sadness and loss that permeates these stories demands some attempt to interpret the emotional impact of the epidemic, as difficult as it may be to draw firm conclusions. Richard Evans has argued that

because of the severity of their impact, epidemic diseases could seldom be accommodated in the emotional structures by which societies lived, in the way

¹¹ While there are few extant files dealing with influenza widows on the Mothers' Allowance, other files from the period give a broader sense of what living on the allowance was like for mothers and their children. The Children's Home records are much more complete for this period, and include photographs, letters from parents, and case notes. These were a true goldmine.

¹² Franca Iacovetta and Wendy Mitchinson, eds., *On the Case: Explorations in Social History* (Toronto: University of Toronto Press, 1998).

¹³ Cynthia Comacchio's recent historiographical essay on the history of families in Canada points out: "...we still know far more about women's roles in families than we do those of men. ... In a sense, the historiography itself has been built on a 'separate spheres' foundation, perpetuating, even while gamely trying to avoid, the women/home, men/work dichotomies." See "'The History of Us': Social Science, History, and the Relations of Family in Canada," p. 214.

that was possible, for example, with the largest single source of (normal) mortality up to the beginning of the twentieth century, the deaths of infants.¹⁴

Although caution is necessary in applying psycho-analytic theories to the past, such theories may help us to understand the range of psychological responses men, women and children experienced when they lost a member of their immediate family to influenza. The death of a spouse has been described as “the most intense stress experienced in a lifetime.”¹⁵ Since the 1960s, researchers have argued that the bereaved usually experience a “course of normal grief,” which encompasses the following phases: initial shock, perhaps including numbness and detachment; a period of acute pain and grief and social withdrawal; and finally an awareness of coping with change and surviving. More recently, it has been suggested that these phases may not be discrete, but rather that grief is experienced as a “mixture of reactions which wax and wane in relation to outside events” or circumstances.¹⁶ The majority of the bereaved negotiate their grief successfully, and adapt to their changed roles and circumstances. However, several factors can contribute to unresolved grief, including some that seem particularly relevant to the epidemic context. These include lack of social support, current life events interfering with grieving, sudden unanticipated loss, the bereaved being in poor physical health, and the surviving spouse suffering

¹⁴ Richard J. Evans, “Epidemics and Revolutions: Cholera in Nineteenth-century Europe,” in Terence Ranger and Paul Slack, eds., *Epidemics and Ideas: Essays on the Historical Perception of Pestilence* (Cambridge: Cambridge University Press, 1992), p. 150.

¹⁵ Catherine M. Saunders, *Grief: The Mourning After*, 2nd edition (New York: John Wiley and Sons, Inc., 1999), p. 148.

¹⁶ John Archer, *The Nature of Grief: the Evolution and Psychology of Reactions to Loss* (London: Routledge, 1999), p. 25.

substantial financial losses.¹⁷ During the epidemic, social support for the widowed may have been less available since so many families were dealing with their own illnesses, and perhaps deaths. Fear of contagion also may have prevented normal social interaction. Similarly, accustomed mourning and burial rituals, themselves essential for healing, were interrupted. Sudden unexpected death, as in the influenza epidemic, “produces shock that has a debilitating effect on the bereaved” which can last months, and in some cases years.¹⁸ The lack of any opportunity to talk with the spouse about his or her impending death has been found to prolong the grieving process.¹⁹

There are numerous physical symptoms associated with grief, including muscle weakness and fatigue, sleep disturbance, loss of appetite, and a weakened immune system.²⁰ In fact, studies show that the health consequences of being widowed—increased risk of illness and mortality—are extremely significant, and have been “replicated in many different countries of the world and across historical periods.”²¹ Widowers may experience greater risk than widows, perhaps suggesting a less successful adaptation to loss. Poorer health has been shown to affect all classes,

¹⁷ Stephen R. Shuchter and Sidney Zisook, “The Course of Normal Grief,” in Margaret Stroebe, Wolfgang Stroebe, Robert Hansson, eds., *Handbook of Bereavement, Theory, Research, and Intervention* (Cambridge: Cambridge University Press, 1993), p. 23-25. See also Paul C. Rosenblatt, “Grief: The Social Context of Private Feelings” in the same volume.

¹⁸ *Ibid.*, p. 142.

¹⁹ C.M. Parkes, “Determinants of Outcome Following Bereavement,” *Omega* 6(4), 1975, p. 303-323.

²⁰ *Ibid.*, p. 42-43.

²¹ Margaret Stroebe and Wolfgang Stroebe, “The Mortality of Bereavement: A Review,” in Margaret Stroebe, Wolfgang Stroebe, Robert Hansson, eds., *Handbook of Bereavement, Theory, Research, and Intervention*, p. 177.

although some evidence suggests that the lower classes experience greater health risks.²²

How might children have responded? Research suggests that the loss of one or both parents in childhood can have a range of negative effects on children in the short and long term. The grieving process may in some circumstances be difficult for children given their reliance upon adults for guidance in interpreting the sudden death of their mother or father:

... even young children are capable of successful mourning, but ... at any age mourning can take a pathological course in terms of either chronic mourning or the absence of conscious grieving. Children are particularly likely to experience pathological mourning because of their dependence on adults for comfort and information to help them understand the reasons for the loss. Often this support is not forthcoming, perhaps as a result of the surviving parent's own grief, and the child finds it more difficult to accept the fact of the loss.²³

Developmental psychologist John Bowlby identified several relevant intervening factors that may reduce the child's adaptability to the death of a parent, including the inability to attain a secure relationship with the surviving parent, separation from the surviving parent after the loss, and having to look after oneself.²⁴ Michael Rutter has observed that just as important as the lost bond between mother (in particular) and child is the quality of care the child receives after the death of a parent. Institutional care may not necessarily have had a negative effect upon orphans, but if the care

²² Ibid., p. 183-184.

²³ G.W. Brown, T.O. Harris, and A. Bifulco, "Long-Term Effects of Early Loss of Parent," in Michael Rutter et al, eds., *Depression in Young People: Developmental and Clinical Perspectives* (New York: The Guilford Press, 1986), p. 260.

²⁴ John Bowlby, *Attachment and Loss, Vol. 3. Loss: Sadness and Depression* (New York: Basic Books, 1980), p. 311.

received in the institution was poor, childhood development could suffer.²⁵ With stable and secure family relationships before death, and adequate care and attention after, the child can recover from the loss of a parent. In the absence of these conditions, however, children may be more likely not to successfully mourn their father or mother, and withdraw their attachment to the deceased parent.²⁶ The individual may have trouble forming healthy relationships in later life. Indeed, “early, unresolved loss can deplete one’s coping mechanisms, compromising mental health and interfering with appropriate personality development.”²⁷ Lasting effects include depression: women have been shown to be more likely to experience depression in adulthood if they lost their mother to either death or separation before age eleven. This is particularly the case if woman’s “vulnerability” to depression is exacerbated by poverty.²⁸

Of course, theories regarding the nature of grief did not play any significant role in shaping medical care or social services in the early part of the century, and were not part of public debate during or after the influenza epidemic. Freud’s path-breaking *Mourning and Melancholia*, published in 1917, opened the door to new debate and practice. But even today, childhood experiences of grief are under-studied and inadequately understood.²⁹ It seems likely that most children who lost one or both

²⁵ Michael Rutter, *Maternal Deprivation Reassessed* (Harmondsworth, Middlesex: Penguin Books, 1972), p. 64-69.

²⁶ Brown, Harris, and Bifulco, p. 261.

²⁷ Saunders, p. 156.

²⁸ Brown, Harris, and Bifulco, p. 254-256.

²⁹ Saunders, p. 156.

parents to influenza successfully mourned and recovered, suffering no serious psychological effects in adulthood. But it is also quite possible that some children in families such as those whose lives are followed in this chapter were at risk for poor health and psychological outcomes. Those institutionalized in the Children's Home were separated from the surviving parent and probably received insufficient care and attention. Those children who stayed in the Home for only a few weeks or months may not have been seriously affected, but children, particularly the very young, who spent longer periods institutionalized possibly grew up to experience mental health problems and difficulties establishing healthy families of their own. In the case of children in families on the Mothers' Allowance, the impact of the father's death probably varied, depending upon how well the mother coped with her own loss, and how disrupted family life was. The financial strain on single mothers could not have helped either them or their children manage their grief.

Psycho-analytic research emphasizes the importance of social support to successful recovery from loss and grief. As during the phase of illness itself, kin and neighbourhood continued to play a critical role in helping families adapt to the loss of parent or spouse.³⁰ In times of need, residents of working class neighbourhoods did everything they could to help one another with generosity and "an implicit

³⁰ Suzanne Morton has noted the lack of attention to widows and female-lead households in Canadian history. The exceptions are her own *Ideal Surroundings: Domestic Life in a Working-Class Suburb in the 1920s* (Toronto: University of Toronto Press, 1995), p. 88-107, and "Women on Their Own: Single Mothers in Working-Class Halifax in the 1920s," *Acadiensis* 21, 2(Spring 1992); Bettina Bradbury, *Working Families: Daily Survival in Industrializing Montreal* (Toronto: McClelland and Stewart, 1993), and "Surviving as a Widow in 19th Century Montreal," *Urban History Review* 17, 3 (1989); Veronica Strong-Boag, *The New Day Recalled*, p. 179-208.

assumption of community reciprocity.”³¹ The first and most important source of assistance was the family network. The closeness among kin in the working classes of this period would have been of great benefit to influenza survivors. Relatives could take in widows and children.³² Friends and neighbours might also pitch in to help a widow or widower financially or with domestic responsibilities. But even within closely knit working class communities, there were limits upon what could be asked of those outside of the family. According to historian Wally Seccombe:

... kin, friends and neighbours were none the less three distinct groups of people, to be treated with appropriate levels of intimacy and trust. ... The elderly woman next door might be asked to mind a child for an hour, but Mum was called upon if the mother of a young child was planning to be away for the day. Cups of sugar were readily passed over the back fence, but money loan was more discreetly obtained from a close friend or relative. Such distinctions might be blurred somewhat in emergencies ... but they were never effaced.³³

In the short term, over the course of days or weeks, family, union, and ethnic community provided effective assistance for many.³⁴ But greater difficulty was encountered in the longer term, when kin and mutual assistance could not necessarily guarantee the level of support needed.³⁵ Some families were in a better position to adapt to changed circumstances than others. In some cases, particularly in an

³¹Wally Seccombe, *Weathering the Storm: Working Class Families From the Industrial Revolution to the Fertility Decline* (London: Verso, 1995), p. 140.

³² Morton, *Ideal Surroundings*, p. 97; Beverly Stadum, *Poor Women and Their Families: Hard Working Charity Cases* (New York: SUNY Press, 1992), p. 21.

³³ Seccombe, p. 139.

³⁴ See Chapter 5 for some of these shorter-term family and community networks.

