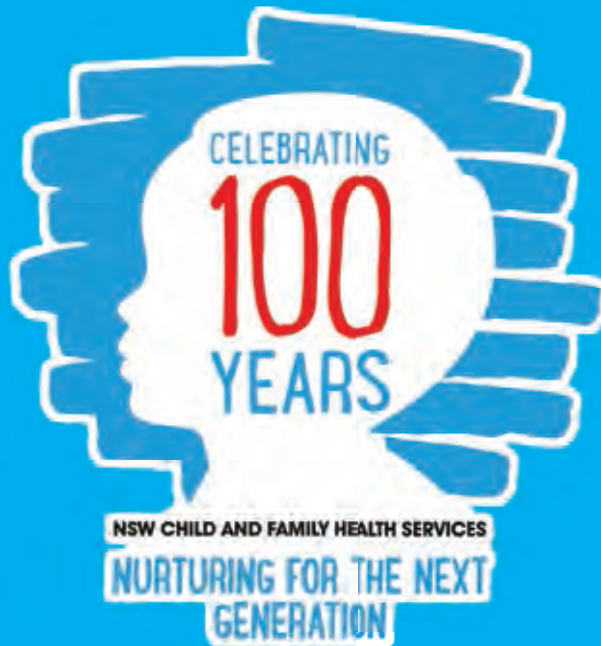


# OUR BABIES: THE STATE'S BEST ASSET

**A HISTORY OF 100 YEARS OF CHILD AND  
FAMILY HEALTH SERVICES IN NSW**





**THIS BOOK IS DEDICATED TO THE THOUSANDS OF CHILD AND FAMILY HEALTH PROFESSIONALS WHO HAVE CARED FOR GENERATIONS OF NSW CHILDREN AND THEIR FAMILIES.**

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## FOREWORD

As part of the centenary celebrations, Local Health Districts across NSW hosted a number of local events for their child and family health services with the final event being a full-day conference, 'Nurturing for the Next Generation', to support the professional development of the current generation of child and family health professionals. This commemorative publication was prepared for the conference as an acknowledgement of the important role of nurses, paediatricians and allied health workers in providing child and family health services in NSW. The heart of this service has always been the nurse. This is as true today as when the Medical Journal of Australia printed in 1914 that 'The valuable asset in each instance is a nurse of undoubted capabilities, of great keenness, technically well trained and endowed with the one essential for work of this sort – commonsense and knowledge of the world!'

During the First World War, as many babies died in Australia as did men on the battlefield. During the war years, the Medical Journal of Australia reported that the reduction of infantile death and infantile disease were central to raising the next generation of healthy children. These are the origins of the child and family health service.

The first centre opened in Alexandria on 24 August 1914, closely followed by Newtown and Bourke Street in Darlinghurst. The Government also funded 20 NSW Districts under the Bush Nursing Scheme. These services had a marked impact on child health outcomes in a very short time, and the benefits from the services have continued to accumulate over the last 100 years. The contribution these services have made to children's health over the century is well worth celebrating!

In the early years of the 20th century, the main work of a child and family health nurse was antenatal care, supporting breastfeeding, teaching 'the hygiene of infancy', monitoring growth and infant nutrition. The focus was on reducing mortality. Today, the infant mortality rate has dropped to 3.2 deaths for every 1000 live births, with a 95 per cent decrease in death rate for children aged 0 to four years. In 2015, child and family health nurses still provide enormous support for breastfeeding, immunisation, infant nutrition and monitoring growth and development. However, with advances in the neurosciences, we now know that what happens in the early years is critical to long-term health and wellbeing. This includes addressing psychosocial risk factors such as perinatal depression, domestic and family violence, and parenting skills. Today, every family is offered a health home visit from a child and family health nurse soon after birth.

This publication is not only about celebrating the achievements over the past 100 years and documenting the historical changes in child and family health services, but also to acknowledge our dedicated staff. We have great pleasure in commending this history to you and extend our appreciation to all those contributors who gave so freely of their time and expertise in its production.

**Adjunct Associate Professor Susan Pearce**  
Chief Nursing and Midwifery Officer,  
NSW Health

**Ms Joanna Holt**  
Chief Executive,  
NSW Kids and Families

## PREFACE

As a mother of two small boys I had already experienced the value of the local baby health centre. I was therefore very pleased to be asked co-write the history of the baby health services in New South Wales.

The infant welfare movement which led to the establishment of baby health services throughout New South Wales was one of the most significant public health initiatives in this century. It played a major role in reducing the enormously high infant mortality rates which previously existed.

One sister who was interviewed talked of her experiences in the earlier part of the days of the baby health service and the changes that have occurred:

'In the new era there is less emphasis on the physical aspects of feeding babies, and more emphasis on the emotional and management side of children. Sickness isn't so important now. In the 1940s and 1950s we were still fighting for babies' lives in many cases, but by the time we got to the 1970s and 1980s the service was all management and behaviour.

The number of women and children the service has reached is astronomical. Over one million attendances by mothers and children were recorded on a continuing basis from the 1930s to the 1970s when figures were no longer available.

The work of the baby health centre sisters, in pioneering the service in the early days, in coping with the continuing heavy demand for their services and in responding to the complex changes in society affecting the care of infants and children, shows an enormous level of dedication and commitment.

Unlike the work of the midwives or other nurses working in the acute care health services, preventive medicine is not dramatic – 'it does not go in for big buildings and foundation -stones with someone's name on them'. The number of healthy children throughout the past 75 years is the major tribute to these sisters.

The recent initiatives which have been implemented including the development of Family Care Cottages and the change in terminology to Early Childhood Services shows the flexibility of these services and their capacity to respond to change.

On a technical note, I have written this history with the terminology that was in common usage at different periods of time. Therefore 'infant welfare' becomes 'baby health' which then becomes 'early childhood' as the terms in common use have changed. I have used the term, 'baby health services' above as this was the term used over the majority of the 75-year period of the history.

**Karen O'Connor**

*(Author of original 1989 publication)*

## ACKNOWLEDGEMENTS

This volume incorporates the book, *Our Babies, The State's Best Asset: A History of 75 years of Baby Health Services in New South Wales*, compiled by Karen O'Connor and published by the NSW Department of Health in 1989. The original acknowledgements for the first 75 years are summarised below. Updating the content of this book to cover 100 years of public child and family health services in NSW has not been as large a task as the first 75 years, but has still been a significant effort. Acknowledgements are due to many people, not all of whom can be named.

Once again, acknowledgement is due to a member of staff for initiating the idea of a centenary volume – this time, Associate Professor Elisabeth Murphy of NSW Kids and Families. This volume would also not have been possible without the ongoing support of Ursula Bayliss, now retired, who contributed from her wealth of knowledge and had faithfully stored the majority of the original photographs from the 75 year book, and other memorabilia.

The work of Helen Signy, who was contracted to write the final chapters, and Deana Henn as Editor must be acknowledged, along with the contributions of many child and family health nurses and other health and associated professionals who were interviewed for the book. Some of them, including Professors Cathrine Fowler and Graham Vimpani, and Sue Campbell-Lloyd from the NSW Health Immunisation Unit, are cited throughout the chapters, but others have generously provided knowledge, memories and wisdom that pervades the text. The families who are featured in the photos, though unnamed, are also acknowledged and thanked.

Finally, the hard work and perseverance of a team of NSW Kids and Families staff (including Gail Mondy, Elisabeth Murphy, April Deering, Deborah Beasley, Anita Ray, Stephanie Wong and Patricia Sharpe) must be acknowledged, because without that group providing the drive, remembering and sourcing a huge amount of information, supporting the writing team, retyping the first 75 years of history, and generally coordinating the effort, there would be no book to publish. It involved commitment within and outside working hours, above and beyond the call of duty – which is, after all, consistent with the last 100 years of child and family health services in NSW!

*The original acknowledgements for the 75 Year History included: Margaret Komarek – for organising original photographs for the book and writing the chapter on 'Reminiscences'; Claudia Knapman – for the research work for the history; Dr Milton Lewis of Sydney University, Dr Cope of The Royal Hospital for Women, Mr John Behr of the Royal Flying Doctor Service – for their support in providing invaluable material; Hazel Woolston from the NSW Nurses' Association; Margaret Stewart from Bathurst Community Health Centre; Nancy Bird; Karitane Mothercraft Society, Tresillian, The Royal Flying Doctor Service, the Royal Far West Children's Health scheme, the Country Women's Association and the Benevolent Society and their staff – for access to original information and assistance; NSW Nurses' Registration board – for their unpublished history of the Board; The Department of Health Library and the Mitchell Library; Ursula Bayliss of the Primary Care Unit – for initiating the idea of the history, coordinating the preparation of the book; Early Childhood Nurses – for collating invaluable material which could not otherwise have been obtained; Mothers and nurses (retired and current) – for participating in interviews for the 'Reminiscences' chapter; The Royal Prince Alfred Hospital's Audio Visual Department of Central Sydney Area Health Service – for photographs; Many other people and organisations – for obtaining information and retrieving photographs. The original sponsors were: Britax Child Care Products; Ego Pharmaceuticals; Faulding Pharmaceuticals; Heinz Baby Foods Advisory Service; Johnson & Johnson; Koren Laboratories Pty Ltd (Curash); Royal Prince Alfred Hospital Audio Visual Department; Tresillian; Sunlight/Velvet – Lever and Kitchen; Kraft foods – Vegemite; and, Wyeth Pharmaceuticals.*

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## TIMELINE

- 1904** • The NSW Public Health Act 1896 passed.
- The Infant Protection Act 1904 passed, providing legal recognition of the critical role of the mother in the early part of an infant's life.
- Medical Officer of Health to the Metropolitan Combined Districts, Dr W.G. Armstrong, obtained funding from the City Council of Sydney to employ a trained health visitor to personally visit and instruct mothers of all newly born babies.
- 1905** • First baby clinic established in England.
- The Benevolent Society opened the Royal Hospital for Women, Paddington.
- 1906** • First baby health clinic in Australia, "The Consultation for Infants", opened by the Benevolent Society.
- 1911** • NSW Bush Nursing Association formed.
- 1912** • Commonwealth Government instituted baby bonus of 5 pounds to all mothers of newly born infants.
- Benevolent Society established antenatal clinic at the Royal Hospital for Women, the second in Australia and third in the world.
- 1913** • The Lady Edeline Hospital for Babies opened in Vaucluse for babies up to two suffering from gastroenteritis.
- 1914** • Infant mortality rate for babies under one year in Sydney was 75 per 1000 live births.
- Baby health clinics introduced to promote infant welfare.
- NSW Government subsidised Bush Nursing Association to open 20 new bush nursing districts. Margaret Harper appointed honorary medical officer of the first baby clinic.
- 1915** • The Notification of Births Act 1915 came into effect; births within specified districts were to be notified within 36 hours of the birth.
- Nine baby clinics in operation.
- 1917** • Sydney Municipal Council discontinued the work of visiting mothers of newborn infants due to increase in services offered by baby clinics.
- 1918** • 33,777 visits made to infants in their own homes.
- Number of baby clinics in NSW grew to 28.
- First baby clinic outside Sydney and Newcastle established at Broken Hill.
- 1919** • The Royal Society for the Welfare of Mothers and Babies Incorporation Act 1919 passed.
- 1921** • First Tresillian Mothercraft Home opened in Petersham. It was named after the building itself which had been a village in Cornwall, South England, where the previous occupants had hailed from.
- 1922** • Infant mortality rate for babies under one year in Sydney dropped to 57 per 1000 live births (from 75 per 1000 live births in 1914).
- 1924** • First Australian Mothercraft Home opened at Coogee.
- First nurse training programs offered by the Australian Mothercraft Society.
- Bush Nurses collaborated with the Royal Society for the Welfare of Mothers and Babies to offer mothercraft training to bush nurses.
- The Nurses Registration Act 1924 passed for the legislation of training and examination of nurses.

## TIMELINE

- 1925** • First baby clinic sponsored by the Country Women's Association opened in Moree with a Karitane nurse.
- 1926** • Baby health centres transferred to the control of the Director-General of Public Health, Sydney, to fall under direct medical control.
  - The Nurses Registration Board launched in NSW, leading to the registration of general, mental health, midwifery and infants' nurses.
  - Margaret Harper wrote *The Parents' Book*, which became a standard text on mothercraft, used widely by mothers to guide them in the care of infants.
- 1927** • The number of baby health clinics in the metropolitan area reached 35.
- 1930** • Incidence of breastfeeding and baby health clinic visits both high: an average of 93 per cent of all babies in their first month were breastfed.
- 1931** • 87 baby health centres (40 metropolitan and 47 country) established, with home visits being made to nearly half of the newborn babies in the State.
  - First travelling baby clinic using a railway car fitted out with nurse quarters and consulting room. The clinic was sent on the Bourke, Cobar and Brewarrina lines with a nurse.
- 1933** • By year-end, 1255 attendances were recorded by the travelling baby clinic with 281 home visits for babies.
  - The Lady Edeline Hospital for Babies closed – no longer needed as the level of infant mortality from diarrhoeal disease was so low.
- 1935** • Infant mortality rate dropped to 39 for children under one year (from 120 in 1885).
- 1936** • Bush Nursing Association reached its peak – 20,628 patients visited by 74 nurses who travelled 74,194 miles during the year.
- 1937** • Tresillian Vacluse established in Sydney's Eastern suburbs, the third of its kind.
- 1938** • Australian Mothercraft Society visits grew to 48,600, from 700 in 1923–24.
- 1939** • Baby health centres in NSW reached 211; 53 in metropolitan areas.
- 1942** • Baby health centres in NSW reached 224.
- 1943** • Annual attendance at a baby health centre exceeded one million and remained at this level until the early 1970s.
- 1944** • The Commonwealth Department of Health produced a book on *The Infant Welfare Centre as a Community Service*. The introduction drew attention to the increasing interest in the needs of the young child.
  - NSW Department of Public Health amended funding guidelines for the establishment and maintenance of baby health centres – allowing for the much greater role of Department of Public Health centre funding.
- 1948** • Silver Jubilee of the Australian Mothercraft Society.
  - The Australian Mothercraft Society introduced a fee for women using its services in response to financial difficulties.
- 1950** • The number of baby health centres in NSW reached 278; 76 in the metropolitan area, 11 in Newcastle and 191 in the country.
- 1958** • Baby health centre services commenced at three Aboriginal stations – Cowra, Burnt Bridge and Bellbrook.
- 1960** • A registrable Community Health Diploma commenced and became mandatory for child health nurses and other disciplines.