³⁵ Goodwin, p. 13.

immigrant city like Winnipeg, there simply was no extended family nearby to help. Strategies for 'getting by' were more limited if children were too young to earn wages and help a widow keep her family together.³⁶ Widowers might have difficulty arranging for family or neighbours to care for their children while they worked. In some cases, the only recourse was charity or public relief, although working class families avoided these whenever possible.³⁷ As Suzanne Morton has noted, refusing charity was consistent with the values of working class respectability, privacy, and independence.³⁸ Even given the courage, flexibility, and adaptability of individual widows and widowers, however, there were many families whose choices were limited in the aftermath of the epidemic.

No Canadian government at any level made special social welfare provisions for "epidemic widows" or widowers.³⁹ Influenza victims who lost the income of a male spouse, or the domestic labour of a wife, were at the mercy of the same social welfare framework as were any of the city's poor. No distinction was made for the extraordinary circumstances of the epidemic, and there was no recognition of common social or public responsibility for the families of disease victims. This simple reality perhaps most clearly reveals prevalent attitudes regarding infectious disease: that illness was an issue of personal moral responsibility (or failure).

³⁶ For a useful debate with regard to the limits on working class survival strategies see "Family Strategy: A Dialogue," *Historical Methods* 20, 3 (1987), p. 113-125.

³⁷ Joanne Goodwin, *Gender and the Politics of Welfare Reform: Mothers' Pensions in Chicago, 1911-1929* (Chicago: University of Chicago Press, 1997), p. 13.

³⁸ Morton, p. 93.

³⁹ This was not the case everywhere. In New Zealand, for example, "epidemic widows were granted special pensions," according to Geoffrey Rice, *op cit*, p. 172.

Winnipeg's overtaxed and meager social welfare networks had to take up the burden of broken families. Municipal relief—the City of Winnipeg's Social Welfare Commission (SWC)—supported one hundred and seventy-eight families affected by the flu in November 1918 (out of a total case-load of 538). In about one-half of these cases, the Commission provided free graves and burials to families who could not afford sky-rocketing funeral costs.⁴⁰ Early in the epidemic, SWC officials had decided, in consultation with the city's medical officer of health, to provide relief without thoroughly investigating the client, although material relief would only be given where a requisition was provided by a health department official, a doctor or a nurse.⁴¹ About one hundred and twenty families were supported in December and January, and ninety in February. The records do not tell us much about their situations,⁴² except that in February 1919 the Commission had 21 widows affected by influenza under its care, only fifty percent of whom were eligible for the province's new Mother's Allowance program.

Created in 1916, Manitoba's Mothers' Allowance program was the first in Canada. In June 1918, there were 119 families receiving benefits. The total cost to the province for the previous year was \$81,285.⁴³ Like mothers' allowances in other provinces, eligibility criteria were strict, limiting the program to widows with at least two children, and women whose husbands were in an insane asylum. Widows had to

⁴⁰ See Chapter 4 for a full discussion of the controversy over funeral expenses.

⁴¹ CWA, Social Welfare Commission Monthly Report, October 1918, Council Correspondence 11647.

⁴² No case files from the SWC appear to have survived.

⁴³ PAM, GR 174 OS179-3, Sessional Papers No. 5, "2nd Annual Reports of the Manitoba Mothers' Allowance Commission for Period Ending June 30, 1918."

present documentation demonstrating their eligibility, including marriage and death certificates and proof of citizenship for naturalized immigrants.⁴⁴ According to Mothers' Allowance regulations, only widows whose husbands were either British- or Canadian-born or naturalized Canadians were eligible for assistance. In addition to the exclusion of non-British immigrants, program regulations further discriminated by sex: the citizenship of the woman's husband (not her own citizenship) defined eligibility. Applications, regardless of the urgency of the widow's need for aid, were regularly delayed if all required documents did not accompany the application.⁴⁵

Thus, not only did the program exclude the 'unsuitable' unmarried mother with illegitimate children, but it also denied support to the many non-British immigrant widows in Winnipeg whose husbands had not naturalized.⁴⁶ The denial of benefits to European immigrant families reflected prevalent Anglo-Canadian concerns over the declining dominance in the population of those of British ancestry. By the end of the First World War in Western Canada fears of 'race suicide' and the 'alien enemy'

⁴⁴ For analysis of Mother's Allowance programs in Ontario and British Columbia see Margaret Jane Hillyard Little, *No Car, No Radio, No Liquor Permit: the Moral Regulation of Single Mothers in Ontario, 1920-1997* (Toronto: Oxford University Press, 1998), and "Claiming a Unique Place: The Introduction of Mothers' Pensions in British Columbia," in Veronica Strong-Boag and Anita Clair Fellman, *Rethinking Canada: The Promise of Women's History*, 3rd edition (Toronto: Oxford University Press, 1997); Megan Davies, "'Services Rendered, Rearing Children for the State': Mothers' Pensions in British Columbia, 1919-1931," in Barbara Latham and Roberta Pazdro, eds., *Not Just Pin Money: Selected Essays on the History of Women's Work in British Columbia* (Victoria: Camosum College Press, 1984).

⁴⁵ PAM, GR174, Mothers' Allowance Act, "A Memorandum prepared by the Commissioners for the guidance of committees appointed by the Cities, Towns, and Rural Municipalities to assist in the administration of the Act," January 1919.

⁴⁶ Exclusion on the basis of ethnicity was also common in American mothers' pensions, many of which were created a few years earlier than the Canadian programs. See Goodwin, p. 162-164; Molly Ladd-Taylor, *Women, Child Welfare, and the State, 1890-1930* (Chicago: University of Illinois Press, 1995) p. 148-151.

were strongly influencing public policy.⁴⁷ Reform movements in education and public health, such as the mental hygiene movement, viewed immigrant parents and children as deficient and were skeptical about their capacity to become good Canadian citizens.⁴⁸ The mothering skills and practices of immigrant women had become the particular target of criticism from public health reformers.

Ethnic discrimination shielded the provincial government from the full cost of a universal mothers' pension program, and allowed it to pass the problem down to municipal welfare officials. Mothers' Allowance was a cost-shared program with municipalities. However, fewer than one-quarter of the widows supported by the SWC fit the Commission's criteria for Mothers' Allowance, which gives a good indication of how many poor immigrant widows in the city were denied benefits. One half of the influenza widows supported by the SWC in February 1919 were ineligible for Mothers' Allowance because their husbands had not been naturalized. Not surprisingly, the eligibility restriction was opposed by municipal relief officials. The SWC noted in its reports to City Council that "one thing is certain – that a policy of 'Exclusion' will achieve nothing – the solving of the problem calls for co-operative effort."⁴⁹

To be sure, some eligibility restrictions were equally disliked by Commission members, who regularly appealed for greater inclusivity in their annual reports to the Legislature. Commissioners argued that the original legislation establishing the program had allowed for a broader scope, but that orders-in-council had limited the

⁴⁷ Neil Sutherland, *Children in English-Canadian Society: Framing the Twentieth-Century Consensus* (Toronto: University of Toronto Press, 1978), p. 210-211.

⁴⁸ *Ibid.*, p. 73.

⁴⁹ CWA, Social Welfare Commission Monthly Report, February 1919, Council Correspondence 11788.

role of the program. The 1918 report recommended reversing the order-in-council that excluded widows whose husbands were not naturalized at death. "During the year a woman by birth a British citizen, but who had married a United States citizen, had to be refused on this account." Such a palatable example (which did not make explicit the coverage of European immigrant widows) may have been used strategically to bring about a change which would nevertheless have benefited many widows of non-British backgrounds. At a joint meeting of the provincial Commissioners and the Winnipeg Mothers' Allowance committee in February 1918, the two groups agreed that the Act should be amended so that any children born in Canada would be eligible to receive benefits, regardless of whether either parent was a naturalized citizen.⁵⁰ There is no evidence that this position—which would have shifted the focus of the program toward providing relief for children, not mothers—was ever formally advanced to the Minister, or the government.

Commissioners also opposed the government's refusal to cover women whose husbands were still alive, but suffering from tuberculosis. As they argued, proper care and nourishment were an important aspect of tuberculosis prevention in these families. Early in 1920, the Commission furthered argued for aid to women whose husbands were disabled or in jail.⁵¹ The government regularly rejected these arguments for extending relief, citing a lack of funds.⁵² Indeed, as Goodwin has argued for the Chicago case, fiscal restraint may have been a more important factor in

⁵⁰ PAM, GR 3730, Box 8, Mothers' Allowance Commission Minutes, February 27, 1918.

⁵¹ PAM, GR 174 92-8, Sessional Paper #25, 3rd Annual Reports of the Manitoba Mothers' Allowance Commission, January 1920.

⁵² PAM, GR 174 OS179-3, Sessional Papers No. 5, 2nd Annual Reports of the Manitoba Mothers' Allowance Commission for Period Ending June 30, 1918.

limiting eligibility for Mothers' Allowance in Canada than historians have generally acknowledged.⁵³

Despite the government's attempts to limit the scope and fiscal resources of the Mothers' Allowance Commission, the influenza epidemic significantly expanded the number of widows receiving aid and, consequently, the cost of the program. Widows' pension programs were not created in anticipation of them playing a critical role in a health crisis. Yet, in this unforeseen scenario, the Mothers' Allowance program helped over one hundred working class families to survive and remain a family unit. Many influenza widows perfectly fit the criteria of the program, and could not be denied benefits. As of November 1919, the Commission was supporting 116 families where the husband's cause of death was influenza; this constituted nearly one-third of the 413 widows on the allowance. This number increased slightly to 131 for the year ending November 1920. The fiscal implications for the state of supporting widows of the flu were immediate and significant. The overall number of families receiving benefits more than doubled between June 1918 and November 1919.⁵⁴ The cost of allowances had also risen by over thirty percent, to accommodate increasing prices for food and rent. These factors together led to a large rise in the cost of the program. At its December 1918 meetings, the Commission was to prepare its proposed 1918-1919 budgetary appropriations. At the beginning of the month, when the full impact of the epidemic was only just beginning to be absorbed, the Commissioners believed that an increase from \$90,000 to \$150,000 would cover projected costs, including that

⁵³ Goodwin, p. 189.

⁵⁴ It is interesting to note that Goodwin finds similar increases in cases in Chicago. (33% in 1919 and 25% in 1920) She does not note, however, the impact of the influenza epidemic.

of covering the wives of 'incurably tubercular' men. By later in the month, this figure had been dramatically adjusted upward to \$200,000. In its January 1920 report, the Commission requested a budgetary allocation of at least \$300,000.⁵⁵

Thus, the Mothers' Allowance, in the earliest years of its existence, played a critical role in supporting women and children affected by the epidemic. Given the severe impact of the disease in Winnipeg's immigrant north end, the benefit of the program to influenza survivors would have been that much more fully felt had benefits been extended to widows of non-naturalized husbands. Even within a framework of limited eligibility, however, the provision of benefits to flu widows demonstrated the importance of the allowance in a way that was entirely unanticipated by government and social reformers, and presented significant new challenges to the administration and the fiscal sustainability of the program.

Data compiled by the Commission give a good overall view of who the widows were. Age profiles indicate the largest number of women were between 35 and 39 when applying for the allowance in 1919, as were their deceased spouses. Seventy percent of the deceased men were between the ages of 30 and 44, and they left behind widows mostly within this age range, although slightly younger on average. Four of every five of these men could be categorized as working class or possibly lower middle class; they were labourers (30%), tradesmen (40%), or clerks (10%). Only a small number of deceased spouses were business or professional men, and about 13 percent were farmers. The majority of these families, like most in the working class, did not own their own homes, but over one-third had managed to purchase either a

⁵⁵PAM, GR 174 92-8, Sessional Paper #25, 3rd Annual Reports of the Manitoba Mothers' Allowance Commission, January 1920.

mortgaged house, or to own one outright. Records also indicate that over one hundred applicants in 1919 owned either a farm or homestead, but most probably did not live on or earn their living from this property, given that only fifty-five applicants indicated that their spouses had been farmers.

The rules of the Mothers' Allowance program demanded that women essentially exhaust all of their financial resources before applying for relief, since allowances would not be granted to women with over \$200 cash assets. Some were fortunate enough to have life insurance or other sources of cash, and, despite the rules, applied for an allowance before they had entirely spent their savings on daily survival. In the early years of the program, these women were turned down, but a change in policy in 1919 strongly suggests that women protested the forced dependency and destitution, and resulting downward economic mobility, inherent in the state's approach to widows' support. That year, the rules of eligibility were changed "to accede to the necessity for conserving the self-respect and thrift of families applying for an allowance." Widows were now allowed to deposit in the government treasury cash or other financial assets above \$200. This change came with a price, however, as the state retained legal and financial control over widows' assets. Furthermore, the state used these assets (earning interest in the government's own treasury) to defray the cost of their program, by applying any interest accrued to the woman's allowance. Only the principal was returned to her, when she was no longer receiving aid.⁵⁶

In 1919, this change in policy with regard to assets was relevant to only a minority of women; most were entirely without resources when they sought relief from the Commission. The poverty of these widows and their families is further

⁵⁶ Ibid.

demonstrated by the fact that one-third of them were already surviving only with the aid of municipal public assistance at the time of application. Women depleted meager savings and exercised thrift, they worked for wages 'outside' and in their homes, and their children may also have worked; but these efforts were not enough to stave off dependency. Many relied upon the financial support of relatives or friends. Indeed, the Mothers' Allowance policy demanded that extended family contribute as much as they were able, and families were contacted to ensure that everyone was doing their part. This included adolescent children. After the age of fourteen, children of widows were expected to work for wages, and only rarely would benefits be granted to support these children while they furthered their schooling. Thus were the children of working class widows channeled into the future ranks of labouring people. The overwhelming majority of children receiving aid was, however, under age fourteen.

From this information we can see the hardships confronting the widows of influenza victims. Mothers who were able to access Mothers' Allowance benefits were probably among the most fortunate, although they traded their independence for state support and intrusion into their lives, as we shall see. Many others were excluded: immigrant mothers, or those who married unnaturalized immigrants; those who could not prove a legally sanctioned marriage; and those who had only one child to support. There were undoubtedly many others unaware of their entitlement to assistance, or unwilling to endure the investigation and regulation of their family life who struggled on their own earnings, with family or church help, or periodic support from other private and public agencies.

Mothers' Allowance benefits were meagre, and calculated down to the penny by Commission staff. The administrators allowed for little more than survival, as we can

see from the support given to Margaret Henry,⁵⁷ whose husband had died of influenza in November 1918, at age thirty-one. He was an asbestos worker, and their family income prior to his death is unknown. Margaret, who was twenty-six, had three children ages five, one and a half, and nine months when she applied for benefits days after her husband died. The oldest of these children, a girl, was born before her marriage, as a result of an affair with a married policeman. Margaret, an immigrant from Sweden, had little formal education, having left school at age twelve, but she was an experienced lay midwife.⁵⁸

After waiting for over a month, Margaret was granted support of \$53.90 per month by the Commission, based upon \$14 rent, \$4 heat, \$.50 light, \$.80 water, \$1.10 cleaning supplies, \$21 food, \$.50 carfare, and \$11 for the clothing needs of the family. The allowance for rent was not, in her opinion, sufficient to obtain a reasonable house in Winnipeg. At the end of August 1920, Margaret wrote to the Commission asking permission to remain at Winnipeg Beach (where she had family) for the winter. "Here at the Beach I can obtain a warm house at a reasonable rental also I can get fuel at a much cheaper price than in the city," she wrote to her case worker. She was given approval for this plan. But the cost of housing and the inadequacy of the allowance continued to be an issue for Margaret, and she and her family often spent the summer months in the early 1920s living in a tent near Winnipeg Beach, near her father and brothers, who were commercial fishermen.

As her children grew older, Margaret Henry became dissatisfied with the limits and rules of the program. According to the notes of her caseworkers, she was

⁵⁷ The names of allowance recipients have been changed to protect family privacy.

⁵⁸ PAM, GR 3730, Mothers' Allowance Commission Case Files, Box 18, File 296.

increasingly restive and determined to gain her independence from the Commission. This was, however, difficult to do in Winnipeg Beach, where there were few job opportunities. It was not the Commission's official policy to help women find work to become self-supporting. In fact, guidelines published in 1919 to assist municipal Commissioners in implementing the program emphasized the mother's domesticity, particularly when children were of pre-school age: in this case, they "must not be encouraged to work out by the day." Another influenza widow, Beatrice Cameron, whose husband died on November 3 while working in Moose Jaw as a railway brakeman, was given an allowance of \$86.40 on the condition that she give up her job cleaning at night. The youngest of her five children was five, the eldest a fourteen-year old boy, and thus they could have managed while their mother worked. This was what Mrs. Cameron herself wanted; she also wished to take in a couple of boarders, which was against Commission policy.⁵⁹

But a policy against recipients' wage earning was not consistently applied. The Manitoba experience seems to support the arguments made by United States' historians Molly Ladd-Taylor and Joanne Goodwin that mothers' pensions never fully supplanted wage earning by widows, and did not pay mothers to stay home and raise their children.⁶⁰ In fact, it was very difficult to survive on only the allowance, and widows and their children worked because of the inadequacy of support, not only out of a desire for independence. Fiscal pressures, significantly increased by the impact of the flu, also encouraged a shift in the state's attitude toward women working. In 1922 (when her youngest child was four years old) Margaret's caseworker made inquiries

⁵⁹ PAM, GR 3730, Mothers' Allowance Commission Case Files, Box 13, File 297.

⁶⁰ Goodwin; Ladd-Taylor.

on her behalf at the Nurses' Registry, to see if any practical nursing work could be found in Winnipeg. Here, however, the credentialism of organized nursing worked against Margaret; the Victorian Order of Nurses agreed to take her on, but only as a "mother's helper," not as a nurse. Prior to the professionalization of nursing and teaching, married and widowed women would have had greater access to this type of paid work.⁶¹

"Mother's helper" was hardly lucrative or enjoyable work. Margaret's first case, taken on in March 1923, was a woman "very difficult to get along with," the caseworker noted in her file. She was paid only \$2 per day, and had to stay overnight. Most of her earnings went to paying childcare for the nighttime. Even without childcare expenses, this income would have been entirely inadequate, as the family's rent alone was \$25 per month. In any case, her relationship with the VON did not last, because her difficult client complained to the organization, which accepted the client's view apparently without interviewing Margaret. She was let go.

Restricted to domestic work, Margaret's options were extremely limited. This reality did not seem to concern the Commission, which continued to facilitate low-paying domestic work for Margaret, but did not use its resources or authority to secure for her more useful work opportunities or further training. Consider, for example, this letter to Margaret's caseworker, which appears in her file, demonstrating the willingness of the Commission to help middle and upper class Winnipeg women find cheap domestic labour:

I am needing a woman to help me with a day's housecleaning on Wednesday of next week. Mrs. X says some of the Mothers' Allowance widows would be

⁶¹ Professionalization thus added to the difficulty of self-support for widows. See Ida Blom, "The History of Widowhood: a Bibliographic Overview," *Journal of Family History* 16(2), 1991, p. 200.

glad of work. Could you recommend one you think would be satisfactory? If she suits me, I should like to have her every Friday morning from nine to twelve.⁶²

The caseworker did in fact contact Margaret offering her this chance at domestic employment. She may not have taken work in this particular household, but her situation in general is illustrated by another letter, written by her then current employer:

[Mrs. Henry] seems to find it pretty hard with her three growing children to make ends meet, and although willing to augment her allowance by working out does not have much opportunity of doing so. I have had [her] as a day worker for a considerable time and have found her most dependable. She is a thorough and conscientious worker, very trustworthy, can cook pretty well and is exceedingly good with children.⁶³

Margaret struggled through the 1920s, working at various domestic jobs, moving often, and constantly finding it difficult to afford clothing and shoes for her children. Her health declined, but this did not prevent her caseworkers from regularly criticizing her standards of cleanliness, or for allowing the children to keep pets. The Commission also pressured her to find cheaper housing for her family, refusing to allow her a rental allowance above \$20.00. She resisted this treatment, as noted by her caseworker in the spring of 1924: "M. knows the amount of allowance some others are getting and is feeling rebellious." In the end, Margaret's escape from this life came through a common-law relationship with a young railroad brakeman, with whom she lived and had two children.

⁶² PAM, GR 3730, Mothers' Allowance Commission Case Files, Box 18, File 296, letter dated May 20, 1925.

⁶³ PAM, GR 3730, Mothers' Allowance Commission Case Files, Box 18, File 296, letter dated April 20, 1925.

Given women's low wages and difficulties finding childcare to allow them to work, re-marriage may have been the best option for widows. Few women on the allowance—twenty out of 413 recipients in 1919—remarried, however.⁶⁴ Mother's Allowance widows were to remain trapped in working class poverty by their lack of skills, experience, education, and child care support. Whatever the intentions of the program, a similar fate seems to have followed their children. Mrs. Cameron's eldest son, fourteen in 1918 when the family was put on the Allowance, was supposed to leave school after completing grade six that year in order to find work to support himself, his mother and siblings. Even though the family's benefits were reduced, Mrs. Cameron kept Andrew in school, "anxious that the children should receive a good education," according to her caseworker. It was the boy's dream to take a course at the Agricultural College and to learn to farm, although (perhaps at his mother's urging) he took classes in electrical engineering, woodturning, and forging as part of his grade nine education. By summer 1920, however, Andrew was out of school, and was working as a messenger at Eaton's, earning \$12 per week. In May, the caseworker wrote to Andrew directly, outlining the Commission's view on his future plans and responsibility to his family:

It would be well to ascertain what a boy your age could earn on a farm this summer, because if your Uncle is agreeable, it would be satisfactory to be earning regular money, as earning children are supposed to contribute to mother's [sic] who are receiving an allowance. ... This amount supplied by the child is deducted from the amount the Mothers' Allowances gives to the mother. I explained this to your mother but thought you would like to know

⁶⁴ PAM, GR 174 92-8, Sessional Paper #25, Third Annual Reports of the Manitoba Mothers' Allowances Commission, January 1920. Widows were much likely to re-marry than widowers, particularly if they had young children. Ida Blom, p. 193-194.

too, as it should be the aim of every family to gradually become self-supporting as the children grow older and commence to work.⁶⁵

The letter concludes by urging the boy to learn a trade. Andrew did not receive the education he and his mother hoped for. He worked as a farm labourer and was only occasionally able to send money to his mother after he left home.