## TIMELINE

- 1964**
  - Golden Jubilee of the baby health service with the first baby health centres established in Alexandria in 1914.
  - Under the Nurses Registration (Amendment) Act 1953, the registration of a new category of nurse was legislated: the mothercraft nurse. Karitane and Tresillian were invited to assist a sub-committee of the Nurses Registration Board to develop a curriculum.
  - The baby health service was now available free of charge to mothers, irrespective of social or financial status.
  - An organised program, Preparation for Parenthood, was established at baby health centres.
  - A two-tiered paediatric service was established: the Well Baby Clinic and the Paediatric Referral Clinic.
  - 415 centres throughout NSW were established with a total attendance of 1.15 million mothers.
- 1965**
  - The administration of health in NSW divided into health districts with a Medical Officer of Health responsible for the prevention and control of disease and maintenance and promotion of health.
- 1968**
  - Attendances at baby health centres for children older than two had risen, leading to proposals for medical screening of all three year olds.
- 1970**
  - The Australian Mothercraft Society underwent a name change to Karitane Mothercraft Society.
  - The focus of the baby health centre broadened with the objective of maintaining the total health of the family and the community at the highest possible level.
- 1971**
  - The use of baby health centres expanded for other purposes including mental health services, community and aid, the elderly and immunisation clinics.
  - A health education officer and liaison officer for Aboriginal health was appointed to the staff of the Bureau of Maternal and Child Health. This Aboriginal health program led to improvements in the health status of Aboriginal people.
- 1972**
  - The number of births in NSW peaked at just over 95,000 after steadily declining since 1962, and rising again between 1968 and 1972.
  - The NSW Department of Public Health initiated a health education program for migrants to make services accessible to migrants with little or no English.
- 1973**
  - Golden Jubilee of the Australian Mothercraft Society. Shift to team approach on the 'total family' picture and increased involvement of fathers.
  - A special training course was introduced for six Aboriginal student nurses to learn community health and mothercraft.
  - The NSW Department of Public Health became the NSW Health Commission with 14 geographically defined regions administered by 13 regional offices.
- 1974**
  - Bush Nursing Association and baby health services became the responsibility of the NSW Health Commission.
  - Screening of pre-school children became the responsibility of the baby health centres.

## TIMELINE

- 1975** • The Community Health Diploma, which had been mandatory for child health nurses since 1960, was replaced by a tertiary diploma course, the Diploma in Community Health Nursing, at the NSW College of Paramedical Studies (later Cumberland College of Health Sciences).
- 1983** • By June, 3858 general trained nurses had completed mothercraft training at Tresillian, as well as 1147 mothercraft nurses.
- 1986** • SIDS peaked, claiming over 200 babies' lives.
- 1987** • Baby health centres underwent a name change to early childhood health centres to reflect the service catering for children from birth to school age, not just young babies.
- 1988** • First coordinated vaccination campaign in NSW against measles launched.
  - NSW Personal Health Record (the 'Blue Book') launched.
  - Commonwealth Government published Health for All Australians report, Australia's first documentation of national health goals and targets.
- 1989** • 75th anniversary of the baby health service.
  - Measles, mumps and rubella (MMR) vaccination was introduced.
  - Report about maternity services, known as the "Shearman Report", released.
- 1990** • The Child and Family Health Nurses Association (CAFHNA) was established to promote the role of child and family health nursing as a specialty field.
- 1992** • The Commonwealth Government released Health Goals and Targets for Australian Children and Youth to improve the health of children and young people in Australia.
- 1993** • The Australian Health Ministers' Advisory Council endorsed the five health goals which became the foundation for the 1995 and 1996 Health of Young Australians and The National Health Plan for Young Australians.
  - The first child and family health conference was held at Macquarie University by Northern Sydney Health to discuss the way forward for the profession.
- 1994** • Early Childhood Health Awareness Week 26 October – 6 November.
  - A Royal Commission into the NSW Police Service authorised Justice James Wood to investigate corruption in the NSW Police Service. The scope of the enquiry expanded by year-end to include the protection by NSW police of paedophiles and the extent of child abuse.
- 1996** • Unacceptably low vaccination rates prompted the Commonwealth Government to launch a two-year pilot managed by the Health Insurance Commission to record the vaccination status of all children under the age of seven.
  - All babies born after 1 January automatically entered on the Australian Childhood Immunisation Register following registration with Medicare.
- 1998** • Legislative reform through the Children and Young Persons (Care and Protection) Act 1998 covered how at-risk children and young people should be managed in NSW and outlined the responsibilities of community services and other agencies, including health services working with children and families.
  - NSW Department of Health introduced a training package for staff outlining how to identify at-risk families and what staff should do.

## TIMELINE

- Under “Immunise Australia”, 1.7 million (96 per cent) school children received an MMR vaccination.
- The General Practice Immunisation Incentives Scheme introduced to financially incentivise GPs to promote child immunisation.
- Mandatory reporting was introduced of child abuse and neglect of children where health professionals had reasonable grounds to suspect risk of harm.
- The Aboriginal Perinatal Mortality Project initiated. The report would find that the NSW Aboriginal perinatal mortality rate was 17.9 per 1000 births in 2000 compared to the non-Aboriginal rate in NSW of 9.7 per 1000 births.
- 1999**
  - Commonwealth-funded vaccines became available to all parents.
  - Families First initiative commenced in NSW in 1999 to focus on prevention and early intervention approaches early in life.
  - The Start of Good Health: Improving the Health of Children in NSW policy was released to provide direction for the health system to deliver services for children and families focusing on early intervention to prevent health issues later in life.
- 2000**
  - The goals and targets set out in the global strategy Health for All Australians by 2000 were revised and published in the Goals and Targets for Australia’s Health in the Year 2000 and beyond.
  - Professor Cathrine Fowler, the former head of education and research at Tresillian, became the first Chair of Child and Family Health Nursing, a position at UTS sponsored by Tresillian.
- 2001**
  - The NSW Aboriginal Maternal and Infant Health Strategy, now known as the Aboriginal Maternal and Infant Health Service (AMIHS), commenced progressive implementation across NSW, with the objective of improving health during pregnancy and decreasing mortality and morbidity in Aboriginal children.
- 2002**
  - Families First implementation, which commenced in 1999, reached all regions across NSW. Coordination of the initiative shifted from the Cabinet Office to the Department of Community Services.
  - Families First re-named Families NSW.
  - The Statewide Infant Screening – Hearing (SWIS-H) program launched in NSW to offer a hearing screen after birth to all babies.
- 2003**
  - NSW Premier Bob Carr made an election commitment that every family would receive a health home visit from a child and family health nurse within two weeks of birth.
- 2005**
  - To support Families NSW, statewide Family Partnership Training offered.
  - Increase in NSW Births from 85,626 in 2004 to 90,610 in 2005.
- 2006**
  - The Personal Health Record (the Blue Book) underwent significant change and was updated to reflect the partnership relationship with the parent and a child and family health clinician.
  - Developmental surveillance using ‘Parent Evaluation of Developmental Status’ and ‘Ages and Stages Questionnaire’ introduced statewide.
- 2007**
  - The NSW Government launched a Special Commission of Inquiry into Child Protection Services in NSW, headed by Justice James Wood.
  - NSW births reach 96,030.

## TIMELINE

- 2009**
  - The NSW Government launched Keep Them Safe, a five-year plan to reform child protection services; child protection became a shared responsibility of all frontline workers.
  - The Children Legislation Amendment (Wood Inquiry Recommendations) Act 2009 passed in NSW to increase the threshold for reporting matters to the Department of Community Services. Legal penalties for failing to report were removed.
  - The NSW Health/Families NSW Supporting Families Early package launched to bring together initiatives to promote an integrated approach to the care of women, infants and families in the perinatal period.
  - Sustained health home visiting (known as Sustaining NSW Families) introduced in three locations to provide home visiting from pregnancy until age two, with up to 26 home visits.
  - Building Strong Foundations for Aboriginal children, families and communities established in seven sites.
- 2010**
  - The universal Statewide Eyesight Preschooler Screening (StEPS) program was launched to provide population-based vision screening to all children prior to school entry.
  - The Maternal and Child Health Primary Health Care Policy (Supporting Families Early) delivered substantial changes to the way services were delivered.
- 2011**
  - Sustaining NSW Families expands to additional two sites.
  - Building Strong Foundations expands to a total of 15 sites.
- 2012**
  - NSW Kids and Families was launched to champion the health interests of children and young people at home, in the community or in hospital, including services for babies, children, adolescents, mothers, parents and families.
  - NSW births reach 99,510.
- 2013**
  - The Personal Health Record (the Blue Book) was revamped to include developmental milestones at each health check, updated growth references based on international standards, and online services information.
- 2014**
  - Steering committee established to advise on a new National Child and Youth Strategic Framework for Health conducted a 20-year retrospective and highlighted how important the 1992 Health Goals and Targets for Australian Children and Youth were in improving the health of children and young people.

## CHAPTER 1

### INFANT WELFARE AT THE TURN OF THE CENTURY

*'Much of the attention to infant and child health rests on the belief that children, their health and their welfare, represent a particularly sensitive index of the adaptation of a society to its environment.'*

Foreword: Bryan Gandevis's  
Tears Often Shed



*Housing conditions in Sydney at the turn of the century.*

NSW Department of Health



*Thomas Street Asylum, 1904*

Benevolent Society of New South Wales

This is a very important theme which underlies a great deal of the reporting on public health measures in the late nineteenth and early twentieth centuries. One of the chief indicators used to determine progress in this area was the infant mortality rate ie the number of deaths of children under 12 months per 1000 births in any particular year.

From the 1870s in Australia there was widespread concern about infant mortality rates, which illegitimate children being shown to be particularly at risk. Of every 1000 children born in the 1880s in New South Wales, 900 would survive to one year and approximately 800 to five years of age. In most of the large cities of Australia at that time the infant mortality rate was greater than that of London and as high as in most of the world's great cities. According to Dr W G Armstrong, the founder of the infant welfare movement in Australia: 'the death rate for infants is probably the most sensitive index we possess of the physical welfare of a town or nation and of the effects of hygienic control.'

As Milton J Lewis writes in his thesis 'Populate or Perish', the infant mortality rates of Sydney were considerably higher than those of the rest of New South Wales for the remainder of the nineteenth century, and continued to remain so until the late 1920s. Lewis points out that the urban-rural difference in infant mortality rates throughout Australia was similar to Britain and Europe, reflecting the importance of infectious disease as a predominant cause of infant mortality. (pp. 1-2)

In 1906 Newman wrote of increased urbanisation in England and Wales during the latter part of the nineteenth century:

*'It is rather the habits and customs of town life which militate against healthy infancy mortality is almost confined... The homelessness of the people is one of the worst features of town life, and is operating injuriously on infancy... a careful observer of the life of the poor in a great city... may not be able to put his finger upon any one item which is affecting the mother and killing the infant... But he will be able to say that the general conditions of domestic life in a city tenement are such as to make the rearing of infants a difficult and doubtful undertaking.'* (Lewis, 'Populate or Perish', p.2)

Armstrong supported this view and argued that the much higher infant mortality rates of Sydney compared with those of the country in the later nineteenth century were due to extraordinarily rapid urbanisation of Sydney which was taking place in these years, to the absence of almost any sanitary control either central or local, to bad housing, an inferior milk supply, bad sewerage, innumerable filthy cesspits, inferior drinking water, and to an increase in the practice of feeding infants artificially instead of at the human breast.

It was not however, to be until the turn of the century that public concern for the welfare of all infants would be sufficiently powerful to enable a full examination of the reasons underlying general infant mortality. Lewis writes that infant welfare work in England and France for most of the nineteenth century was primarily concerned with providing shelter for the child and protecting him/her from outright abuse. These humanitarian efforts were directed, moreover, towards a special category of infant, the deprived or disadvantaged child. Similarly, in New South Wales, the emphasis rested on the protection of illegitimate infants from exploitation and on the provision of shelter for parentless infants. This concern for abandoned



Poster: *The Natural Feeding of Infants* by Sir Truby King.

infants led to the establishment in Sydney in 1874 of the Sydney Foundling Hospital (later known as the Infants' Home, Ashfield).

The Benevolent Society, a private charity supplemented by some public funds, cared for the destitute and sick and had long been involved in providing shelter for abandoned infants and unmarried mothers. The Society's Asylum, in 1862, became known as the 'Lying-in Hospital of New South Wales'. This was the only public maternity accommodation in Sydney, and catered mainly for single women. The Society also provided outdoor relief throughout the nineteenth century into the twentieth century, by giving food from the Society's own stores to genuine cases of need – such as when the husband was sick, injured or absent as well as to deserted wives, widows and orphans, the aged, the blind or afflicted, and the destitute in need of bread.

Efforts were also made to introduce legal protection of the infant against ill-treatment, with one of the first attempts at reform concerning the registration of births and deaths. Another attempt involved the introduction of an Infant Protection Bill in 1902 which sought to reduce the scandalously high mortality rate of illegitimate babies by requiring licensing and inspection of foundling institutions in New South Wales.

The high mortality rate in these institutions was felt to be due to the absence of the mother with consequent marasmus or failure to thrive by the infant, and the fact that gastroenteritis or diarrhoeal disease, leading to marasmus, was highly infectious.

The Honourable Dr C K Mackellar, who introduced the Infant Protection Bill which was subsequently passed in 1904, stressed the critical role played by the mother in the early part of the infant's life.

Behind the specific concerns with the level of mortality of illegitimate babies, there was an emerging concern about the mortality of infants in general. Milton Lewis writes:

'It has been suggested that the marked change in attitude in England towards the health of the child, noticeably round the turn of the century, was the product of a number of forces: the scientific study of society; the growth of democracy in the political and industrial spheres such that enforcement of a deterrent poor law became impossible; the rise of feminism, with women entering public positions traditionally held by men; the falling birth-rate, which made babies a commodity in short supply; the revelations concerning national fitness which emerged from the recruiting process for the Boer War; the increasing effectiveness of medicine, manifested particularly in fields of bacteriology and epidemiology.' (p. 119)

In Britain, awareness that a healthy and growing population was central to national strength, turned the concern of the public health doctor or individual local authority with infant welfare into a national concern.

The event which, in New South Wales played the same role in promoting the political importance of the infant death rate as the debate over national efficiency in Britain, was the Royal Commission on the Birth-Rate. This served to publicise the problem of infant mortality and to make it one of universal concern. The person instrumental in having the enquiry instituted and who played a prominent role was Dr C K Mackellar.

In New South Wales the proportion of children in the population dropped from around 40 per cent in the mid-nineteenth century to around 30 per cent in the 1890s. The Royal Commission drew attention to the widespread practice of contraception and abortion and argued that this was one of the factors primarily responsible for the decline in the birth rate, while rejecting the notion that economic conditions caused many to resort to limiting families by the practice of contraception.

The Royal Commission also drew attention to infant and child mortality and, in particular, to the impact of 'summer diarrhoea'; the main victims being artificially fed infants. Gandevia in 'Tears Often Shed' notes that the Commission identified the following causes of infant mortality; artificial feeding of infants, defective care by midwives, ill-health of mothers, lack of maternal knowledge, inexpert infant feeding, poor infant food substitutes, inadequate domestic hygiene, misuse of drugs, infanticide and baby farming.

The Commission also placed special weight on the need for proper feeding and care of babies, urging education of mothers in this respect. This was to become the main thrust or organised infant welfare work in Sydney.

Diarrhoeal disease, probably the most common cause of infant deaths in cities of the Western world in the period of their modern growth, remained an outstanding source of infant mortality in economically less developed countries in the 1950s. Lewis points out that the problem of a high death rate from diarrhoeal conditions was not isolated to Sydney, as high mortality rates from this factor commonly occurred in other urban areas of Australia, the United States, the United Kingdom and Europe until well into the present century. Newsholme in 1899 put before the English public health authorities a well-reasoned, thoughtful summary of the causes of epidemic or summer diarrhoea.

Briefly he showed that summer diarrhoea was a 'filth disease' due to the contamination of infants' food, usually in the home. (Lewis, p.3)



Rural homestead – early 1900s

The infant mortality rate began to decline in the late 1880s, after actually increasing to the mid 1880s. In the early 1900s a turning point was reached with a rather dramatic fall marking the beginning of an uninterrupted decline to unprecedentedly low levels of mortality. Dr G J Cuthbert Browne, Director of Maternal and Infant Welfare in New South Wales from 1937 to 1964, wrote in 1950 that: 'the greatest over-all improvement in infant mortality rates from all causes was in the decline of diarrhoea and enteritis, which together, during the first quarter of the century represented a dreadful community scourge with the return of every summer'. Modern age-specific mortality rates are approximately 20 per 1000 under one year and one per 1000 in the once to four year age group (Gandevia). This represents a drop in the infant mortality rate of approximately 500 per cent over a period of almost a century. There is much debate in the literature about the factors contributing to this decline. Lewis, Armstrong and Gandevia all point to it being multi-causal.

From 1885 there was a substantial improvement in the environmental sanitation of the city from what was an appallingly low level previously. Gandevia writes of increasing public awareness and community responsibility about health which was spurred on by an outbreak of bubonic plague at the turn of the century. Lewis highlights public

health measures such as an adequate sewerage system and water supply and, later, an improvement in the garbage disposal system which significantly reduced the risk of intestinal disease infection for the general population and, in a 'mediated way', the risk to infants of death from diarrhoeal disease and associated maladies.

Lewis argues that improvement in the metropolitan milk supply was probably a less important factor at least until the 1930s. He suggests that although the suppression of the use of chemical preservatives, such as boracic acid, led to improvement, the liquid milk received in the home often contained high bacterial levels. Even in the 1920s baby clinic nurses routinely advised mothers, including those in working-class areas, to use the more expensive dried milk as the average fresh milk was so unsafe. Lewis also points to unplanned changes like the disappearance of horses from the city which reduced opportunities for flies to breed and to spread intestinal infections. (p. 284)



*Dr W G Armstrong*

Armstrong supports these arguments and emphasises the impact of legislation and organisation of public services; the passing of the Public Health Act in 1896 and the appointment of medical officers of health to the most populous districts, with highly trained sanitary inspectors commencing work municipally.

Armstrong also points to the great move of social betterment which spread over Australia after Federation, leading to rising wages and industrial expansion with greatly improved conditions of living. The reduction of average family size over this period was also a contributing factor in the decline in the mortality rate.

Lewis argues in 'Populate or Perish' that it was organised infant welfare work which played a decisive role in the reduction of infant mortality in Sydney from early 1900s. (p. 285)

WG Armstrong was the first person in Australia to systematically tackle the problem of infant mortality. The State of New South Wales was the first area in the southern hemisphere to establish infant welfare work which was among the earliest such work in the world. It preceded, as Lewis writes, the beginning of Truby King's better-known work in New Zealand by three years.

Armstrong himself wrote in 1939 that the services he established were based on the operation of similar activities in England and France at the close of the last and in the early years of the present century.

Armstrong had been interested in the issue of infant mortality since he began private practice in 1888 after obtaining his medical degree at Sydney University. He pursued this issue when he studied for the Cambridge Diploma of Public Health in England in 1894-95 and when appointed first medical officer of health for the metropolitan district in 1898, was committed to trying to reduce infant mortality in Sydney by an assault on the problem of diarrhoeal disease.



Armstrong examined at first hand in 1895 the work of Dr Pierre Budin in Paris whose first consultation de nourissons was established in 1892. The French work was in advance of English developments, and the objects of these and similar institutions in the French provinces was to keep children during the first two years of life under regular medical supervision, with weekly weighing and examination, to urge breastfeeding and to provide specially prepared cows' milk for those babies who could not be breastfed. Early English efforts until 1905 concentrated on the provision of infant milk depots which did a valuable service by attracting public attention to the need for preventive effort and by stimulating both medical and lay efforts in the right direction. Consultation for the babies fed on depot milk was added by Dr G F McCleary in 1905, leading to the establishment of the first baby clinic in England.

Armstrong chose not to follow the French or English in distributing modified, sterilised cows' milk. He was, however, considerably influenced by the work of English public health doctors such as Newsholme on the causes of the high mortality among urban infants and especially among infants of the working classes. Newsholme's work was particularly important, according to Lewis, as it focused on the domestic sources of diarrhoeal disease, causing Armstrong to concentrate his efforts on improving the quality of mothercraft, particularly the vital need to breastfeed.

Newsholme argued that breastfed infants had only one-tenth of the average tendency of infants to fatal diarrhoea, while he also felt it was possible that condensed milks may have formed an important pre-condition of diarrhoea by causing defective nutrition. Therefore the relatively simple means of advising mothers on proper feeding and hygienic care of the infant became the key points of the infant welfare movements in several countries and were followed by Armstrong.

Armstrong, as Medical Officer of Health to the metropolitan combined district of Sydney and City Health Officer, began his campaign by issuing a brief pamphlet of 'advice to mothers', a copy of which he had sent to every address in the city at which a birth had been registered.

In 1904 Armstrong obtained from the City Council of Sydney authority to employ a trained health visitor to visit personally and instruct the mothers of all newly born babies in the city who were not under direct medical care. Miss Margaret Ferguson was employed in the position by virtue of the fact that she had qualified as a health visitor by obtaining the Certificate of the Royal Sanitary Institute and had two years' experience under Armstrong in general health visiting in poorer parts of Sydney. (nb The resident of the Board of Health, Asburton Thompson requested the Royal Sanitary Institute, London, the recognised body in England for certification of sanitary inspectors, to conduct examinations in Sydney. The first examination was held at the end of 1900.)

Ferguson began her work in May, 1904, described by Armstrong as follows: 'A daily list of all births registered is obtained from the registrars and within a few days after registration, the home of each child born in a poor neighbourhood is visited by a woman inspector of the municipal council, who interviews the mother, talks to her confidentially on the management of the child ... and earnestly inculcates cleanliness, leaving, also, at each house a copy of a leaflet setting forth the dangers of infantile diarrhoea and giving instructions on the feeding of infants. The principal points impressed on the mother ... are the great superiority of breast-nursing ... should breast feeding be impossible, the use of properly modified fresh cows' milk is advocated, and warnings against the long tube bottle the 'dummy' or 'comforter' and the use of starchy or patent foods tendered. The conditions as to cleanliness ... of the dwelling are noted ... and reported ... at headquarters, where any action which may appear to be indicated by the information in the report is taken by the Medical Officer of Health.' (Armstrong's 1939 article, annotated by Lewis, p. 133)



*Trained nurse home visiting, Ultimo, 1906  
Benevolent Society of New South Wales*

The pamphlet that the mother was given on the dangers of infantile diarrhoea and on the feeding and management of infants, strongly stressed the importance of breastfeeding. The slogan of the whole campaign was 'there is no feeding equal to breast feeding'.

In view of the dramatic results obtained by health visiting in the City of Sydney, the New South Wales State Department of Public Health increased the number of health visitors by two in 1909 to undertake similar work in the more populated industrial suburbs immediately surrounding the city. Mrs B E Cooper-Day, who was also a qualified sanitary inspector, was placed in charge of Redfern, Darlington, Glebe, Alexandria and North Botany with a total population of 99,870 persons. Miss C M Burne, ex-nursing sister of the Coast Hospital and later to become matron, first of the Lady Edeline Hospital for Babies and afterwards of the Coast Hospital, was appointed soon after to work in the suburbs of Annandale, Balmain and Leichhardt, with a combined population of 72,442. So as well as Sydney city, visiting took place in nine of the congested industrial suburbs.

Armstrong continued this work which he called the 'Town Hall campaign', until the end of 1914, when he was transferred to the head office of the New South Wales Health Department. Over the decade he pursued this policy, the proportion of breastfed children rose from 72 per cent in 1904 to 94 per cent 1914, whilst the mortality rate fell from 116 per 1000 births to 68 per 1000 births.

Armstrong himself partly accounts for the surprising gain in breastfeeding from 85 per cent in 1912 to 94 per cent in 1914 to the introduction of the Baby Bonus which caused an earlier registration of births in 1913 and 1914.



Sydney Street scene in the 1900s  
Tresillian

Between the years 1904 to 1912 the average time between the birth and the first visit to the mother and new baby was 5.3 weeks. After 1912 the Baby Bonus of five pounds began to be distributed to all mothers of newly born infants by the Commonwealth Government. As parents lost no time in registering the births of their children in order to obtain the bonus, the average time from birth to the first visit fell to three weeks in 1913 and 2.3 weeks in 1914.

On February 15, 1915, an Act known as The Early Notification of Births Act was assented to, requiring that births occurring in proclaimed districts be notified within 36 hours of the birth.

Lewis points out that the impact of the campaign on infant mortality rates was assisted by the fact that the social group contributing disproportionately to infant mortality was the very one on whom the advisory service was concentrated:

‘The mothers reached were working-class residents of the inner city area who were unlikely to be influenced by private practitioners and whose infants were more at risk, given their environment, from the threat of diarrhoeal mortality.’ (p.285)

The emphasis on prevention in the quality of maternal care was one solution to the problem of infant mortality. It was technically appropriate and effective despite socio-economic differences, did not challenge the social status quo (i.e. urban poverty and class differences in mortality) and did not challenge the prerogatives of private practice by its form of public intervention. These arguments would also hold for the introduction of mass facilities in the form of infant welfare clinics which occurred in 1914.



Source: Norman Lindsay



*Nurses and infants at the Benevolent Society's  
Hospital for Infants, Thomas Street, 1916  
Benevolent Society of New South Wales*

## CHAPTER 2

### BEGINNINGS OF ORGANISED BABY HEALTH CLINICS

*'There is no wealth but life. That country is richest which nourishes the greatest number of noble, happy human beings. So if we want noble and happy human beings we must do what we can to care for and educate our mothers.'*

Isla Blomfield, Australian Nurses Journal, 1912



*Benevolent Society's Consultation for Infants Clinic, 1913*

*Benevolent Society of New South Wales*

The Benevolent Society was one of the major organisations providing maternity services in the nineteenth century. In 1905 the Society opened a new hospital, the Royal Hospital for Women, Paddington. The 1905 Annual Report of the Society states that the medical staff recommended in that year that a 'Consultation for Infants' be established in connection with the Outpatients Department, where infants born in the hospital or surrounding districts might be brought once a week until two years of age for inspection and to be weighed. The medical staff stated that this had been tried in connection with some of the maternity hospitals in France, and resulted in considerably diminishing the mortality amongst the infants so supervised. The object was to strictly supervise the children and to advise the mothers as to their diet (Annual Report, 1905).

The Consultation for Infants was opened in 1906, and by the end of the year had attended to 150 infants. By the beginning of 1907 infants of the States were also being brought for examination and medical control weekly. The Consultation for Infants was the first baby health clinic in Australia.

In 1907, in order to provide adequate accommodation for the Outdoor Department (now entitled outpatient services) which included the Consultation for Infants, the Directors of the Royal acquired the old Paddington council chambers. These premises were renovated to provide adequate patients' waiting rooms, consultation room, examination room etc., together with a properly equipped dispensary. During 1907 the infants' clinic had a total of 1,388 attendances. These services were sustained from the Benevolent Society's own funds and were provided for the very poor.