Helen Johnson was thirty-seven years old, with five children aged nine and under, when her husband died of influenza on December 6, 1918.⁶⁶ She applied for Mothers' Allowance only a week later, with the help of the new labour alderman W.B. Simpson, who had contacted the Commission on Helen's behalf immediately after the death of her husband. She and all of her children were also infected with influenza, and Helen was particularly weak, as she had given birth prematurely while suffering from the flu. While her baby survived, the family's illnesses left her with outstanding doctor's bills.

Helen's application for assistance was delayed until the end of December because the investigator at the Commission was herself ill with influenza. In the meantime, the family got by with the help of the Typographical Union, of which Helen's husband had been a member. The union had paid the \$200 funeral bill, and given Helen an additional \$175 in death benefits. With no hope of future income, however, Helen was "right up against it," as one of the required character references noted. Helen's husband had earned \$29 per week as a printer, and she had apparently stretched this salary far, creating a welcoming home downtown, "very tidy and clean, and very nicely furnished," according to the caseworker. On the allowance, the

⁶⁵ PAM, GR 3730, Mothers' Allowance Commission Case Files, Box 13, File 297, letter dated May 7, 1920.

⁶⁶ Helen's story can be found in PAM, GR 3730, Mothers' Allowance Case Files, Box 13, File 300.

family's income dropped by over one-third, moving them into the ranks of the unskilled and poverty-stricken working class. Helen resisted this downward mobility with all her considerable personal resources. In spring 1919, her caseworker found her wallpapering and laying flooring:

She has got a special price on some inlaid linoleum which was slightly damaged and was putting it on her kitchen floor. She has her home fixed up very cosy. The baby is growing splendidly and all the children are well.⁶⁷

In these first months, Helen perfectly fit the role of worthy mother from the Commission's point of view, and her caseworker's reports weave a sympathetic "tale of protection."⁶⁸ These describe a well-kept home, healthy children, and her eldest child (a step-son, from her husband's first marriage) doing well at school. Despite all of Helen's efforts, her family's well being did not last. Sometime in late 1919, her two-year old son developed scarlet fever, and spent several months in hospital. Helen's own health was poor after she developed a serious cold with bronchial complications in December. Then suddenly the eldest boy died in May 1920.⁶⁹ Helen was grief-stricken, but also angry about the medical treatment given her children, according to caseworker records:

May 19, 1920: third child in poor condition. Dr. Morton advises removal of tonsils. When [visitor] suggested taking the child to Children's Hospital for operation M. grew somewhat indignant. Said a great deal about inadequate

⁶⁷ PAM, GR 3730, Mothers' Allowance Case Files, Box 13, File 300, Caseworker notes, June 17, 1919.

⁶⁸ Karen W. Tice, *Tales of Wayward Girls and Immoral Women: Case Records and the Professionalization of Social Work* (Chicago: University of Illinois Press, 1998), Ch. 5, "Tales of Protection: Personal Appeals and Professional Friendship."

⁶⁹ The cause of his death is not noted in the records. It may have been scarlet fever, but he had been immunized for the disease in January.

treatment supplied by [Mothers' Allowance] in case of sickness. Now after losing one child M. insists on having best treatment obtainable for any others who take sick. M. has \$200 (amount allowed) in the bank and intends using as much of it as necessary.⁷⁰

Mothers' Allowance budgets did not allow for any private physician's expenses. Families were expected, like others without income to purchase health care, to attend the Winnipeg General or Children's Hospital outpatient clinics, and to be hospitalized as public ward patients. Helen clearly believed that inadequate medical attention on the public ward had contributed to the death of her older son, and was willing to spend her own small savings to pay a doctor of her choice to care for her surviving children, even if this meant the disapproval of the Commission. She sought out her own physician when her third eldest needed his tonsils removed; after the surgery, he was attended at home by the family physician. Over the next two years, Helen and all her children experienced persistent health problems and she continued to find ways to pay for private medical care. The Commission recognized that poverty may have played a part in the poor health of this family, by granting a special \$5 per month allowance in 1921 to help Helen afford more nourishing food, albeit only at the written request of a physician. In general, the Commission took no responsibility for any relation between its inadequate benefits and illness. By 1923, the youngest child, who was born during the epidemic, had developed tuberculosis.

Helen Johnson's determination to provide a comfortable home and to ensure that her children received quality medical care, and her defiant opposition to Commission policies, demonstrate remarkable strength in the face of personal tragedy. She did not believe that her financial dependence upon the state meant foregoing her autonomy to

⁷⁰ PAM, GR 3730, Mothers' Allowance Case Files, Box 13, File 300, Caseworker notes, May 19, 1920.

make decisions and to act in the best interests of her children. Helen's allowance was cancelled in January 1933, when she had only one child under the age of fifteen. Letters in her file indicate that her sons were then forced to apply for relief. Like Margaret, Helen had endured years of poverty on the Mothers' Allowance when her children were young, and had no opportunity to become self-supporting. After having performed her function as a mother to her children, the Commission no longer considered itself responsible for her, and it is likely that she faced, if anything, even greater destitution in her old age.

It is impossible to ignore how deeply inscribed by illness and disease were the lives of these families. Helen's husband's death from influenza destroyed the basis of a demanding, but still reasonably comfortable working class life, and the poverty she and her family endured on government benefits contributed to ongoing struggles with disease, death, grief, and fear. Historians interested in mothers' pensions have rarely commented on what precipitated applications for assistance, and it therefore remains poorly appreciated that in the early years of the Mothers' Allowance program, seventy to eighty-five percent of widows' spouses had died of diseases including influenza, tuberculosis, heart disease, cancer and pneumonia.⁷¹ Eight of every ten of these men were under age forty-five. Illness appears to have dogged these families. The experiences of widows on the program demonstrate the clear linkages between disease and poverty that, in the post-World War One period, shaped and were shaped by relationships of class, gender, and ethnicity.

⁷¹ PAM, GR 174, Mothers' Allowance Commission Annual Report, January 1920. Six disease categories are listed as causes of death in 279 of 413 cases. An additional 73 deaths are listed as "miscellaneous". These may also have been disease-related. Accidents, suicide, and murder are categorized separately, totaling 47 deaths.

Influenza widows who received Mothers' Allowance would have been better off than many. In the case records of Michelina Sereduk, there are some glimpses into what fate awaited those excluded from receiving benefits.⁷² Mrs. Sereduk's husband died of influenza on November 6, 1918, but his health had for several years been so poor that he was seldom able to work. This couple, originally from Poland, struggled from the time of their arrival in Canada in 1909. He was an unskilled labourer, and could neither read nor write. The family had managed to survive on the small earnings of Michelina and the children (of whom there were five surviving at the time of the husband's death), with occasional charitable and municipal aid. Because her husband had never sought naturalization as a Canadian, Michelina and the children were not eligible to receive the Mothers' Allowance when he died during the epidemic.

After her husband's death, Mrs. Sereduk was sexually assaulted by her brother-in-law, and bore a daughter. She took the initiative and charged him in court, but he skipped bail and returned to Austria. The court awarded her the bail money (\$100), which she saved and lived on for as long as possible. Between 1918 and 1924, Michelina and her children were supported by the Social Welfare Commission. Little information is available about the events of those years, but records do suggest that theirs was considered a problem case by welfare officials. In 1921 the Social Welfare Commission sent her and her two sons to the Winnipeg Psychopathic Hospital for intelligence testing. The doctor's report on Michelina concluded:

It was very difficult to definitely establish her mental status on account of her lack of knowledge of English. As nearly as could be ascertained she is definitely backward mentally and probably belongs in the class of Morons.

⁷² PAM, GR 3730, Mothers' Allowance Case Files, Box 15, File 1324.

And with regard to her older son, aged twelve:

... he has the mental age of 8 1/2 years and an intelligence coefficient of .67. He is very considerably retarded mentally, and, in fact will probably be an institutional case. ... Grade three no doubt represents the top limit of his ability.

Evaluations like this physician's were consistent with the racialized discourse of the mental hygiene and eugenics movements, which argued that immigrants were over-represented among the "feeble-minded" and the medically and morally "unfit."⁷³ The supposed heredity of feeble-mindedness was considered an important threat to racial quality in Canada. Groups such as the Canadian National Committee for Mental Hygiene, the National Council of Women, and the Canadian Council on Child Welfare lobbied governments for the careful exclusion of mentally defective immigrants from entering Canada, and advocated measures such as the inspection of school children, the segregation of inferior from normal children, institutionalization, and forced sterilization. "Mental deficiency" was also linked to juvenile delinquency, prostitution, and pauperism.⁷⁴

Not everyone with whom Mrs. Sereduk came into contact, however, had such negative views of her family or her abilities as a mother. The SWC testified to her

⁷³ Mariana Valverde, *The Age of Light, Soap, and Water: Moral Reform in English Canada, 1885-1925* (Toronto: McClelland and Stewart, 1991), p. 108; Cynthia Comacchio, *The Infinite Bonds of Family* (Toronto: University of Toronto Press, 1999), p. 58-59; Angus McLaren, *Our Own Master Race: Eugenics in Canada 1885-1945* (Toronto: McClelland and Stewart, 1990), p. 46-67. The 1920's was the heyday of Charlotte Whitton's campaign against the admittance of 'feeble-minded' immigrants and their children.

⁷⁴ The Canadian National Committee for Mental Hygiene was founded in 1918. Neil Sutherland, *Children in English-Canadian Society: Framing the Twentieth-Century Consensus* (Toronto: University of Toronto Press, 1978), p. 71-78.

worthiness as a candidate for Mothers' Allowance, stating: "we have never known her to complain ... As a mother she is very kind and faithful [she] is dependable in every way." By 1924, the Mothers' Allowance Commission regulations had changed to allow naturalized widows to apply for aid, and Mrs. Sereduk was encouraged to become naturalized and apply for the Allowance. In support of her application, and perhaps hoping to head off her disqualification because of her youngest (illegitimate) daughter, the SWC agent noted:

The only fault we have ever had with this mother is her illegitimate child but I am convinced that Mrs. Sereduk's story about the way it happened is true and feel that she deserves sympathy and consideration as she has suffered a lot in the result of this misfortune.⁷⁵

The family was awarded Mothers' Allowance benefits of \$66 per month (plus winter fuel allowance) in spring 1924. The years of severe deprivation living on SWC benefits had, however, taken their toll on Michelina. Described as "small and frail," she had developed chronic bronchitis, then tuberculosis, of which she would die in 1928. She was, nevertheless, noted as a good housekeeper, her home characterized as "exceptionally clean, splendidly kept no matter when one would come into the house." This was quite an accomplishment, given that her housing situation in 1924 was obviously inadequate. The family of five lived in three rooms on the main floor of a frame house in the north end, and the building was "infested with vermin," the investigator noted. Mrs. Sereduk did not wish to move, however, despite the pressures of the Commission, which viewed the neighbourhood as "most undesirable and

⁷⁵ PAM, GR3730, Box 15, Mothers' Allowance Case Files, File 1324, Letter from Social Welfare Commission, February 11, 1924.

unwholesome for the children." With her grown daughters living close enough to help out, she had good reason for tolerating cramped and infested rooms.