In 1908 an Outpatients Department was inaugurated in connection with medical work among infants at the Benevolent Society's Hospital for infants and the Asylum for women and children at Thomas Street, Sydney. While it was recognised that medical advice was available at no cost from public and private sources, very often a destitute mother was unable to pay for necessary medicine or to be hospitalised with a sick infant due to other family commitments.

Therefore the Department was opened with the following arrangements:

*'Regularly the Honorary Visiting Medical Officer attends the Institution, where poor mothers bring their infants. They are examined and prescribed for; but arrangements are also made in the Doctor's absence for the cases to be temporarily dealt with. The prescription, which includes the necessary infant's food, is provided at the dispensary on the spot, and milk, if ordered, is arranged for either by delivery at the home or by the mother sending to the Institution for it. On the day following the medical examination, a trained nurse is sent to the woman's home and teaches her the mysteries of feeding and the general details of properly nursing her infant. If necessary, the woman is daily called upon, while she herself attends the Doctor weekly, until the child is well and she is capable of doing without the necessary aid.'* (Annual Report, 1908, p. 15)

It was the first work of its kind in the country and was located close to Central Railway Station for ease of access.

In 1909 the Paddington Consultation for Infants arranged for trained nurses attached to the Outdoor Department to provide visiting service to mothers attending the clinic that had been established in Thomas Street, Sydney. The focus of the two clinics differed however, as the Paddington clinic was principally for 'well' babies while the services established at Thomas Street, Sydney were designed for infants in need of medical attention.

The Hospital for Infants was renovated, reorganised and formally constituted as the Renwick Hospital for Infants. The new hospital was renamed after the late Sir Arthur Renwick who had been President for the Benevolent Society, and it was officially opened in 1911. The Consultation for Infants at the Royal Hospital, Paddington, was attached to the new Renwick Hospital, as part of its Outpatients Department.



*Benevolent Society Clinic, Outpatients' Department, Quay Street, 1928*

*Benevolent Society of New South Wales*

By 1913 regular clinics were held twice a week in Thomas Street, Sydney and once a week at Paddington. The Annual Report for that year emphasised the educational influence of the Outpatients Departments, for as well as treating sick infants the mother was also taught the rules rearing a healthy baby. The staff of the Renwick Hospital were so impressed by the benefits accruing from expert supervision in the home that it was proposed to develop a complete district nursing service based on the premise that 'prevention is better than cure'. In 1918, 33,777 visits were made to infants in their own homes.

In 1921, the Renwick Hospital for Infants was transferred to new premises in Summer Hill. An Outpatients Department was opened at the new hospital, with the existing clinics still operating.

The Paddington service was discontinued in the early 1930s. The city service ceased operation in 1957 when the site was sold, and the Renwick Hospital for Infants continued to operate until 1964, when it became the Grosvenor Hospital.

Another service supported by voluntary work was the Alice Rawson School for Mothers, which was established in 1908. Its motto was 'Save the Children for the Nation'. The concept originated in Belgium where a doctor had been responsible for dramatically lowering the infant mortality rate in the local district by commencing a School for Mothers.

The National Committee for Women proposed that a School for Mothers be established in Sydney, and the first school was opened in Bourke Street, Darlinghurst, named after the daughter of the then Governor of New South Wales. A government subsidy of 250 pounds per year was provided to support its activity in later years.

The school was open each afternoon, and babies were weighed, advice given as to general management of infants and tea provided for the mothers. The rest of the time was spent by the nurse in visiting mothers in their own homes.

The aims of the School for Mothers were the education of mothers, the encouragement of natural feeding and the provision of a proper substitute where natural feeding was impossible.

In an article on the Alice Rawson School for Mothers written by Isla Blomfield, who had trained at the Royal Prince Alfred Hospital,



*The Incubator*

*Tresillian*



*The Alice Rawson School for Mothers, Bourke Street, 1914  
NSW Department of Health*

Sydney, worked in Sydney, London and China, and then was Matron of the School in 1910 and 1911, there is a discussion of the problems preventing breastfeeding by mothers and other associated concerns:

'One of the chief reasons which prevents natural feeding is overfeeding ... and the mother thinks its natural food is not satisfying enough (and) wean the baby or supplements the breast with all sorts of unsuitable foods, with the result that in summer the baby is an easy prey to gastroenteritis ... The second reason which prevents natural feeding is that the mothers, not knowing the importance of taking proper nourishment themselves, live chiefly on tea and bread and butter ... the mother is also instructed in the importance of fresh air, cleanliness and ventilation (and) also warned against soothing syrups.' pp 7-8)

The number of Schools was expanded with additional facilities being opened in Newtown and a third in Alexandria. The nurses of the Alice Rawson Schools also provided support to the 'sanitary inspectors' employed by Armstrong in his 'Town Hall-Campaign'. Armstrong's visitors were only able to visit each home once and so lists of names were provided for the nurses from the Alice Rawson Schools to follow-up, particularly where babies were artificially fed or where babies were regularly losing weight and required regular weighing.

The inability of the mother's instinct alone to provide for the feeding and rearing of a child was constantly emphasised, as Blomfield reported that mothers were capable of a great deal of self-sacrifice but were heavily handicapped by ignorance and an immense amount of equally ignorant advice. She felt that this was not just a problem for mothers of the poor, as in New Zealand there had been identified just as much ignorance among the well-to-do. In recognising the generality of the lack of maternal knowledge and the need for services by all classes of women, Blomfield was ahead of her time.

Breastfeeding and other social reforms were seen as the answer to all social evils including criminality and insanity:

'If women in general were rendered more fit for maternity, if infants were nourished by their mothers and boys and girls were given a rational education, the main supplies of population for our asylums, hospitals, benevolent institutions, gaols and slums would be cut off at the source.' (Blomfield, p. 9)

The final or 'terminal' report of the Alice Rawson School for Mothers states that the total number of visits paid by the three nurses attached to the School in 1914 was 5,534 and the number of weighings 3,584. The home visiting service of the Alice Rawson Schools was similar to the services provided by Armstrong's visitors in his 'Town Hall Campaign' in that the nurses were not to provide any form of treatment to unwell infants, but to refer them for medical treatment. The focus on the care of 'well' babies would become a major feature of Government subsidised baby health services.

In 1912 the Benevolent Society of New South Wales, established an antenatal clinic at the Royal Hospital for Women under the direction of Professor J C Windeyer. This was a major pioneering effort, only the second to be opened in Australia and the third such clinic in the world. The clinic was location in the Outpatients Department of the Royal, in the same area as the Consultation for Infants. In the 1930s preparation for child-birth classes were

established covering antenatal exercises and basic educational instruction for labour. The provision of antenatal services would also be a feature of Government subsidised baby health services.

In 1913 the Lady Edeline Hospital for Babies was established at the instigation of the Honourable Frederick Flowers, the first Minister for Public Health in the New South Wales Government, at 'Greycliffe', Vacluse. The hospital was for babies up to two years of age suffering from gastroenteritis, with accommodation for 50 babies, and after discharge a weekly clinic was provided at the Department of Public Health until children had fully recovered.

In 1914 W G Armstrong was transferred from the Town Hall, City Council of Sydney to the head office of the New South Wales Department of Public Health. The newly constituted Minister of Public Health, the Honourable Frederic Flowers, after consulting with Armstrong, decided to continue and expand the infant welfare movement throughout New South Wales and to associate it with the Alice Rawson School for Mothers and other bodies with similar objectives. A conference was held on June 17, 1914 with all interested organisations, and after further consultations, the Minister decided to establish baby clinics or infant consultation centres along the lines of those operating in England and France, to be administered by the Minister with the aid of a Board.

The Ministerial Minute, dated July 20, 1914, reads as follows:

'I propose to establish a Board to be known as The Baby Clinics, Pre-Maternity, and Home-Nursing Board, to carry out that portion of my policy relating to the present health of women and children. The primary duty of the Board will be created and administer baby clinics in suitable localities in the metropolis.

The clinics will:

1. Be clearing houses for sick babies which will be recommended to existing infants hospitals.
2. Advise pregnant women, confine them in their own homes in special cases, and arrange in other cases for their accouchement in the women's hospitals.
3. Advise mothers in regard to the feeding of their infants, send nurses to instruct the mothers in their homes, and provide for medical attention in their own homes in special cases where the circumstances warrant it.
4. Advise mothers in regard to their unborn babies and thereafter right up to the time the children are of school age – that is five years of age.
5. Pay special attention to the dental troubles of pregnant women and of children under school age. Dental cases will be sent to the Government Dental Hospital by special arrangement.
6. Arrange, where special circumstances warrant it, for recently-confined mothers to go with their babies for a week or two's rest to the Convalescent Home at Rose Bay.
7. Arrange for the medical treatment of mothers and infants in their own homes where special circumstances warrant it.



Lady Edeline Hospital  
NSW Department of Health



In this way every child will be able to get medical attention up to the time it goes to school, the schools' medical service will then look after the children.'

The Baby Clinics, PreMaternity and Home-Nursing Board was accordingly established, consisting of Dr P B Clubbe, Dr R T Paton, the Director-General of Public Health, Mr N Mayman, the President of the Benevolent Society of New South Wales, Miss Alice Friend, Secretary of the Alice Rawson School for Mothers, and Mrs Jessie Dickie. Dr Clubbe was appointed chairman of the Board.

It was determined that the personnel of each baby clinic was to consist of an honorary physician and two nurses. No babies suffering from illness were to be treated on the premises, but referred to a hospital or the family doctor. One of the two nurses was to remain at the clinic to receive mothers and babies and the other to undertake home visiting. Each day lists of births were obtained from the district registrar, and these were all visited. Where the mother was under medical care, no further action was taken unless the child was later brought to the clinic voluntarily.

In August 1914, the three Alice Rawson Schools for Mothers were taken over by the Government, and established as Baby Clinics. The first clinic was opened at 22 Henderson Road, Alexandria on August 24, 1914. Nurse Edith Pike, originally from the Alice Rawson School for Mothers, was Head Nurse and paid a salary of 135 pounds per annum. The Second Nurse, Nurse Irene Williams, was paid 130 pounds per annum. The clinic was open from 9.00 am to 5.00 pm with one hour for lunch. The premises were taken on a five year lease at a rental of 17 shillings and sixpence per week.

Dr Margaret Harper, later to become very significant in the infant welfare movement, was appointed as honorary physician and attended each Wednesday afternoon for two hours. Dr Ludovici became the honorary obstetric physician and attended each Tuesday afternoon for two hours, due to the prenatal focus of the clinics as well as postnatal.

Other clinics followed at Newtown, Bourke Street, Woolloomooloo and Balmain, and by the end of the 1914 negotiations were underway to open others at North Sydney, Glebe and Newcastle. Four nurse inspectors had also been appointed by the end of 1914, including Miss C M Burne, one of the nurses who had worked for Armstrong previously, to ensure continuity in the work undertaken. Other nurse inspectors were B E Day, E M Gould and Lucy Spencer. Nurse Flora Gallagher, from the Alice Rawson School at Newtown stayed at the Newtown clinic and Nurse Annie Dollard moved from the Bourke Street Alice Rawson School to the North Sydney Clinic when it was opened.

By the end of 1914 the daily average attendance at a clinic was from 20 to 30, and steadily increasing. C M Burne describes the role of the clinic nurses, in the Report of the Department of Public Health for 1914.

'Attached to each Clinic are two nurses, one for outdoor work, who visits the mothers in their homes and instructs them in detail in the value of breast feeding and the hygiene of infancy. Special stress is laid upon the need for cleanly surroundings, ample ventilation and free access of sunlight. The danger of infection from flies is pointed out and mothers are urged to keep the infant as far as possible sheltered from flies, and to take special precautions



Alexandria Clinic, 1914  
NSW Government Printer

to keep all food protected from contamination by them.

The indoor Clinic nurse attends to the older babies brought to the Clinic, weighs them regularly, and gives instructions to the mother concerning the care of the infant and herself and shows her how to prepare and make foods, if the child has to be artificially fed. In all other cases the mother is urged to breastfeed the child up to the age of nine months ... Expectant mothers are also advised as to the care they should take of themselves during pregnancy.' (pp. 43-45)

Statistics were also kept (yes, even then!) on the number of visits, the types of feeding of infants, and if artificial, the nature of the food used.

An article in the Medical Journal of Australia, 1914, describes the interior layout of the first Governmental Infant Clinics;

'These clinics are simplicity itself. No excessive equipment is to be found in the almost humble rooms, and temporarily bare necessities have to suffice for conducting the work, until experience has taught what factors will tend to improve on the results already obtained. In the two existing clinics, two rooms of small dimensions have been engaged in a small, but clean, house. The front room in each case is the clinic proper, while the back room services as a waiting-room for the mothers and their infants. A table with scales for weighing the babies, books and cards for the keeping of records and a very limited number of simple mixtures complete the stock-in-trade. The valuable asset in each instance is a nurse of undoubted capabilities, of great keenness, technically well-trained, and endowed with the one essential for work of this sort – common-sense and knowledge of the world.' (p. 590)

The coming of the First World War meant restrictions of Government funds. The Board resigned in protest because of a dispute over the control of funds, as the question of finance had not been adequately resolved. A new Board, with the new Minister for Public Health, the Honourable George Black as President, began to function in July 1915. Lucy Spencer was appointed as nurse inspector to this Board, and her duty was to visit each clinic regularly, and provide a full report of their operations to each Board meeting. W G Armstrong was also made a member of the Board. Additional funds were made available and from nine clinics in 1915 the number grew to 28 by the end of 1918. In October 1915, the Baby Clinic Board was affiliated with the National Council of Women.

The clinics met with some opposition on the grounds that they constituted an intrusion into private medical practice. Milton Lewis in 'Populate or Perish' documents events which occurred in 1916 which led to constraints being placed on the operations of the clinics. In January 1916 the New South Wales branch of the British Medical Association resolved that it was opposed to the clinics unless the Government guaranteed that the clinics would only be used by people unable to pay private fees. The Baby Clinic Board agreed to amendments to the role of the clinics which had been proposed by the British Medical Association, honorary medical officers of the clinics and medical members of the Clinics Board.