The difficult conditions facing this extended family seem only to have deepened through the 1920s and into the Depression, when the surviving children and their families were forced onto relief. By late 1926, Mrs. Sereduk was seriously ill with tuberculosis, but resisted medical treatment at the General Hospital outpatient clinic. According to her file, she feared that the doctors at the General would insist upon her being admitted to the King George infectious diseases hospital, which she did not want. There is no record of her being hospitalized before her death. After Michelina's death, care of the children was taken over by one of the married daughters, who continued to receive some money from the Commission for this purpose.

Mothers' Allowance recipients represent a significant minority of influenza widows in Winnipeg. Their lives demonstrate that long after the events of the epidemic had faded from public attention, families continued to struggle with its consequences. Widows and their children took full advantage of the financial advantages the program afforded them, but often resisted its restrictive policies and ignored the interference of the social workers and medical professionals upon whom they relied for continued support. The Allowance provided, in return for surveillance and the loss of personal autonomy, a stable income, even if it was inadequate. If the relationship between caseworker and widow was friendly, social support could be part of the equation. While the Allowance was not the only way female-led families survived the impact of the epidemic, it seems to have been a viable option for many working class widows.

The situation of influenza widowers was different. Earning higher wages, men were generally better able to provide for their children, and in a better position to purchase the household services and childcare needed to keep the family functioning. Men were also much more likely to remarry after the death of a spouse, thereby replacing the needed female labour in the household. However, the loss of a mother, particularly in the first year of life, had a more negative impact upon the survival rates of children than did the loss of a father. In the early twentieth century, infants whose mothers died could be as much as four times more likely to die in the first year of life.⁷⁶ Studies have shown that there are several ways in which the death of a mother could jeopardize the well being of children. These ways are related to the primary caregiving role of women, and to their close ties to their children. Historical demographers have argued that children may experience “negative change in care giving when they are sick, have more responsibility for household chores, have their meals served at a less regular time, and often find themselves in unkempt homes” after the loss of a mother.⁷⁷ Because of the power of gendered roles in the family, men may have found the adjustment to domestic work and childcare difficult to make; some studies also suggest that men may have found coping with their own and their children’s grief more difficult.⁷⁸ Children were also less likely to be close to their

⁷⁶ Frans van Poppel, “Children in One-Parent Families: Survival as an Indicator of the Role of the Parents,” *Journal of Family History* 25, 3 (July 2000), p. 271.

⁷⁷ Erik Beekink, Frans van Poppel and Aart C. Liefbroer, “Surviving the Loss of the Parent in a Nineteenth Century Dutch Provincial Town,” *Journal of Social History* 32, 3 (Spring 1999), p. 643-644.

⁷⁸ Stephen R. Shuchter and Sidney Zisook, “The Course of Normal Grief,” in Margaret S. Stroebe, Wolfgang Stroebe and Robert Hansson eds., *Handbook of Bereavement. Theory, Research and Intervention* (Cambridge, 1993) p. 23-43.

fathers, and therefore experienced a greater immediate sense of loss upon a mother's death.⁷⁹

Widowers may have found crucial sources of social support more difficult to obtain. Women in families more often maintained friendships and relationships with neighbours and kin, and may have been better at gaining support via those networks.⁸⁰ There were no social provisions for influenza widowers that would have supported fathers' capacity to raise their own children without a spouse, such as public childcare or financial support to pay for in-home services. Indeed, the problems facing single fathers were not on the public agenda, either after the epidemic or more generally.⁸¹ Despite high maternal mortality and the incidence of ill health among women during this period, single male parenting was not an issue in early twentieth century social reform. Widowers were forced either to find solutions to their domestic needs on their own, often through remarriage, or turn to institutionalization as a temporary or permanent solution.

Putting children in an orphanage was not a preferred solution and, as we shall see, many parents did everything they could to avoid this unattractive option. Orphanages were often criticized as overcrowded, unpleasant institutions that inadequately served

⁷⁹ For changing conceptions of family and fatherhood during the period around the Great War, and the increasing displacement of fathers from childrens' lives, see Cynthia Comacchio, "Bringing Up Father: Defining a Modern Canadian Fatherhood, 1900-1940," in Lori Chambers and Edgar-André Montigny, eds., *Family Matters: Papers in Post-Confederation Canadian Family History* (Toronto: Canadian Scholars' Press, 1998).

⁸⁰ Beckink, et al, p. 644.

⁸¹ Comacchio, "Bringing up Father," p. 296-297. The lack of attention to the circumstances of widowers is reflected in the historical literature, which focuses to a much greater extent upon the experience of widows. Blom, p. 203.

the physical and social needs of unfortunate children. Early twentieth century social reform movements argued against institutionalization for orphaned or delinquent children, and maintained the need to preserve the family, or an equivalent “normal” family life with foster parents, wherever possible.⁸² Despite these criticisms the services provided by orphanages continued to address otherwise unmet social needs in the early twentieth century, much as they had in the nineteenth.⁸³

As we saw in the previous chapter, the Winnipeg Children’s Home, the city’s main Protestant orphanage, played an important role as a potential source of childcare during and after the epidemic. It is unfortunately impossible to verify the exact number of families affected by the flu who utilized the Children’s Home, as the facility did not consistently record the cause of the death or illness of the parent in childrens’ files. Judging from casefiles, however, the use of the orphanage by a surviving parent during and after the epidemic was significant. This social need was not an easy one for the institution to meet. As with most social agencies, influenza strained an already overburdened organization. In the fall of 1918, the Home was \$9000 in debt to creditors, and paying only its most pressing bills. The year’s Annual Report indicated a deficit of \$10,147 on overall expenditures of \$42,374. The Home complained of declining donations and legacies, as well as the inability to hold the

⁸² See footnote #11, this chapter.

⁸³ There is little available literature on orphanages in Canada. Two instructive articles dealing with who used orphanages and why are Bettina Bradbury, “The Fragmented Family: Family Strategies in the Face of Death, Illness, and Poverty, Montreal, 1860-1885,” in Joy Parr, ed., *Childhood and Family in Canadian History* (Toronto: McClelland and Stewart, 1982); Diane Purvey, “Alexandra Orphanage and Families in Crisis in Vancouver, 1892-1938,” in Russell Smandych, Gordon Dodds and Alvin Esau, eds., *Dimensions of Childhood: Essays on the History of Children and Youth in Canada* (Manitoba: Legal Research Institute, 1991).

Annual Bazaar at the usual time because of the flu epidemic. Clearly, the lack of government support was also a factor in the Home's financial troubles. Nearly \$13,000 of the Home's revenue in 1918 came from maintenance paid by children's parents or guardians. It received only \$8000 in grants from city and provincial governments.⁸⁴

The Home cared for a total of 402 children during 1919, most of them either "Canadian" or "English", and Protestant. (The Roman Catholic Church and the Jewish community each had orphanages of their own.) Most of these children were placed in the Home on a temporary basis; in 1919, 240 children were discharged, most to a parent or guardian. Of these children, only nine were true orphans, with both parents dead. In fact, the majority of children had both parents still living, and nearly one-half had one parent alive; 340 children were admitted by either a parent or guardian. In a majority of cases, the reason for admission was the illness (34%) or death (21%) of the mother.⁸⁵ The Home also took in the illegitimate children of unwed mothers, sometimes infants. Most children were admitted by their own parents/guardians, with fewer than one-fifth in 1919 being admitted through the Children's Aid Society. The Children's Home, then, should be seen as a type of live-in child care institution rather than an orphanage per se. It was an organization used by working and occasionally middle class parents in difficult circumstances.⁸⁶ They were expected whenever possible to pay for the care of their children, \$10 per month

⁸⁴ PAM, P2156, Children's Home of Winnipeg, 34th Annual Report, 1918.

⁸⁵ PAM, P2156, Children's Home of Winnipeg, 35th Annual Report, 1919.

⁸⁶ For working-class usage of orphanages in times of family crisis, see Purvey; Bradbury, "Fragmented Families."

per child, which probably caused significant hardship to many working class families. Most of these children were eventually to return to their families, although the length of their stay in the institution could be months or even years. In 1918, the Home put out only twenty children for adoption.

The Home was overcrowded in 1918, and as a result the children living there suffered terribly during the epidemic. The medical information collected and published by the Home was far from thorough, so the number of children infected is unknown. Nevertheless, many client files from the period mention influenza. The Home was quarantined and did not allow visitors in November and part of December. The institution attempted to stop admitting children, but the need was so great that it was forced to make some exceptions. The regular routine of the institution was greatly disrupted, and maintenance payments from families were not collected. Quarantine of the Home due to infectious disease was unfortunately not an uncommon occurrence. In an overcrowded building, diseases such as chicken pox, scarlet fever, diphtheria, and whooping cough caused the deaths of 17 children in 1918, and 26 in 1919. Infant failure to thrive was also a significant factor in high mortality rates.⁸⁷ During the influenza epidemic, the Home was also infected with diphtheria and whooping cough. Most children died not in the institution, but after they had been transferred from the orphanage to the Children's Hospital.

These facts were known to the public as it was impossible to keep them out of the local press. During the epidemic, the situation in orphanages was reported publicly, although conditions in the Catholic St. Joseph's Orphanage, and the Home of the

⁸⁷ The Home's problems with infant mortality were common in orphanages. See Rooke, *Discarding the Asylum*, p. 121-130.

Friendless, appear to have been worse than in the Children's Home. By early November, the Home of the Friendless had lost eleven of the children in its care to influenza.⁸⁸

One of the first deaths at the Children's Home occurred on November 15, that of a six year old boy who had been diagnosed with pneumonia. It is highly possible that Billie had contracted influenza and developed respiratory complications. He had been admitted to the Home in April 1918 by his aunt and uncle, who lived on Pritchard Avenue in the north end. His aunt, who had been caring for him, had to go out to work, and had no other childcare options. The Home sent a letter to the couple explaining briefly the circumstances around his death:

we are very sorry indeed that little Billie has passed away. We had hoped that he would pull through, and the reports from the hospital seemed a little more encouraging the last day or two. Please accept our sincere sympathy in the death of your little nephew.

Knowing the poverty of this family, the institution offered to bury Billie in their plot in Brookside Cemetery.⁸⁹ The institution seems to have made every effort to ensure the dignified and appropriate burial of the children who died while in their care, and they handled these sad events with considerable sensitivity.

The fear of contagion prompted parents to withdraw their children from the institution in some cases, even if the circumstances that led the family to place their children in the Home had not improved. Chronic illness of the mother was a central factor in the institutionalization of two of three children, a seven year old boy and an

⁸⁸ MFP, November 9, 1918, p. 5.