As a result clinics were only to deal with infants under one year of age, to provide services only to those unable to pay private medical fees (i.e the hospital class of patients), to exclude the treatment of sick babies,



*Nurse Ellen Gould, one of the most distinguished nurses who worked as a nurse inspector in Baby Health Clinics in 1914. She covered the Annandale, Balmain, Forest Lodge, Glebe and Leichhardt areas*



*Nurses' room, Alexandria Clinic, 1914  
NSW Government Printer*



Alexandria Clinic 1914  
NSW Government Printer



Treatment room, Newtown Clinic, 1914  
NSW Government Printer



Waiting room, Newtown Clinic, 1914  
NSW Government Printer

to see their main function as advising mothers in poor areas on infant care and to ensure that clinic nurses were under medical supervision.

However, the medical profession did gradually accept that private practice was not in danger from the clinics, as the basic premise that the clinics would not provide treatment was adhered to. In addition, the clinics did eventually provide services to women of all classes. Lewis indicates that by the late 1920s the clinics were advertised as being intended for use by mothers of all social levels.

In February 1915 the Early Notification of Births Act came into effect; births within specified districts were to be notified within 36 hours of the birth. The object was to ensure that in the less well-to-do districts the mothers of newly-born infants would be visited by a trained nurse within the first week of their confinement, with a view to seeing that necessary advice and attention were given for the welfare of the infant and the mother.

The Newcastle Baby Clinic was established in Parry Street in 1915, in an atmosphere of concern about the infant mortality rates in the area which were consistently higher than the New South Wales figures. Since 1898, Newcastle had a comparatively high rate of infant mortality which, until the mid 1960s was well above the average for Sydney. In 1915, the infant mortality rate for infants under 12 months for Newcastle was 77.1, in 1916 it was 81.5, compared with 67.9 for New South Wales as a whole. This high incidence of infant mortality was at variance with infant mortality rates for non-metropolitan New South Wales in total, which had a lower rate than Sydney in the latter part of the nineteenth century, and in the earlier part of the twentieth century, only overtaking Sydney's rates in the early 1930s.

Docherty in 'Newcastle, The Making of an Australian City', argued that the high level of Newcastle's infant deaths was due to poverty, poor living conditions and the value system of a predominantly working-class community with between a fifth and a third of infant deaths being due to gastro-enteric diseases. This was partly due to the rapid increase in the industrial population of Newcastle, and its overall level of urbanization with its consequent poor environmental health. Even in 1920, the infant mortality rate in Newcastle was 172, (compared to a total New South Wales rate in 1916-1920 of 65) whereas in another shire of the Hunter district, the Bolwarra Shire, the rate was 37.

From the turn of the century, government medical officers of health, notably Dr Robert Dick in the 1900s, waged a continuous battle over public health in Newcastle. Dick felt that the improper feeding of babies, in particular the widespread practice of using cows' milk was one of the major factors contributing to the high death rate. (Cows' milk was often adulterated with water which lowered its nutritional value and introduced the possibility of infection.) This supports Lewis' argument that real improvements in the milk supply did not occur until the 1930s.

Despite the establishment of baby clinics in Newcastle, with seven clinics operating by 1925, concerns continued about the high infant mortality rate. In 1917 the medical officer in the Hunter region commented on the high level of infant mortality in mining areas and suggested that care and education of the mother was required prior to the birth of the child, proposing home visits to the prospective mother. In 1919, Robert Dick, the medical officer for the Hunter River district, argued for the further extension of baby health clinics as part of an 11 point program to reduce the infant mortality and sickness rates among infants.

Compared to the general experience in New South Wales, the effect of infant clinics on infant mortality rates in Newcastle appears to have been less significant. However the reaction to these clinics also varied, as Dr Wallace, the government medical officer of health, states in 1925 that:

'differences of social class were evident in Newcastle mothers' responses to the baby clinics. While all mothers were visited after the birth of a child and invited to attend the clinics free of charge, only about half actually attended the clinics and these were mostly from well-to-do classes.'

So, unlike Sydney's experience, those who failed to respond were the poorer people who probably continued to account for a disproportionate number of Newcastle city's infant deaths.

The first clinic outside of Sydney and Newcastle was established at Broken Hill in 1918. The infant mortality rate in Broken Hill had also been extremely high with 99.3 per 1000 births in 1915 and 96.3 in 1916, i.e higher than Newcastle. The medical officer for the Broken Hill District, J F Bartley, comments in his report for 1919 that:

'the nurses... no matter how strenuous and scientific, cannot cope with a process of starvation.' (Annual Report of the Department of Public Health, 1919.)



Glebe Clinic, 1916  
Tresillian

He attributed the abnormally high infant mortality rate of the area (147.7 in 1919, compared to 99.2 in 1918) to malnutrition, a result of industrial unrest, unemployment and the mother's failed breastmilk supply. Again in 1920 he argued that if the economic position of the people had been better, particularly the welfare of expectant and nursing mothers, the infant mortality rate for the year may have shown some improvement.

In 1917 the Director-General of Public Health commenced the excellent work of the baby clinics, and noted that many of the 241 infants treated at the Lady Edeline Hospital for Babies had been referred by them. In 1917 Sydney Municipal Council discontinued the work of visiting mothers of new born infants due to the increase in services offered by the baby clinics. At the end of the 1918 there were 28 clinics throughout New South Wales and by 1919 there were 30 clinics with 14 in the metropolitan area.

There was much discussion about the types of services required to save preventable deaths toward the end of the First World War. During the war, as many babies died in Australia as did men on the battlefield. The Medical Journal of Australia reported in 1917 that:

'the waste of healthy young lives in the great war is a colossal calamity which the Empire must face and attempt to remedy with all available means. Added to this waste of adult lives there is the fact that vast areas of the Commonwealth need a far larger population of workers ... The problem of the next generation rests primarily on a reduction of infantile death and infantile disease, and the rearing of strong Australian children.' (p. 553)

Many experts in the area, particularly medical practitioners, advocated the development of antenatal services either in the form of antenatal clinics, antenatal rest homes or increased

maternity services, particularly hospitals. However, this would not occur in relation to baby health clinics until the late 1920s.

The first 20 years of the twentieth century had seen the establishment of formally organised and founded baby health clinics, principally in metropolitan Sydney. Gandevia writes that:

'the 50 year period from 1870 to 1920 virtually established the pattern of modern medical practice as the mortality peaks of the late nineteenth century subsided. The major dangerous infections declined, with immunization being the major factor in the case of whooping cough and diphtheria. However, this change was caused by many factors, as developments in medical science coincided with substantial and dramatic social and economic changes. However, there is no doubt that the infant welfare movement contributed substantially to these improvements.'



*Glebe Clinic, 1916*  
*Tresillian*



*Tresillian, Petersham, 1935*  
NSW Government Printer

## CHAPTER 3

### THE FIRST MOTHERCRAFT HOMES

'Infants will live and thrive in spite of poverty and bad sanitation, but they will not survive bad mothercraft!'

Medical Journal of Australia, 1917



Lady Edeline Hospital, Vacluse  
NSW Department of Health

The end of the First World War saw a movement develop for the co-ordination of infant welfare services in Australia and in New South Wales.

### THE ROYAL SOCIETY FOR THE WELFARE OF MOTHERS AND BABIES -TRESILLIAN

The establishment of the Society for the Welfare of Mothers and Babies in 1918 was the outcome of a conference called by the Honourable F Flowers, Minister for Health in 1918. The Health Ministry was a new department in the McGowan Labor Government reflecting their policy of expansion of medical services aimed at ensuring the better survival of mothers and babies.

At this time many organisations were contributing to the saving of infant life – these included the Baby Clinics, the Sydney Day Nursery Association, the Royal Alexandria Hospital for Children and Renwick and Lady Edeline Hospitals. There was a recognised need for co-ordination of the efforts of all people working for the welfare of mothers and babies and for the preservation of the traditional role of the voluntary organisations in this area.

This initiative was also partly due to Neville Mayman, President of the Benevolent Society and Deputy Chairman of the original Clinics Board. He had been sent to New Zealand early in 1918, writes Milton Lewis, to investigate the work of the Plunket Society, Dr Truby King's highly successful infant welfare organisation. Mayman reported favourably on the Plunket Society and other measures taken in New Zealand to promote infant and maternal welfare. Mayman felt that a co-ordinating body which would oversee existing efforts and seek funds from the public in addition to a Government subsidy could produce the same good results as the Plunket Society.

An Act incorporating the Society was passed by Parliament in 1919 and an office was established in the Chief Secretary's building with Mr Innes-Noad, MLC as President. In April, 1919 H M King George V assented to the prefix 'Royal' and Queen Mary became Patron in 1920. More recently, on her visit to Australia in 1954, H M Queen Elizabeth II granted her patronage to the Society.

By the Act of Incorporation the Executive Council was constituted to manage the activities of the Society, consisting of office bearers, appointees of the Minister for Health, and representatives of the British Medical Association, Baby Clinics, charitable organisations, the Nurses' Association and the Royal Alexandra Hospital for Children.

The Director General of Public Health represented the Health Department on the Council of the Society.

As summarised in the Act the goals of the Society were:

1. The saving of baby life and the amelioration of the conditions of life of children up to the age of which they are required to attend school.
2. The ensuring of proper nursing and health conditions to every expectant mother prior to and every mother subsequent to childbirth.
3. Such further objects and purposes as may be proclaimed by Government.

In 1919 the members of the Baby Clinics Board joined the Council of the Society and constituted a committee to which the management of the baby clinics was weakened and would not be re-established until 1926. Members of the committee included the Honourable S R Innes-Noad, MLC, and Drs W G Armstrong, C Clubbe, W F Litchfield, E Ludowici and M Harper.

The Society became very active; a 'baby week' and lecture tours were instituted, an active publicity campaign was commenced with the distribution of pamphlets, and during the 1919 influenza epidemic the Society helped to look after 500 destitute children. The Society's services were available to all women irrespective of class.

In December 1919, Sir Truby King visited Sydney as a guest of the Royal Society. He had established the Plunket Society in Dunedin, New Zealand, in 1907. Armstrong's earlier initiatives had been developed based on British and European influences rather than New Zealand developments. While the early baby clinics certainly owed some of their concepts to his Plunket Society, it was felt that his ideas, including the use of emulsions, were different to views in New South Wales and that conditions were different to those in New Zealand. Australia was less favourable to infant life with its harsher climate, overgrown cities and its isolated rural settlements. Dr King did however recommend that the training of clinic nurses be standardized, a factor which would contribute much to the effectiveness of the clinics. Dr Margaret Harper was therefore commissioned to provide a report upon the working of the Karitane Hospital at Dunedin, including its value as a training hospital.

Dr Harper on her return from New Zealand, felt that although there were differences between the two countries, certain of the New Zealand methods were applicable. She recommended:

1. The establishment of a training school for nurses on lines somewhat similar to those on which the Plunket hospitals are carried out although only babies with their mothers should be admitted.
2. That the Society should undertake the standardization and distribution of the pamphlets published for the information of parents.
3. That as cow's milk is used extensively in the feeding of infants and young children the Society should make every effort to bring the milk supply of Sydney to a safe and healthy standard.' (Dr Margaret Harper, Lysbeth Cohen, p.21)



*Dr Margaret Harper  
Royal Alexandra Hospital for Children*

As a result, with the assistance of Government funds, the Society purchased a house at Petersham, in the Western suburbs of Sydney, and established the first Tresillian Mothercraft Home, in 1921. (Note: The name 'Tresillian' comes from the home itself, which was named after a village in Cornwall in southern England.)

Margaret Harper was the inaugural Medical Director, a position she retained for 29 years from 1920 to 1949. Lysbeth Cohen, in her biography of Dr Harper states: 'she is now recognised as one of Australia's most distinguished women, a pioneer who helped establish the position of women in Medicine, internationally known for her contribution to paediatrics and the care of newborn and premature babies. She will be remembered





*Tresillian in the 1920s*

*Tresillian*

most particularly for her part in the field of Mothercraft and many babies owe their lives directly or indirectly to her.

In 1906 Margaret Harper completed her medical degree at Melbourne University, worked at the City Mission and then the Queen Victoria Hospital, Melbourne, before being appointed as a resident to the Royal Hospital for Women, Paddington in 1907. She worked at the Consultation for Infants at the Royal which was established in 1906. In 1910 she became a resident at the Royal Alexandra Hospital for Children at Camperdown, becoming Chief Resident Medical Officer and then in 1914 the first woman to be an Honorary Physician.

In her early years at the Children's Hospital she was greatly influenced by Dr (later Sir) Charles Clubbe and Dr Litchfield. Working with Dr Litchfield they trialled English methods on the artificial feeding of babies and as a result were the first doctors to introduce the modern methods of infant feeding into Australia.

Margaret Harper remarked when told of the proposals for the establishment of baby clinics, 'this is the work I should like to do'. In 1914, she was appointed Honorary Medical Officer of the first Baby Clinic. Her work with the Royal Society followed as well as the commencement of a private practice in Wollstonecraft and then Macquarie Street. She lectured part-time at Sydney University, which would lead to her appointment as the first Lecturer in Mothercraft in Sydney University, the first appointment of its kind in the British Empire. She wrote the 'Parents Book' in 1926, which would become a standard text on Mothercraft, used very widely by mothers to guide them in the care of their infants. Between 1924 and 1939 she was an Honorary Medical Officer at Rachel Forster Hospital, the Honorary Director to the Tresillian Homes and Baby Health Centres (which reverted to Government control in 1926), Honorary Paediatrician lecturing in Mothercraft at the Royal Hospital for Women and Honorary Physician at the Royal Alexandra Hospital for Children.