⁸⁹ PAM, P5436, Children's Home of Winnipeg, Case File 2217. The names of children and family members have been changed to ensure confidentiality.

eight year old girl, in spring of 1918. This couple also had a two year old boy, and had for a time alternative arrangements for his care. The brother and sister went home temporarily in the summer, when their mother was well, but the two boys were admitted in January 1919. Their father worked for the CNR, earning only \$70 per month, and couldn't care for his children alone during his wife's periodic illness. This family paid the standard fee of \$10 per month per child. How they afforded this fee is not clear. The case, according to their file, was known to several social welfare institutions, including the Winnipeg General Hospital social service department, and the Children's Aid Society. During the second wave of influenza in March 1919, the youngest child developed influenza and had to be hospitalized. The family was very concerned for the health of the boys, and the file notes that "The Father felt uneasy about [the six year old boy] after [the baby] was sent to the Hospital with influenza." The older boy was withdrawn from the Home, and the younger discharged to the family directly from the hospital on March 15, 1919.⁹⁰

The anxiety caused by the threat to the health of their children is further illustrated by the case of a father who had moved to Florida seeking work and left his twelve year old daughter, whose mother died in Winnipeg of unknown causes in 1915, in the Home.⁹¹ This father, although he worked as a semi-skilled labourer and likely earned low wages, regularly sent money for his daughter's keep, and occasionally sent an extra dollar to be given to his daughter. The two apparently wrote to each other. A photograph of them from 1917 (when he must have visited the Home) shows them both neatly dressed, the girl with ringlets and a bow in her hair, wearing a pretty dark

⁹⁰ PAM, P5436, Children's Home of Winnipeg, Case File 2228.

⁹¹ PAM, P5434, Children's Home of Winnipeg, Case File 2010.

colored dress. Her father is wearing a wool overcoat, white shirt and bow tie, and is carrying his hat.

On November 29 1918, the Home wrote to the father in Jacksonville, Florida, with the bad news that the girl had contracted the flu:

We are sorry to say that the influenza has broken out in this Home and that Ida. has taken it. She went with some of the other children to the King George Hospital on the evening of the 27th inst. And we trust that she will soon be well again. Her temperature was high, and she was not very well this morning when we called the hospital to enquire, but we are hoping to have better word before long. We shall let you know how she is, and trust that you will not feel too anxious regarding her. Everything that is possible is being done for her and for the other children.

Another letter followed December 2, this time sent to Miami:

We are sorry that Ida does not seem better, but trust that in a day or two we shall have better reports to give you. She is not dangerously ill, but running a high temperature is common in this influenza. We wrote to you a day or so ago, and trust that you received the letter. One was returned to us today from Jacksonville, and we enclose it now, and trust that this will reach you all right. We shall keep you informed as to Ida's progress.

In broken English, (the family were originally from Holland) the father replied in a letter sent December 8, in which he stated his concern about his daughter, but also took the time to courteously express his thanks to the institution in charge of her well-being:

I received your two letters and I thanks you very much. Mrs I feel very much sorry for me little Ida that she is sick. I will hope she is very soon better. I am very glad that she is not in dangerous condition so we can have the best hope for her. I suppose there are more children sick on it Home. I give my best wish for all. ... you tell me in your letter you are willing to inform me about Ida's sickness in the next time. Well Mrs I give my greating thanks in advance when you are willing to do so and I trust very much in your people that you be good to her. Mrs I hope you will let me know very soon if she is wors or go better. My thanks.

He was in for a long wait. The Superintendent did not write to him until January 14 to assure him that his daughter had recovered from influenza. There is no record in the file of his response.

Several very young children died in the Home during the epidemic. One of these was the infant son of a thirty-three year old unmarried domestic servant, and a labourer. He was admitted to the Children's Home at age three months, in May 1918. He had spent the first three months of his life in the Brandon General Hospital. Even though the mother could not care for her child, and feared losing her job in rural Manitoba (which she felt was a good position), she often wrote to the Home to inquire about her son. She requested, however, that correspondence from the Home be sent to her in plain envelopes, because the mail was delivered by school children. "You cannot imagine how curious some people are, and I prefer that they should know as little as is possible," she explained.⁹²

After the child was admitted, the Superintendent wrote to her about her baby's arrival in the Home:

Your baby was brought to the Home, on Friday, by a nurse from the Brandon Hospital. He is very thin. The nurse says there has been difficulty with his feeding, and he has never been able to digest enough to properly nourish him. She could give us no particulars.

From the beginning, the baby's health was precarious. He developed a serious abscess on his head in late May 1918, and was admitted to the King George Hospital on July 3 with diphtheria. The mother was not informed of his hospitalization until August 19. His poor health obviously made the mother extremely anxious:

⁹² PAM, P5436, Children's Home of Winnipeg, Case File 2225.

I have been expecting to hear from the Home as the last letter was sent when Baby was in the hospital. Please give me full particulars of his illness and I sincerely hope he is better. Is he not back to the Home yet? Can he sit alone yet? And has he any teeth? Also send his weight so I will have an idea how big he is.

It was difficult for the mother to obtain full information about her child's condition.

Responses from the Home to her letters were cursory, and less than reassuring:

The doctors have been unable to get a negative swab up to the present time, and until they obtain that he will of course have to remain in the hospital. As he is rather a delicate child his recovery is not so rapid as we would wish. He has no teeth yet, but I cannot tell you of his weight just at the present time. When Murray returns to the Home we shall write you further concerning him.

In response, the mother argued that more information should be forthcoming from the Home:

I received your letter last night, and am certainly surprised that I have not been kept more closely in touch with [Baby's] condition, since he must be seriously ill. You can not imagine how anxious I am about him, and would ask you to write me often letting me know from time to time how he is.

In the midst of the baby's illness, his mother was also having a dispute with the Home over money owed for her child's keep. She conscientiously sent payments, and kept careful records. The Home claimed that she owed them one month's payment, or \$10. In the end, after several letters, they admitted she was correct and was not in arrears.

At the end of October 1918, the child was still in King George, and the Superintendent indicated that he was slowly improving. Then a telegram was sent to the mother on November 13, indicating that baby had died, and asking her to wire back instructions regarding his burial. The mother replied by telegram, authorizing the institution to bury him in whatever cemetery they advised, and asking them to send her the bill. The cause of death was given as pneumonia. It is, again, quite likely that the child had contracted influenza, and lacked the strength to fight the infection.

A letter was written from the Home to the mother the day of the child's death. It expressed sympathy, but also a resigned acceptance that perhaps was intended to stave off blame or responsibility for the tragedy:

We feel very sorry indeed for you, and especially as we had no reason to believe that [Baby] was worse than he has been. ... [we] were shocked to have the word of his death this morning. The nurse said that he had been very weakly for his age, and I fear from the report of him previous to his going to the Hospital that even if he had lived he would have been a very delicate child.

I have just phoned again to the King George Hospital, and had a long conversation with one of the head nurses of the hospital. She said that everything possible was done for [Baby.] The head nurse on the flat on which he was had looked after the baby as if he had been her own, and had grown very much attached to him. She repeated what had been reported in October – that [Baby] had been improving steadily; that they had been much encouraged by his condition, and that suddenly he had developed a temperature, and then pneumonia had set in, and that his vitality had not been sufficient to withstand the attack. She said that they were all feeling very badly over the loss of the baby. You will be glad to know that he did not suffer much. The nurse said that he had just slept away, and that he had not been distressed by the disease.

We shall wait for instructions from you regarding [Baby's] burial. It is likely that we shall have to arrange with the undertaker for his removal from the hospital at once, but please let us know further regarding any arrangements which you may wish to make. Or would you wish him to be laid away in the Children's Home plot?"

This news must have been a severe shock for the mother. She was unable to come and see him buried. On November 18, 1918, she wrote:

I received your letter on Friday evening and thought perhaps I might get another on Saturday telling me where you had buried my Babe. I hope you had him buried in the Children's Home plot but when I sent the telegram I didn't know where would be best.

You cannot know what a shock it was to me, for the [sic] seemed to be the only bright spot to look forward to when I could have him with me but it is with deepest gratitude I tender my thanks to you one and all, for the care he received.

Would you kindly tender my thanks to the nurse, at the King George Hospital, for the way she has cared for him, and even though I may never have the pleasure of her acquaintance, I will never forget her.

Kindly send me all the particulars of his burial, and thanking you for your sympathy.

On November 20 the Superintendent wrote back informing her that they had buried him in the Children's Home plot. The mother replied:

Dear Friend,

I received your kind letter telling me of Baby's funeral. I am so glad he is buried in the Childrens plot. What a sacred plot it must be with just pure sweet innocent little children. In what cemetry is it? I would like to know just where he is laid, as I may have a chance some time to see his little grave.

I hope you will not mind sending me the bill, as I prefer waiting for it. How is it the undertaker charges are so small. I thought the little coffin alone would have been a good deal more expensive, or do they make more reasonable charges for the Home.

In the end, the bill for the funeral was four dollars.⁹³

This poignant exchange of letters suggests that the Home's employees, and the nurses who cared for sick children in hospital, sometimes formed strong emotional bonds with their charges.⁹⁴ Perhaps such emotional attachments to children held additional significance because interaction with parents was often tense and sometimes conflict-laden. In the previous mother's case, only after resistance and demands for service from the Home (she was, after all, paying for the care of her son) was she kept regularly informed of his progress. Her status as an unwed mother, and a poor domestic servant, allowed the Superintendent to initially deny her respect and attention, and to dispute her integrity with regard to payment. Most of the children in

⁹³ PAM, P5436, Children's Home of Winnipeg, Case File 2225.

⁹⁴ The record of a deserted baby boy suggests this as well. The boy was found outside of the Eaton's store on September 12, 1918, and was named Baby Tim. The T.E. Eaton Co. had donated some clothing for the child. Baby Tim did not thrive, and had to be sent to the Children's Hospital on October 26, where he died November 7, 1918. When he was found, the baby had a little cloth bag safety-pinned to his clothing. The bag was filled with salt and a 10 cent coin, with a note "for good luck," left by whomever was so desperate as to have to leave him on the street. These items were carefully kept in a small paper envelope, labeled "Little Tim" and can still be viewed in the archival file. PAM, P5436, Children's Home of Winnipeg, Case File 2253.

the Home came from working class families, whose low social standing was reflected in their relationship with the institution. Parents handled this in different ways, from the courteous, almost deferential, approach of the father in Florida, to the single mother's open opposition to being excluded from her child's life.

There were, therefore, several reasons why the Children's Home was likely a last resort for men and women who lost their spouses in the influenza epidemic. Overcrowded living conditions and the risk of contracting contagious diseases generated parental fears, while the loss of parental authority in relation to the institution required fathers and mothers to deploy a range of strategies from accommodation to resistance in their contact with staff. Most of the families who used the Home because of the flu saw it as a temporary place where children could be cared for while other options were explored. The length of time it took widowers to find care for young children varied considerably, from weeks to years. The preponderance of influenza widowers, not widows, among orphanage clients lends support to the view that fathers found the death of their spouse extremely disruptive to family life, and had a more difficult time providing care for their children than did women who lost their husbands. The labour of women in the household as wives and mothers was not easily replaced, even though most men had greater financial means to provide for children. Children who lost a parent in the epidemic may therefore have suffered greater economic losses when their father died (as we have seen earlier in this chapter) but they may have experienced a more traumatic separation from the surviving parent and siblings in the case of their mother's death.

Infants born during the influenza epidemic were at great risk. Baby B, for example, was born on November 9, 1918, in the midst of the epidemic. Her mother

died of influenza, probably immediately after giving birth. Her parents were Russian Jews, living in the north end. It seems that there was no family or friends to take the child. Baby B was admitted into the Home at the end of December, at the request of Louis Greenberg, the Superintendent of the Jewish Orphanage. He explained that “while it is true that there is a Jewish Orphanage and Children’s Aid in existence and that we ought to and are quite willing to look after our own, still the fact remains that we have neither the help, the place, nor the equipment for the care of such infants...”⁹⁵ After initially denying the request, because of the quarantine on the orphanage in November, the baby was admitted. There is little information about her short life, but she died of pneumonia in the Children’s Hospital on March 5, 1919. This may also have been an influenza death, as the second wave of influenza affected the Home that month.

Some fathers did find a way to take their infants out of the institution. Baby K, like Baby B., was born during the epidemic, and her mother also died of influenza. She was admitted to the Home the third week of December, but did not remain there long, according to her records:

Father caring for two older children. Returned to Home after one week and said that he wanted to have the baby – was taking child to his parents’ home in the country where he was going to care for it and the other children. Paid through Children’s Aid \$3.10 for child for the week.⁹⁶

The grandmother of a one and one-half year old girl whose mother died of flu December 17 had been taking care of her and her three and one-half year old sister, until her father briefly admitted the youngest girl in February 1918 because the

⁹⁵ PAM, P5436, Children’s Home of Winnipeg, Case File 2270.

⁹⁶ PAM, P5436, Children’s Home of Winnipeg, Case File 2268.

grandmother could no longer manage. Perhaps the crisis in their extended family was brought on by the illness of the older daughter, who was in hospital with diphtheria. In any case, the family decided to withdraw the baby after less than two weeks, and did not go through with the planned institutionalization of the three year old girl. Another, more satisfactory, arrangement must have been made.⁹⁷

Other widowers, however, needed more than a week or two to make the arrangements necessary in order to reclaim their children. A Polish father of two boys aged two and seven years, who worked as a teamster for E.L. Drewry, took his children out of the Home after seven months, but not before the youngest child developed flu during the spring wave.⁹⁸ Other similar cases suggest that time allowed fathers to find arrangements they preferred to institutional care, although this did not always mean family reunification. In February 1919, the Home admitted a nine month old girl, the youngest of five siblings whose mother had died of influenza.⁹⁹ Their father was a thirty-four year old carpenter. He had originally requested that the Home also take his two and one-half year old daughter; she was never admitted, for unknown reasons. Neither were his other three children; presumably they were boarded out with extended family or neighbours. By July 1919, he had left Winnipeg, perhaps seeking work. Writing from Wapella, Saskatchewan, he informed the Home that he would visit soon, and then pay his arrears for maintenance of his baby daughter, Sarah. Whatever the father observed during that visit appears to have

⁹⁷ PAM, P5436, Children's Home of Winnipeg, Case File 2291.

⁹⁸ PAM, P5436, Children's Home of Winnipeg, Case File 2269.

⁹⁹ PAM, P5436, Children's Home of Winnipeg, Case File 2298.

disturbed him and generated considerable anxiety and confusion about the infant's well being, as he wrote to the Home's nurse at the end of August 1919:

I am writing you to know how my little Daughter is improving and is she picking up any and do you think that she would do any better if I put her in a private home as I think I have a good place I could place her but I would not like to take her out if she would not do any better than where she is as I had rather let her stay a few months longer if I thought she would not improve on it ...

The Secretary replied, but not before reprimanding him for writing directly to the nurse, whom the Secretary stated, "[has] nothing to do with the cases at all." The father was advised in this letter to put the baby in a private home if possible, as "all babies would do better if they were given individual care, but is not always possible to give it to them." For whatever reason, the father did not at this time secure a private home for his daughter. In early 1920, Sarah contracted a life-threatening illness, perhaps scarlet fever, which had infected many children in the Home. Her father was sent a letter strongly suggesting that she would not live, and asked him to come to see her despite a quarantine. Perhaps feeling defensive, the Secretary pointed out that the girl had "never been very strong and we have done everything to keep her well." She surprisingly survived, however, and remained in the Home until spring 1922, by which time she was four years old, her short life having been spent almost entirely in institutional care. Sarah was released into the care of a couple, at the request of her father. There is no indication that this was a formal adoption arrangement.

This family's records suggest that finding care for his five children was a considerable financial burden for the father, who could not maintain a home for them without the contribution of his spouse. Three of his children were privately boarded,

for which he paid \$25 per month per child. The Home's fees were \$10, then \$12, per month, and the father was in arrears \$150 dollars by 1922. A visitor's report from 1921 suggested that he was getting too few contracts as a carpenter, but also noted with approval that he "wish[ed] to assume his full liabilities ... [and] has kept a note of what was owing to the Home." Thus, it was not only influenza widows who encountered financial difficulties as a result of losing their spouse; men, too, could find supporting the family after losing their wives very difficult. This father without a doubt experienced a downward slide in his standard of living by the crudest economic measurement, not to mention the psychological and physiological affects of the stressful circumstances he had to manage. On the other hand, this father continued to play a role in the lives of his children and to have regular contact with them, and the Home continued to be lenient with regard to his payment.

There were resources available to children and their parents, and families had strategies for adjusting to a different life after the loss of parent or spouse to influenza. While the circumstances of many must have been bleak, individual women, men and children displayed considerable resiliency and courage. Bettina Bradbury has argued that working class usage of institutions such as orphanages "fragmented the kin group for a time, but in many cases ensured the family's survival."¹⁰⁰ The availability of short- and medium- term supports, as unappealing as some may have been, did allow parents to put their lives back together and reunite with their children in a time of greater stability. In combination with family and neighbourhood networks and other community supports, or through remarriage, many fathers were able to find

¹⁰⁰ Bradbury, "Fragmented Families," p. 128.

ways to re-establish a home life. For widows, economic hardship was often the most difficult challenge to meet. The Mothers' Allowance, a program greatly expanded through the eligibility of over one-hundred and twenty influenza widows in 1918-1919, made life somewhat more sustainable for those who qualified. The epidemic's impact upon poor women and their children would have been significantly greater had these benefits not been available. Nevertheless, its racially motivated exclusion of immigrant widows, and its meagre benefit levels, limited what it could accomplish in stabilizing family life for influenza victims. As case files amply record, widows and their children continued to suffer dire poverty, and illness followed many of them throughout their lives.

Chapter Seven - Conclusion

We are living in the midst of a great progressive revolution and the inevitable consequence must be the reconstruction of society upon a better basis ... What we need is an epidemic of revolution... We believe in destruction truly, but we do not believe in destruction only. We believe also in construction and we are going forward to assist the forces that will reconstruct conditions on this earth...

— Rev. A.E Smith (1914)¹

Bolshevism is not indigenous to [North] American soil. It is a disease that, like influenza and cholera, comes from overseas and with which no native-born American would likely be afflicted unless there were something about him congenitally abnormal.

— Charles Parkhurst, National Security League (1920)²

Since Alfred Crosby first labeled influenza in 1918-1919 the “forgotten pandemic” thirty years ago, a significant quantity of research has emerged to make his label no longer necessary. We now have a much richer understanding of the scope and devastation of the disease, and have a picture of how the epidemic affected communities all across the globe, and in a variety of social contexts. Nevertheless, it remains difficult to evaluate the influenza pandemic’s impact upon the twentieth century world. Studies from colonial settings such as South Africa, Australia and New Zealand have pointed to the importance of the epidemic as a catalyst for changes in public health legislation and infrastructure.³ Janice Dicken McGinnis has similarly

¹ Quoted in Richard Allen, *The Social Passion: Religion and Social Reform in Canada 1914-1928* (Toronto: University of Toronto Press, 1971), p. 23.

² Murray Levine, *A Political Hysteria in America: The Democratic Capacity for Repression* (New York: Basic Books, 1971), p. 12-13.

³ Howard Phillips, “The Origin of the Public Health Act of 1919,” *South African Medical Journal* 77 (1990); Geoffrey Rice, “The Making of New Zealand’s 1920 Health Act,” *New Zealand Journal of*

argued that the flu was instrumental to the creation of the federal Dept. of Public Health in Canada in 1919.⁴ In the aftermath of the epidemic, the inadequacies of health care provision and the willingness of nurses to enter the breach were used to bolster nursing's professional status. In her keynote address to the National League of Nursing Education in Baltimore in 1919, Ira Couch Wood used "that great call of the influenza" to set nurses apart from other untrained health care providers, and to highlight that nursing involved more than feminine nurture and emotion:

When that call came, I know of nothing more tragic than the women whose hearts were deeply touched and who came in hundreds and thousands saying 'Can we do anything?' We realized that with all their good-heartedness and sympathy and emotion, they had no contribution to make because they had not a single day of training which would have shown them the way to be helpful in that great emergency.⁵

Thus, influenza became another chapter in the struggle over the boundaries of nursing as a profession.

The influenza epidemic certainly was no triumph for modern science and medicine. As Alfred Crosby has stated, "There was nothing in that subject for the healer to point to with pride."⁶ The lack of effective medical treatment made the disease frustrating for physicians and nurses. The rate of infection among health care

Health 22, 1 (1988); Linda Bryder, "'Lessons' of the 1918 Influenza Epidemic in Auckland," *New Zealand Journal of History* 16, 2 (1982).

⁴ Janice Dicken McGinnis, "The Impact of Epidemic Influenza: Canada, 1918-1919," S.E.D. Shortt, ed., *Medicine in Canadian Society* (Montreal: McGill-Queen's University Press, 1981), p. 471-472.

⁵ Quoted in Katrina Rodies, "That Great Call: The Pandemic of 1918," *Nursing and Health Care Perspectives* 1998, 19 (5), p. 205.

⁶ Alfred Crosby, *America's Forgotten Pandemic: The Influenza of 1918* (New York: Cambridge University Press, 1989), p. 11.

professionals themselves severely restricted what they could do to help others. Like their counterparts in the United States, Winnipeg public health officials relied upon two strategies to curtail the spread of the disease: attempts to educate the public and to prevent people from gathering in crowds.⁷ To these preventive efforts, they added hospital isolation and a massive vaccination campaign and, as the epidemic spread and public pressure mounted, placarding and quarantine measures, although senior health officials did not genuinely believe these would help.