In the early 1930s she conducted a weekly fifteen minute broadcast on ABC Radio Station 2FC on Mothercraft, and was introduced as 'The Lady Doctor' due to the requirement that doctors in the media should be anonymous. She also negotiated with Drug Companies to produce nursing aides for mothers. In 1936 she was appointed a member of the New South Wales Hospital Commission, on which she remained until 1944. The Commission was part-time and an honorary body and she brought to it her experience in maternal, baby and child health. She was one of five women to be made foundation fellows of the Royal Australian College of Physicians. Dr Harper's importance to the organisation and her contribution is recognised in the Society's 1970 Jubilee Report and in 1982 a therapeutic day care clinic for mothers and babies located at Carpenter House, Wollstonecraft, was named the Margaret Harper Clinic (partly established with funds raised by a group of her associates and friends).

Dr E. Sydney Morris, who was the Director- General of Public Health wrote in 1946 of Dr Harper's work and influence:

'there is no need to tell you what a powerful influence Tresillian became under the guidance and inspiration of Dr Harper. It became the mecca for nurses from all over the Commonwealth who desired to obtain post-graduate mothercraft training and also an educational centre for the medical profession ... When I first

came into contact with Dr Harper and Tresillian in 1920-1921 I was profoundly impressed by her methods and results, especially the manual expression of breast milk.' (Infant Welfare in NSW, p.2)

Initially, the courses offered at Tresillian were for general or midwifery trained nurses only. Later in 1924 a course for untrained girls as mothers' helps was introduced. The course for general trained nurses was of three months duration and the trainees paid a fee of 15 pounds later raised to 25 pounds. From 1914 to 1932 the Society trained Froebal Nurses. These were students who studied for six months at the Kindergarten Union and six months at a mothercraft hospital. The 12 month course for mothers' helps was increased to 15 months in 1933 and the name of these nurses changed to 'mothercraft nurses'. The longer course enabled them to attend nursery schools for lectures and practical work and learn to take care of children up to the age of three years.

In the first two years of its operation, Tresillian treated 432 patients and babies as inpatients, and over 4,000 outpatients. Over 100 nurses were trained. At the home difficult feeding cases could be dealt with and efforts made to re-establish breastfeeding when this had failed or partially failed. The baby clinic sisters were the first to come for formal training, and Tresillian training become a requirement for appointment as a clinic nurse. This was followed by nurses from every State in Australia. The Bush Nurses and Far West nurses were also encouraged to come.

Joyce Carr in her article on 'Fifty Years of Service' in the Australian Nurses' Journal describes how in 1920 the Royal Society was still struggling for existence and still pressing for legislation in the vital matter of funds to continue its work, purification of the milk supply, registration of nurses and midwives, and the inclusion of a child care in the education of doctors. However, the progress it had achieved in the first years was remarkable: two model welfare centres were established, each with a baby clinic, a pure milk and ice depot, and accommodation for branches of the Sydney Day Nursery Association and the Kindergarten Union of New South Wales; the publicity campaigns were continued with additional pamphlets, lectures, press articles, books and films; baby clinics were opened and staffed; medical conferences on infant care were arranged; as well as the opening of the Mothercraft Home and Training School.

The infant mortality rate under one year in Sydney was 75 per 1000 live births in 1914, by 1922 it had fallen to 57 per 1000.

Sir Innes-Noad believed strongly that the way to build a successful Australia was through ensuring healthy children and that this could be achieved through legislative and moral guidance from the state. Jan Kelly, in her thesis 'Not Merely Minded', on the development of Nursery Schools between 1905 and 1945, talks of the breadth of his vision for the role of welfare centres which went beyond the original goals for these services. He wanted to: 'extend the service both beyond early infancy and also to the children of working mothers who would find attendance at the clinic difficult to arrange. He proposed airy, attractive buildings 'clean and pleasing to the eye' which would contain under the one roof, but each with its separate entrance, a comfortable furnished reception room leading to a bright cheerful clinic, plus a day nursery and kindergarten, on separate sides of the building.



*Tresillian in the 1920s*  
*Tresillian*



*Welfare Centre, Dowling Street,  
Woolloomooloo, 1921  
NSW Government Printer*

The buildings would be financed by the state but the services operated by the respective specialist organisations i.e. the Welfare Society, the Day Nursery Association and the Kindergarten Union.' (p.140)

Sir Innes-Noad's vision was welcomed by the Day Nursery Association which agreed with his philosophy and saw the Welfare Centre idea as a way of overcoming its problems with buildings. Early in 1918 the Woolloomooloo Nursery had severe problems owing to the very dilapidated condition of their premises.

While very little was done immediately, state and public interest in the preservation of child life and the welfare of young children in the immediate post-war years did finally result in permanent homes for the Woolloomooloo and Surry Hills nurseries, though each took some time to obtain the premises.



*Welfare Centre, Riley Street, Surry Hills, 1927  
This Centre consisted of a Baby Health  
Centre, a Day Nursery and a Kindergarten  
NSW Government Printer*

The Woolloomooloo Welfare Centre was the most urgent need, and a search had been on for some time for suitable crown land on which to erect a purpose-designed model Welfare Centre, even before the establishment of the Royal Society for the Welfare of Mothers and Babies. The accommodation problem worsened to the stage where in March 1919, the Day Nursery Association advised the Government that it would close the nursery unless funds were immediately forthcoming. In May, during the worst of the influenza epidemic, the nursery did close but the building was used as a soup and milk depot and 'no child belonging to the nursery was neglected'.

In June 1919 the Government did finally act by resuming land between Dowling Street, Duke Street and Reid Avenue that had been associated with the proposed Eastern Suburbs Railway. The existing Woolloomooloo nursery building continued to deteriorate to the stage where 'one of the ceilings came down, narrowly missing a child' and so temporary accommodation was found until 1921 when the brand new premises were opened on 13 October 1921 by J J McGirr, then the Minister for Public Health and Motherhood. The building however did not meet the requirements set down by Ethel Ranken, the Honorary Secretary of the nursery, and the process of alteration to rectify the design faults began within two months of the opening.

The vision of a combined Welfare Centre was also implemented in a row of six terrace houses in Riley Street, Surry Hills, which Mrs Dixson had given to the Welfare Society in August 1919. In April 1921, work on remodelling the terraces began.

The first Tresillian Mothercraft Training Home was so successful that a second home was established at Willoughby in the northern suburbs and a third at Vaucluse in the eastern suburbs in 1937.

The Lady Edeline Hospital for Babies was closed in 1935 as the level of infant mortality from diarrhoeal disease had fallen so low that it was no longer needed. Dr E S Morris, Director-General of Public Health suggested that the premises be given to the Society, which became Tresillian Vaucluse.



*Baby Health Centre, Riley  
Street, Surry Hills, 1923  
NSW Government Printer*

In the 19 years since the establishment of the Tresillian homes some 5,900 babies and 4,400 mothers had been treated, while 950 trained



*Kindergarten, Riley Street, Surry Hills, 1922*  
NSW Government Printer



*Mothers' Rest Bungalow, Royal Agricultural Society's Annual Show, Sydney 1927*  
NSW Government Printer



*Tresillian Hospital, Vacluse, 1937-69*  
Previously Lady Edeline Hospital Tresillian

nurses had obtained certificates. Those who could not afford to pay were admitted free of charge. Babies were in special circumstances admitted without their mothers and at Tresillian North and Tresillian Vacluse there were special wards for premature babies.

An unpublished paper entitled 'Historical Outline of Tresillian' also talks of the educational role of the Society. In 1919 there were 13 members on the 'Propaganda Committee' and it was claimed by the President that; 'the influence of the Society's propaganda has had an immense effect on public interest, and has been largely instrumental in making mother and infant welfare the live subject it undoubtedly is.' (p.10)

Subsequently, the Society actively promoted publicity campaigns in the city and country, conducted Baby Weeks, produced pamphlets, established a Mothers' Rest Bungalow with displays at the Royal Agricultural Society's Annual Show in Sydney, published regular baby management advisory columns in women's journals and arranged lecture tours in country areas on infant and maternal welfare. One of its most influential publications was Dr Margaret Harper's 'Parents Book' which had had 19 editions by the end of World War II.

The Historical Outline describes the differences which began to eventuate between Truby King and Tresillian:

'The important components of the Plunket system, the basis of Tresillian training, were standardisation of methods and a scientific approach to inducing lactation and to calculating the food value of artificial feeding when it had to be resorted to.'

By 1923 Truby King was critical of the methods employed at the training school, claiming they were not following his principles – Margaret Harper responded that the environment in Sydney required adaptations to the Plunket system, the 'conditions and the climate of Australia requiring continuous supervision by medical experts'. In addition, the first two matrons appointed to Tresillian who had both undertaken Karitane training in New Zealand, were not a success and it was only the third matron, who was Tresillian trained that proved satisfactory.

Acrimonious debates and correspondence in the newspaper ensued because some critics complained that New South Wales did not immediately achieve the reduction in infant mortality rates which Truby King had achieved in New Zealand (Note: a detailed account of this debate is available in Milton Lewis' thesis 'Populate or Perish'). As Bryan Gandevia observes 'scientifically, and in retrospect the differences were minor', but the followers of Truby King formed the Australian Mothercraft Society (Karitane) and set up separate establishments in New South Wales and Victoria. The debate did not die down until the 1930s as the pattern of infant welfare services in New South Wales became established.



Sir Truby King  
Karitane

## KARITANE – AUSTRALIAN MOTHERCRAFT SOCIETY

Sir Truby King was a distinguished scholar and practitioner in the mental health area. His experience made him realise that many problems could be eliminated by educating the expectant mother in preparing herself for motherhood and in educating the nursing mother in self-management and in management of the child. He believed good conditions would also prevent injury at childbirth.

Sir Truby King started the movement in 1907 in Dunedin, New Zealand. He originally used his own home at Karitane to provide nursing care for babies with feeding problems. Lady Plunket, wife of the Governor of New Zealand, took an interest in his work and assisted with fund raising committees. Consequently a network of Karitane Mothercraft Hospitals was set up in New Zealand. The name 'Plunket' nurse has its origins from this era. These hospitals also provided mothercraft training for nurses.

The Australian Mothercraft Society was started in Australia in 1923 by Sir Truby King with the same constitution, aims and objectives as the New Zealand model. The London version, the popularly known Plunket Society, was officially the London Mothercraft Training Centre, and was formerly known as the Babies of the Empire Society.

A number of parents and their friends, whose babies had benefited by the work done by the Plunket Society in New Zealand and London, formed the first Council of the Australian Mothercraft Society, and undertook the task of raising funds. Funds raised at the first meeting of the Society were equivalent to \$2.11.



Miss Elizabeth McMillan was sent from New Zealand by Sir Truby King and became the first Matron of Karitane. She inaugurated the first clinic at 283 Elizabeth Street in 1923, called the Plunket Rooms, and mothers and babies needed a doctor's recommendation before admission. This clinic had 1423 visits from mothers and babies in 1924, of which 240 were first visits.

The first Karitane Mothercraft Home was opened in a cottage at Coogee in 1924. In 1925 there had been 894 visits from mothers and babies, 317 first visits. It was decided to re-open in Elizabeth Street because of the long journey to Coogee. Mothers had been admitted with babies to increase or regulate the flow of breastmilk, and to learn about feeding and mothercraft. Babies were admitted suffering from malnutrition from weaning too early, wrong feeding and management. The Society promoted breastfeeding as the best feeding option.



Karitane, Coogee, in the 1920s  
Courtesy Beryl Bowes

A Home in larger premises was established at 23 Nelson Street, Woollahra in 1927 at a cost of 8,000 pounds, and the Coogee clinic closed. Here, besides admitting mothers and babies, services also catered for premature and failure to thrive babies. Clinic work continued in the city and other clinics were opened. The Karitane Products Society was owned by the New Zealand organisation and a premises in Redfern was opened for the manufacture and sale of Karitane Products such as Karilac.

Nurse training was also a fundamental priority with the Australian Mothercraft Society and the first training programs were offered in 1924, involving two forms of mothercraft training. A four month course in Plunket nursing was offered to general or midwifery trained nurses, and untrained women and girls wishing to become Karitane Baby Nurses were able to enter a 12 month course. Their role related to the care of the normal nursing mother, baby and young child in their own home.

In 1926 over 100 applicants had been received in the previous 18 months to take the 12 month course, the fee being fifty-two pounds for board and residence.

The Society's aim was 'to help mothers and save the babies'. This included free teaching and guidance to young parents and any members of the community desiring help regarding the care of the normal mother during pregnancy and postnatally and the normal baby. The Society answered correspondence from country and overseas mothers as another service. The Society felt the best work was done when the husband and wife called at the Plunket Rooms as soon as they knew they were to become parents, bringing a letter of recommendation from their family doctor.

An article in the Daily Telegraph in 1926 designed to raise funds from the public carried the slogan 'Perfect Motherhood is Perfect Patriotism'. This highlighted that the concern for infant welfare was due to national and 'race' reasons as well as humanitarian concern. Sir Truby King visited Sydney on several occasions and on one such occasion stated that Australia needed a greater population, a white race;

'If the population of Australia do not do their duty to the race there cannot be any resistance to other races coming in and populating this fair land.' (1938)

The Australian Mothercraft Society was a voluntary organisation and its income was derived from the fees of mothers and student nurses while in residence at the Karitane, Sydney Mothercraft Centre at Woollahra, and on donations and annual subscriptions of members of the Society and their friends. The annual meeting of the Society in 1937 'was shaken to its foundations during the year when it was discovered that a credit balance of three pounds was in hand' (Sydney Morning Herald, 1937). This was another example of the involvement of middle and upper-class Sydney women in philanthropic and charitable work which was strongly evident in the first half of the twentieth century. The Society did not in fact receive financial assistance from the Government until the 1970s.

The 'social set' supported the Australian Mothercraft Society from the outset, as shown in advertisements and social columns in the leading newspapers on functions organised to raise funds. Garden fetes were held regularly at Woollahra for this purpose. Official patronage was provided by successful wives of the Governors of New South Wales including Lady Game and the Countess of Gowrie (formerly Lady Hore-Ruthven).

In 1930 the Australian Mothercraft Society sought similar recognition as had been given to the Royal Society for the Welfare of Mothers and Babies and urged that nurses trained under the Mothercraft Society at Karitane be recognised at state baby welfare centres in the same way as nurses from Tresillian. However, the Council of the 'Tresillian' Society continued to dominate the baby clinics, and Lewis writes that the common training provided by Tresillian for the clinic nurses ensured uniformity of instruction. This difference between the two main organisations which established the first Mothercraft Homes would persist until later in the century. The greater role of the medical profession in the 'Tresillian' Royal Society and its functions would also remain a difference, and ensured the continued dominance of the Royal Society.



*Lady Hore-Ruthven, Woollahra, 1935*  
*Karitane*

## CHAPTER 4

### RURAL SERVICES - BABY HEALTH GOES BUSH

'It is necessary to secure the active support of an informed public to successfully carry through any comprehensive scheme for social and health reform. Women's organisations are very important in this respect.'

Dame Janet Campbell, Report on Maternal and Child Welfare in Australia, 1929-30



Lady Dudley, founder of the Bush Nursing Movement

Despite the fact that the rural areas at the turn of the century and in the early part of the twentieth century had a lower infant mortality rate than Sydney, health facilities for country women were often non-existent. According to the Australian Women's Diary, 1989:

'pregnancy and childbirth could be terrifying experiences. Many women were confined without help or had to travel hundreds of miles, leaving their husbands and small children. If children were sick, medical help was often not available. Accidents and snake bites were dreaded'. (p.96)

#### BUSH NURSING ASSOCIATION

Lady Dudley, in a trip around the outback areas of Australia in 1908 with her husband, the then Governor-General, wrote:

'they are so isolated, the old people, the women expecting a baby, the mothers, the children, all need some nursing support. What can be done to help them?'

As a result she proposed the establishment of the Bush Nursing Association whose object was to provide nursing and emergency hospital services to districts where no doctor resided. Lady Dudley had already been responsible for the establishment of a similar movement in Ireland with much success throughout the scattered districts of that country. The service in Australia was to be similar to district nursing services already operating in some of the cities and larger towns.

The scheme was slow to commence because of lack of medical support, concerns about the levels of wages to be paid, difficulties in obtaining nurses with appropriate qualifications and concerns about the long distances they would have to travel and the lack of means of locomotion. The Bush Nursing Scheme was first established in 1911 in Victoria, and it operated with district councils and a central state organisation. District people, having decided that they could meet part of the cost of 135 pounds per annum for the establishment of a bush nurse, formed a district council and advised the central council. If required, the central council would subsidise the annual costs of the service. The nurses' services were provided absolutely free to those who could not afford to pay, while those who could afford to pay something were expected to do so with contributions going to the district committee.

In New South Wales, the first bush nurse was appointed at Jindabyne. The role of the bush nurse involved treatment of the sick and teaching school children first aid, principles and practice of hygiene and the care of infants.

The Association constantly had difficulties in recruiting nursing staff which meant that centres often had to close for short periods. This was exacerbated by the First World War.

The By-Laws of the Bush Nurses were expanded to include holding a baby clinic in the centre and visiting the mothers and babies in the district to see to their welfare. In 1924 it was arranged with the Royal Society for the Welfare of Mothers and Babies that a special course of four months training in mothercraft was to be offered to Bush Nurses on the condition that they stayed with the Association for 12 months.





*Crossing a flooded creek, 1934*



*Left: The car breaks down, 1934*

*Below right: Daily rounds by bicycle 1937*





*Nimmitabel Centre, 1933*



*Aboriginal Camp, Tabulam, 1936*



*Patient's home, Ebor, 1931*

In 1914 the Government agreed to provide a subsidy to the Association so that 20 new bush nursing districts could be opened. The number of districts continued to expand, so that by 1936 when the Bush Nursing Association was at its peak, 74 nurses travelled 74,194 miles to visit some 20,628 patients, within the year. This included 478 obstetric patients of whom 277 were babies born in Bush Nursing Centres.

The Australian Nurses Journal of 1918, describes the conditions of life for the bush nurse in Rye Park, including arrangements regarding accommodation:

'When heavy rains come and the creeks rise, it is occasionally impossible for the daily mail coach from Boorawa to get through and still more frequently the roads and tracks leading to the farms are unpassable... Until recently the nurse has been boarded in a home in the village but a few months ago the Committee decided to rent a cottage for their nurse so that she might have her own home and all the privacy which is so essential ... A room in the cottage, has been set apart for the use of an in patient ... and the Committee has provided the necessary household assistance and has engaged a lady help ... Nurse Macqueen some time ago invested in a pony and sulky, and as there is a good paddock and a shed at the back of the cottage, pony and sulky are easily accommodated. The nurse on horseback or the nurse driving in the sulky are familiar figures all through the district, and even at night the sound of 'Blackey's trot' is recognised. I wonder where the nurse is going?' (p.10)

Lady Gwendolyn Game, wife of the Governor of New South Wales, was an ardent supporter of Bush Nursing and was Patroness of the New South Wales Bush Nursing Association in the 1930s. Lady Game organised a Garden Party at Government House which raised 7,000 pounds for Bush Nursing in 1932. Local committees were constantly organising fundraising events, such as the 'New Year Carnival' and 'the Shearers Ball'. However, fundraising proved more difficult in times of hardship including droughts, floods, the two wars, the depression, in periods of failed crops and at time of 'credit squeezes'.

The Bush Nursing Association worked in cooperation with other organisations both to provide services and arrange back-up services as required. This included the Country Women's Association, which as an organised body was often responsible for raising funds for the establishment of Bush Nursing Hospitals. Both the Royal Far West Children's Health Scheme and the Australian Aerial Medical Service (later to be called the Royal Flying Doctor Service) were used by the Bush Nurses to transport emergency and non-emergency patients to appropriate health facilities.

According to the Australian Women's Diary 1989:

'As communications and transport in remote and inland areas improve the need for the bush nurses decreased. Better ambulance and hospital services meant that medical care was available to people even in the far outback areas.'

So in 1974 the services of the Bush Nursing Association became the responsibility of the State Health Commission and the supporting organisation was disbanded. Many centres did continue to operate under the Government.



Rye Park Bush Nurse, 1918

The role of the Bush Nurse is well described in the Diary as follows:

'For more than a half century, bush nurses working in small community-based facilities provided vital medical services for the women, men and children of the bush. They treated anything from snake bite to measles. They provided emergency treatment during bushfires and floods. They were there when accidents occurred. They delivered babies. They advised mothers on childhood diseases and conditions. They often had to do housework for the patients, look after the children, and even milk the cow.'

The history of the Bush Nursing Association in Carinda from the book 'Carinda as it Was and is Now', describes the history of one community and their Bush Nurses:

'In 1911, Carinda was one of the first four districts to apply for a Bush Nurse. On January 8, 1912 Nurse Joan Twynan was appointed as the nursing sister in Carinda, and during the 12 months she stayed she helped to pioneer and lay the foundations of the Carinda Centre. The history of the Bush Nurses in most areas was initially a problem, and in Carinda the nurse first lodged in the local hotel although soon a cottage was supplied and furnished for her use. The only means of transport in the early years was to ride a horse or drive a sulky and often the Carinda Police Trooper would accompany the nurse to difficult cases and during the influenza epidemic she would be called upon to work at all hours of the day and night.'

The President of the Walgett Hospital actually wrote a letter to the 'Sydney Morning Herald' complaining that subscriptions were being diverted to the Bush Nurses at Carinda and Lightning Ridge from his Hospital and more patients than ever were coming along to the hospital because of the bush nurse or doctor.

The Bush Nurse only stayed four years in Carinda as the Centre was closed. Being war time, the call for patriotic funds was numerous. Country people had boys at the War, and the gap in the rural workforce was being filled by their families thus reducing their spare time for charity work.



"Weighing Day" at Bellata Bush Nursing Centre, 1930

The Bush Nursing Association in Carinda was re-opened in 1928, with the arrival of Sister Higgs. The Country Women's Association in Carinda decided to work towards building a suitable centre for a Bush Nurse; plans were soon drawn up and the building under way. It consisted of timber and fibro, with two large rooms for the Hospital and bedsitter and kitchen for the Nurse, surrounded by wide gauzed verandahs. It was officially opened in May 1929 by the Organising Secretary of the Country Women's Association of New South Wales, Miss Fitzpatrick. It had cost just under 700 pounds to build. The Country Women's Association handed the Centre over free of obligation to the Bush Nursing Association. Within 12 months finance was extremely difficult due to the Depression and the Country Women's Association was asked by the Bush Nursing Association to run the Centre as a Country Women's Association hospital. This arrangement continued until 1946 when it was leased to the Bush Nursing Association, the Country Women's Association still being responsible for the furnishings and maintenance of the building. It was never a light burden for the community of Carinda to maintain a Bush Nurse.

In 1950 and 1956 there were floods in the district and the Bush Nurse gave valuable service as many people were cut off from doctors. Local efforts for maintaining funds were severely disrupted owing to the incessant wet and impassable roads. On the other hand, when drought prevailed, the same effect on the centres was felt as the spending power of the population was severely affected. In later years the Rodeo Bush Nursing Association Committee organised an Annual Rodeo which supplied substantial revenue.

Increasing costs, declining affluence in the rural community and the usual public apathy meant that Carinda's Centre was one of the many to close in 1974 when the Health Commission of New South Wales took over. The Health Commission Sister, Sr Glenda Spencer, from Quambone, 60 kilometres away, visited weekly as does a Clinic Sister, still using the Bush Nursing Association building.

### THE COUNTRY WOMEN'S ASSOCIATION

The Country Women's Association was established in New South Wales in 1922 and, as already outlined, had been concerned with the welfare of women and children in the country. One of their primary objectives was the improvement of health standards for women in the country far from doctors, hospitals and medical facilities. The Association became responsible for establishing baby health centres in rural New South Wales with the salary of the nursing sister paid by the Department of Health and other costs such as furniture, equipment, costs of building or rooms paid for by the Association.

Helen Townsend in 'Serving the Country, the history of the Country Women's Association in New South Wales', writes that Dr E Sydney Morris, Director of Public Health in New South Wales in the thirties and forties, appealed to the Country Women's Association in 1923 to open and support baby health centres. Dr Morris himself writes that by enlisting the support of the Country Women's Association 'the concepts of infant welfare services were spread widely and also by providing premises and equipment, also lessened the drain on the Treasury'.

Sister Williams, who toured the country supported by the Country Women's Association and the Royal Society for the Welfare of Mothers and Babies, talked at the second Annual General Conference of the Association held in Moree in 1924 in prenatal care, postnatal care, and the feeding and clothing of babies. Helen Townsend writes that: 'Her enthusiasm and the information she gave was of enormous importance to country women living in areas where there was no information available.' (p.44)

The figures Sister Williams quoted on the high levels of maternal and infant mortality must have inspired the women attending the conference for, by January 1925, the first baby clinic sponsored by the Country Women's Association was opened in Frome Street, Moree, and a Karitane nurse was installed. The Government paid the sister's wage and the Country Women's Association met the costs of board and transport and provided all the necessary furniture and equipment.

The Country Women's Association also purchased a house in Frome Street, Moree to be used as a hostel for mothers waiting to go to hospital for delivery. The baby health clinic was opened in a room at this hostel, although some baby health services had previously been conducted in another building in Frome Street.



*Sister Merriman at Jindabyne Bush Nursing Centre, 1938*



*Dubbo Country Women's Association Baby Health Centre, 1938*

*From "Serving the Country", courtesy Country Women's Association of New South Wales and Doubleday*

In this way the women could receive prenatal advice from the nursing sister. The clinic was later moved to a room provided by the Council in the Council Building until the mid 1970s when the clinic was again relocated to a new government office block. In 1988 a new clinic was erected at the end of the maternity section of the Moree Hospital, now known as the early childhood service unit.

The Government became responsible for funding the costs of furniture and then transport. Where Country Women's Association branches had built their own Country Women's Association Rest Room and Baby Health Centre there was thus eventually less expense associated with maintenance costs. These changes occurred in 1930 and Country Women's Association Baby Health Clinics increased from 10 in 1930 to 22 in 1931 because of the more generous funding arrangements.

Helen Townsend states that Dr Truby King's principles of scientific baby rearing were much in vogue at the time: 'with heavy emphasis on strained orange juice by the teaspoon, strained vegetables and heavily regulated sleeping and feeding time'. While much of this information is now regarded as being unnecessarily regimented:

'at the time it was a framework in which life saving information on health, hygiene and normal progress through infancy was imparted. It came at a time when desperate, ignorant women would dose a child with a strong proprietary medicine, when young babies were fed fatty or sweet foods improperly prepared or were given rags dipped in medicine and honey to suck if they were fretful. Mothers knew neither how to avoid nor how to treat simple but potentially lethal diseases in babies such as diarrhoea or gastroenteritis.' (p.45-46)

The Country Women's Association supported the Karitane system of mothercraft and in 1927 passed a resolution that the Country Women's Association should be at liberty to choose the Plunket System if they preferred it, and should not be tied to having 'the Government clinics'.

The Country Women's Association felt that 'the Plunket System was the most practical in its workings, and the most successful in results'. They also supported the lobby of the Australian Mothercraft Society to be fully recognised and subsidised by the Government.

In 1931 a private bill was passed in Parliament under which the Country Women's Association became a legal entity. This Act of Incorporation made it legally possible for the association to acquire, hold and sell property.

The Country Women's Association Rest Room played an important part in the history of the development of baby health services. The Rest Rooms were established by branches of the Country Women's Association as a place where women travelling to town could find a haven; women with children could go there to make a cup of tea, change the baby, often get a meal and generally relax. As well as providing a place for meetings of the Country Women's Association and a venue for baby clinics, they were used by other community organisations. Often a library and a children's playground was added.