Were these the right measures? Could more have been done? Certainly, we know now that the resources devoted to vaccinating thousands of soldiers and civilians in Winnipeg were essentially wasted, as the vaccine provided no protection against the unknown virus. This was no small matter, either financially or in terms of precious manpower. This faith in vaccination was a product of its time, to a certain degree, but there was never any firm consensus among scientists that any vaccine for influenza would be efficacious. Winnipeg health officials, perhaps influenced by the enthusiasm of Fred Cadham and William Boyd, plunged into an undertaking of questionable value.

But there were additional weaknesses in the public health response. Among the most serious of these was the failure to alleviate the suffering of influenza victims in the community, a task the state left almost entirely to the voluntary sector. Sandra Tomkins has argued that the most “pragmatic and progressive” measures taken to

⁷Lawrence Koblenz, “A Judgement in Time: Medical Responses to the 1918-1919 Influenza Epidemic in the United States,” Paper presented to The Spanish Flu After 80 Years Conference, Cape Town, South Africa, 1998, p. 15. Measures taken in Chicago, considered by Koblenz to be “typical,” were virtually identical to those taken in Winnipeg, including vaccination. Chicago also, however, took measures to ease the wartime rationing of coal, in order to help the poor more effectively heat their tenements.

combat influenza in London, England were initiated by laypersons (not health authorities) on local council public health committees.⁸ Similarly, in Winnipeg it was laypersons—middle class Anglo-Canadian women and leaders in some immigrant communities—who implemented, with the assistance of professional nurses, a program of medical care and food relief for the poor. These voluntary networks relied almost entirely upon charitable donations, receiving little if any financial support from the city or provincial governments. The volunteerism of middle class women, in particular, saved countless lives and alleviated the suffering of many.

But volunteerism has its limits in an epidemic context. There were never enough women volunteers to fully address the need. Gendered notions of who should perform bodily care largely excluded men from helping. Relief organizers argued that they could do a better job if they had the financial resources to pay relief workers a wage, as many working women could not afford to forego income by volunteering. The state refused to provide them with these resources. The irresponsibility and miserliness of the city's Board of Control (which made the majority of decisions during the epidemic) was again revealed in its refusal to consider reimbursing the wages of hundreds of theatre operators put out of work for six weeks through its ban on public gatherings. The politics of class are starkly revealed in that school teachers, the other large category of laid-off workers, received their full salaries throughout the epidemic.

The failure by municipal health authorities to invite the full participation and cooperation of immigrant and workers' groups in the fight against influenza was a

⁸ Sandra M. Tomkins, "The Failure of Expertise: Public Health Policy in Britain During the 1918-1919 Influenza Epidemic," *Social History of Medicine* 5, 3 (December 1992), p. 453.

further indication of the attitudes dominating city hall. The state took an expert-driven, top-down approach to disease control, rather than one based upon community action and grassroots participation. It is, in fact, difficult not to conclude that the exclusion of labour from disease control planning was deliberate. Historians of public health in this period have argued that the most successful anti-disease campaigns required “tact, organization, patience, and above all a willingness to engage in a dialogue with the public and its representatives,” particularly labour and immigrant groups.⁹ Community cooperation not only brought better results; it also minimized resistance from workers and immigrants.

Thus, it is not necessarily the case that class and ethnic tension was an inevitable outcome of the epidemic. Rather, it was to a considerable extent the outcome of social inequality and of the decisions made (or not made) by Winnipeg’s social and governing elite, and by workers’ response to these circumstances. Indeed, this thesis argues that the epidemic can be seen as a lost opportunity for the development of cross-class and cross-ethnic bonds. The contact zone between north and south Winnipeg generated by the volunteerism of middle class Anglo-Canadian women provided one such opportunity. Here the epidemic’s sudden trauma and pressing human need threatened to destabilize accustomed social boundaries. However, as we have seen, women organizers and their male counterparts in the dominant culture

⁹ Guenther B. Risse, “A Long Pull, A Strong Pull, and All Together’: San Francisco and Bubonic Plague, 1907-1908,” *Bulletin of the History of Medicine* 66 (1992), p. 284. San Francisco had an active Citizen’s Health Committee, which Risse describes as “a peacemaker placed between the forces of corporate wealth and organized labor.” p. 286. See also Judith Walzer Leavitt, *The Healthiest City: Milwaukee and the Politics of Health Reform* (Princeton: Princeton University Press, 1982), p. 252-264.

framed the volunteer response so as to minimize the chance that social hierarchies would be undermined by an outpouring of generosity and empathy.

A central goal of this study has been to draw attention to working class experience during the epidemic and its aftermath, and to situate influenza within the context of post-World War I working class and ethnic radicalism and class conflict. This focus has accomplished two things. The first is to illustrate that the influenza epidemic was an important factor in the growing momentum toward labour revolt in Winnipeg in the winter of 1918-1919. Working class leaders were resolutely determined not to have influenza deter them from their agenda of social change at the workplace and at the ballot box. Given the circumstances, there was a grimness in their success. It is impossible to know what workers and their representatives were thinking as they campaigned to defeat an anti-labour mayor at the polls, and took a general strike vote, in the midst of death and loss in their neighbourhoods. Certainly, nothing they said publicly betrayed any fear or lack of resolve. In fact, influenza added fuel to their fire. The Trades and Labor Council argued that the state's decision to close public gathering places and lay off workers without compensation was a betrayal of British justice and a violation of principles of fairness. The state was denying working men a living wage with which to support themselves and their families during a time of severe crisis and need. Women activists reacted with outrage to the price gouging of the funeral industry, and the refusal of the state to prevent it. It was a clear social injustice that working families were made destitute by the desire to provide their loved ones with a decent burial, while capitalists profited. Thus, workers viewed the impact of disease as socially constructed, and as demanding social solutions.

Secondly, the struggles of families and neighbourhoods to survive the epidemic are linked to the mobilizing successes of the workers' movement in 1918-1919. Evan Stark's argument that during the trauma of epidemic disease workers reach out, away from the capitalist market toward a non-capitalist "society" based upon mutualism, is a convincing perspective from which to understand how the epidemic pushed ordinary workers and their families toward greater class consciousness and solidarity. This analysis demonstrates how an event such as the influenza epidemic holds within it both devastation and the seeds of emancipation and recreation. The evidence clearly shows that working families had their worlds turned upside down by the disease. But for those who survived, the epidemic suggested both the fragility of the social order and the capacity of workers' communities to sustain life. Coming on the heels of the human losses and hardship of the First World War, the influenza epidemic further "politicized the networks of everyday life,"¹⁰ particularly among working class women.

Surely, there were those left out of this burgeoning solidarity. It is not entirely clear to what extent mutual assistance during the epidemic crossed barriers of ethnicity. Most of Winnipeg's formal mutual aid networks were organized along ethnic, not class lines. While the epidemic probably strengthened ties among workers within immigrant groups, it may not have facilitated bonds among workers of different groups. There were also many victims who were either too isolated to receive assistance from within community networks, or who could not be helped by these accustomed sources of support. As evidence presented here shows, kin

¹⁰ Temma Kaplan, "Female Consciousness and Collective Action: The Case of Barcelona, 1910-1918," *Signs* 7, 3 (1982), p. 545.

networks and mutual aid were the first and probably most important sources of support, but the scale of the epidemic at times overwhelmed these resources. The most marginalized suffered greatly. If the records of the Margaret Scott Nursing Mission are a fair indication, very poor unskilled immigrants—mostly Eastern Europeans—had fewer resources and support networks with which to cope with the flu, and were forced to seek relief or charity.

When viewing the epidemic from the perspective of working class victims and their families, it becomes clear that its full impact can only be understood if the normal time frame within which historians examine epidemic disease is extended. News of influenza disappeared from the public eye as quickly as it had arrived. After the worst of the disease had passed, few in the press or in government appeared to be concerned with how families were coping with the loss of spouses and children. These families melted into the ranks of those who had lost their loved ones in the war, in workplace accidents, and to illnesses such as tuberculosis. Their numbers, however, were significant. Social agencies both public and private struggled to meet the demands for support coming from working class families. In the months and years following the influenza epidemic, it was probably the Manitoba Mothers' Allowance that played the most important role in keeping families together despite the loss of a breadwinner. This program, however, would not support immigrant widows of non-naturalized immigrants. As a result, immigrant widows and their families could be forced to survive on much less generous and unreliable municipal relief. But, as this study has been careful to point out, it was not only women who headed families alone after the influenza epidemic. Single fathers, too, actively struggled to maintain family life. For single fathers with young children, replacing the domestic contributions of a

deceased spouse could be a challenge. Although men may have been more easily able to support their families than were widows, this is not to say that fathers could always afford costs such as childcare.

It seems important to acknowledge the grief that struck so many families in this period. Canadian historians have not had a great deal to say about the impact of grief and loss within the family, and are sensitive to the risks of uncritically applying psychological and psycho-analytic theory to the experience of people in the past.¹¹ Neither have historians of influenza commented extensively upon the grief of influenza survivors. The potential harm that the sudden and traumatic losses of the epidemic caused men, women, and children has been largely neglected. Despite the need to be attentive to historical and cultural contexts, it is not enough to simply say that people coped, or to trivialize their experience by arguing that people were accustomed to illness and loss in this period because of generally high mortality rates.¹² In part, my effort to give voice to working class parents experiencing grief upon the loss of their children, or fear for their childrens' health, was occasioned by the extraordinary richness of the Children's Hospital case files. They provide an all too rare opportunity to explore the emotional dimension of the epidemic experience within a family context.

The 1918-1919 influenza epidemic should occupy a central place in the history of labour, working class, immigrant and family history in Canada. Like the First World War and the Winnipeg General Strike, it was to shape the lives of hundreds of individuals and families. As the two quotes that begin this chapter suggest, epidemics

¹¹ My thanks to Adele Perry, Tamara Myers, and Julie Guard for discussions in this regard.

¹² John Archer, *The Nature of Grief: the Evolution and Psychology of Reactions to Loss* (London: Routledge, 1999), p. 28-30.

and social revolution are two sides of a coin, both metaphorically and experientially, the embodiment of both destruction and creation. We are only just beginning to understand the epidemic as a force in the crucible of change that the world witnessed during these years.

Abbreviations

CWA	City of Winnipeg Archives
MFP	Manitoba Free Press
MSNM	Margaret Scott Nursing Mission
PAM	Provincial Archives of Manitoba
SWC	Social Welfare Council (Winnipeg)
WT	Winnipeg Tribune
VAD	Voluntary Aid Detachment
WGH	Winnipeg General Hospital

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Board of Control (Minutes and Correspondence)
Bureau of Child Hygiene
Dept. of Public Health
Health Committee Minutes
Social Welfare Commission

Provincial Archives of Manitoba

Province of Manitoba:

Provincial Board of Health
Board of Welfare Supervision/Public Welfare Commission
Mother's Allowance Commission

Private Organizations and Institutions:

Children's Aid Society of Winnipeg

Children's Home of Winnipeg
 Children's Hospital of Winnipeg
 International Association of Machinists, Specialists and Helpers, District
 Lodge 2
 International Union of Bricklayers and Allied Craftsmen
 Margaret Scott Nursing Mission
 United Brotherhood of Carpenters and Joiners of America Local 343
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