The Younger Set of the Country Women's Association played a role in fund-raising activities, with their objective being to 'further the aims of the Country Women's Association in general and in particular to use every opportunity of being instructed in First Aid, Home Nursing and Mothercraft'. Girls were eligible to join at 18 and



*Inverell Country Women's Association  
Baby Health Centre*

*From "Serving the Country", courtesy  
Country Women's Association of New  
South Wales and Doubleday*



*Hillston Country Women's Association Hospital*

*From "Serving the Country", courtesy  
Country Women's Association of  
New South Wales Doubleday*

often remained as members until 30 with the aims of performing a social service and arranging social functions. The Inverell branch of the Younger Set was responsible for raising funds for the purchase of a block of land for 160 pounds and for the building of a baby health centre for 520 pounds, which served the community until 1974.

By 1937, 15 years after the establishment of the Country Women's Association 14 emergency and maternity hospitals and 65 Health Centres, with 69 sisters had been organised.

Some Country Women's Association branches found it difficult to find premises in which to operate a baby clinic (or baby health centre/health centre, as referred to in Country Women's Association publications). In Junee it took 12 years for the clinic to be relocated from an empty shop donated by the local family to a new centre. At Coolamon, a Tresillian trained nurse who was a member of the local community volunteered to run a clinic at the Rest Room every Saturday afternoon, as there were not many women with babies in the district. This continued until 1936.

Full time centres were not all that common and sisters had to travel long distances between towns, often by buggy or on horseback. Even after obtaining cars, they were often slow and unreliable. One nurse who attended Leeton three days a week worked at Narrandera two days and at Lockhart once a fortnight. The nurse at Mudgee travelled to Gulgong and Rylstone every week as well. (Townsend, 'Serving the Country'.)

Some baby clinics established by the Country Women's Association had nurses provided by the Royal Far West Children's Health Scheme (as against staffed by Government-salaried sisters). The Country Women's Association supported the scheme and made their Rest Rooms available to nurses from the scheme's clinic cars.

In 1942 there were 142 clinics and the numbers continued to increase after the war, particularly with the altered funding arrangements introduced in 1944. By 1953 with the Country Women's Association membership at its highest (approx. 30,500 members) the Country Women's Association had established 157 baby health centres.

By 1962 there were 173 clinics supported by the Country Women's Association, which increased further to over 200 such centres in 1970. During the 1960s and 1970s the Health Department (or Health Commission from 1973) took over many Country Women's Association's clinics so that by 1982 the Association maintained about 150 clinics statewide.

One member of the Country Women's Association writes of her experiences in supporting the baby health centre, which was run at the Association's Rest Room, Oberon from 1937-1965;

'The Baby Health Centre was given every assistance possible for Mothers and Babies.



*Opening of the Country Women's Association Baby Health Centre, Bathurst, 1952*

*Courtesy Country Women's Association, Bathurst Branch*



*Gloucester Baby Health Centre, 1952-1987 established by the Country Women's Association*

*Courtesy Sister Leonie Bell and the Gloucester Advocate*

We purchased a pram, bassinet, covers, blankets, pillows, scales, baby screen, Sisters screen and toys and still have a blue baby cabin box which we kept stacked with bay clothes for needy babies.

Mothers travelled 15 to 20 miles in sulkies on horseback and then cars over very bad roads to receive prenatal care and checkups for their babies and children.

Later we extended our premises adding kitchens and inside and outside toilet facilities and a playground for children. We also had a ramp provided to allow prams to enter the hall with ease and provided meals and cups of tea.'

The commitment of the Country Women's Association to support the nation of Australia by providing baby health services to mothers and children in country areas is exemplified in the quote from Progress, the Association's publication, in 1937:

'Science is to the fore in Country life teaching the man on the land the scientific way of raising stock, crops, poultry, orchards etc. but these Centres teach the most important of all – Mothercraft – for the development of our country and the British Empire.'

## CHAPTER 5

### RURAL SERVICES - BABY HEALTH GOES MOBILE

'Drummond suddenly knew it was the children of these far-out places, the families of boundary-riders, pump-keepers and others like them, who needed him most.'

E.W. Docker, *Clear the Runway*, 1984, p.2



*An isolated primitive home occupied by a mother and her five children*

*Mitchell Library, State Library*

### ROYAL FAR WEST CHILDREN'S HEALTH SCHEME

Reverend Stanley Drummond and his wife Lucy were founders and mentors of the Royal Far West Children's Health Scheme, an organisation which provided expert medical facilities as well as recreation to children from the most isolated parts of New South Wales. Drummond experienced at first hand the problems of children in rural areas; 'victims of climate, isolation and poverty' when he was a Methodist missionary based at Cobar.

Drummond's first idea was to give disadvantage children from the outback a holiday by the sea and the first camp was held in 1925 at Manly. This was soon combined with the provision of medical services as Drummond found that there was considerable unnecessary illness and grief through an inability to obtain adequate medical help, often through ignorance.

In March 1928 he and his wife decided to end their church work and concentrate totally on the work with children, even though they had no income or guaranteed financial support. He extended his search for children in need, often against the initial wishes of the parents, some of whom preferred to hide their handicapped children. But no child was taken to the city without the recommendation of a doctor.

During 1930 the idea of Travelling Baby Clinics was developed on the suggestion of Dr J Maclean of Trangie. Drummond immediately gained the approval of Dr Morris, the Director of Maternal and Baby Welfare, to undertake preventive work with expectant mothers and young babies. The Commissioner of Railways supported the idea, and a railway car was fitted up as a travelling home for a nursing sister, with bedroom, bath, kitchenette and refrigeration, while a large space was furnished as a consulting room and clinic. Gauze windows and shades reduced discomforts caused by mosquitoes, flies and glare. As well as fitting out the carriages, in later years the Railway Department added other concessions to the running expense of the clinics.

The first Travelling Baby Clinic was inaugurated in January 1931. The No. 1 Clinic Car was sent on the Bourke, Cobar and Brewarrina lines, with an English nurse, Sister Hilda Brooks, in charge. It stayed in each centre from two to ten days as the work demanded. The service was extended by using local transport beyond the station to places such as Louth, Yantabulla and Wanaaring. The local Presbyterian minister, Mr Faulkner, took Sister Brooks 118 miles to Wanaaring in his car to respond to a request for the clinic nurse.

'There were so many mothers and babies collected there that even the Sister was surprised. One woman had driven 60 miles to meet a trained nurse who could give her advice about her baby.'

By the end of 1933, 1255 babies had attended the clinic, 281 visits had been paid to babies in their own homes and 28 lectures given.

Sid Coleman, previously Mayor of Bourke, who operated a taxi service, took flying lessons and bought an aeroplane so he could fly Sister Brooks to other centres to give parents advice and practical help with their children. This was probably the world's first Aerial Baby Clinic.

Drummond made representations to the Government that landing grounds should be constructed at Kerrigundi, Louth, Wanaaring, Yantabulla, Ford's Bridge, Urisino and Tilpa to accommodate an



aerial ambulance, which he planned to implement. In 1933 a grant of 3,000 pounds was made available by the Unemployment Relief Council and the landing strips were constructed. This made flying safer for the baby health nurse and allowed the extension of the air service to provide quick transport for doctors and patients in the districts of Bourke and beyond. The concept of the aerial ambulance would be achieved however with the introduction of the Aerial Medical Service (later to become the Royal Flying Doctor Service).

An initial flight using the airstrips covered 550 miles in less than four hours in an extreme emergency while the road journey, impossible anyway because of heavy rain, would normally take more than one day each way.

Additional railway clinic cars were introduced in 1934; clinic car No.2 with Sister Kellie in charge to serve the Walgett, Mungindi and Boggabilla lines and clinic car No.3 with Sister Humphreys to travel the Coonamble and Coonabarabran lines.



*Nurses' early "tent clinic"*  
Mitchell Library, State Library  
of New South Wales

Sister Brooks was replaced after three years by Sister Webb and her work with the Aerial Baby Clinic was extended over the border into Queensland. She regularly visited Brewarrina, Warren, Nevertire, Nyngan, Cobar and Bourke and the intervening places; every six weeks she did a circuit by plane. By 1935 the Aerial Baby Clinic was reaching 239 babies 'Back of Bourke' alone, and Nancy Bird, a well-known aviatrix, was engaged as the pilot as Sid Coleman had retired.

Nancy Bird in 'Born to Fly' describes her experience flying in rural areas:

'I was amazed by my first sight of these outlying settlements, and by the primitiveness of the living conditions. We saw little families in their corrugated iron shacks on stony ridges, without a bush or a tree to break the monotony', and 'you had to see the heroism of some of those outback women to appreciate it – heroism sustained year after year in terrible conditions and heat, without help, without conveniences, without holidays and without a proper diet.' (p. 97-98)

Sister Webb never conquered her distaste for flying; Docker, in 'Clear the Runway' describes her reactions;

'Nancy Bird was not yet twenty when she took off from Bourke aerodrome with the sister in the front of the cockpit staring grimly in front of her and the baby scales packed under her feet.' (p.8)

A change was made to the clinic arrangements in 1935; it was decided not to send the clinic car to Bourke any longer but to open a clinic to be staffed by Sister Silver who would do the regular aerial clinic tour with Nancy Bird.

At Christmas Sister Silver dressed up as Father Christmas and was flown in by Nancy Bird, who had collected some money and purchased suitable toys. It was a 200 mile trek by car in 114 degree heat, after landing at Urisino. Every child on their route received a stocking.

'At Urisino Station the plane was exchanged for a motor vehicle and she went another 320 dusty, bone-jarring kilometres to the remote huts of the bore keepers and struggling solder-settlers. The temperatures were often over 55 degrees Celsius inside the vehicle, there was little water and oppressive dust storms. The mothers gave her a wonderful



*Sister Silver with Santa Claus costume  
and Nancy Bird, loading toys for children  
beyond Urisino Station in 1935*  
Royal Far West Children's Health Scheme



Mothers and children meet Sister Silver and Nancy Bird at Byroch, 1935

Courtesy Nancy Bird



Aboriginal family visiting the clinic car  
Royal Far West Children's Health Scheme



Parents leaving the clinic car  
Mitchell Library, State of New South Wales

welcome, and were well aware that the staple outback tucker of black tea and damper was no diet for growing children. They needed reassurance as much as anything else, though the fresh food she was often able to bring was always gratefully received. At the larger centres they gathered alongside claypan landing strips, and when she saw they were all wearing their best clothes, including hat and gloves, she realised how important the visit of the sister was. These people were in need of more than routine medical care.' (Women's Weekly, 1988)

She was also responsible for Aborigines at their riverside camps at Brewarrina and Bourke. Their main problems were poverty, poor health and lack of housing; problems she saw as being essentially the same 50 years later. She also held clinics at the Bourke baby clinic and the local hospital and felt well rewarded by seeing malnourished children improved, and eyes that could have been blinded by trachoma regain sight; 'But perhaps my greatest thrill was the drop in the mortality rate among mothers and babies.'

When Sister Silver retired in 1938 the Aerial Baby Clinic was discontinued and the Royal Flying Doctor Service was the next organisation to offer an aerial health service.

The sisters in the clinic cars covered 3,000 miles by rail, car and plane, on average every five weeks, seeing about 1000 mothers and babies. They distributed fresh oranges regularly provided by the Leeton branch as fresh fruit had previously been unobtainable. The clinic sisters also travelled by car to areas not connected to the rail line. They lectured to the school children on mothercraft, hygiene and first aid. The girls bathed dolls and learned about daily care of babies.

In the worst years of the Depression, the itinerary for the clinic car took two or more months to complete.

Communities provided free accommodation to the sisters, sometimes in hotels, sometimes in their own homes or alternatively at Country Women's Association's Rest Rooms.

Sister Mary Debenham worked in the clinic car in the 1930s. She trained at Tresillian and after working in private nursing was asked by Dr Cuthbert Browne, the Director of Maternal and Child Welfare to join that Far West. Before commencing, she undertook a month's training in a clinic in Sydney. She recounts her first day on the job:

'The first day I arrived there I shall never forget. The temperature was something like 40 degrees Celsius – boiling hot. I got off the train at Coonamble and there was no one to meet me. I found my way to where the clinic car was berthed down near the goods shed. I opened the door and evidently they had given a huge consignment of Scott's Emulsion which was used to give to babies in those days – and in the shunting all the bottles had got broken. And there'd been a dust storm, and there was dust and emulsion all over the floor. By that time somebody who was on the committee for baby health work had arrived, and she took me up to the town. They had a house with a long verandah that went all around with netting, and a cake shop, and she sat me down to a cup of tea, and then we found the rector and his wife, a Mrs Williamson, and she came down the next day and helped me clean up the mess.'

A fourth clinic car was added in the 1930s to service the south-west and Riverina. A permanent clinic in addition to Bourke was opened at



Opening of Rail Car No. 4 in the 1930s  
Royal Far West Children's Health Scheme

Cobar. Expansion of the services was dependent on the fundraising efforts of various supporting groups. Radio stations provided support for the clinic cars such as 2DU Dubbo's 'Wagon Wheels', 2TM Tamworth, 2PK Parkes 'Sunshine Club', 2WA Wagga's 'Women's Social Club'. The radio stations also contributed to the Far West's other services including the Home established in Manly in 1935.

During the war it was difficult to obtain sufficient staff to keep all the clinics going, and the Home at Manly was requisitioned by the Australian Women's Army Corps. Removal of the children receiving treatment to Springwood and the general upheaval limited expansion. Children were sent home early, and the clinic Sisters were given follow-up responsibility. However the support of the clinics was needed more than ever while husbands were away and Matron Hill at Manly worked to keep the clinics staffed. After the war things began to improve. Figures for 1944 for one nurse, Mary Dedenham, were as follows:

No. of Schools visited	126
No. of visits to homes	548
No. of children seen at car	164
No. of babies weighed	401
No. of miles travelled by train	13,374
No. of miles travelled by car	9,923
No. of miles travelled by plane	670

'30 towns have been visited twice this year and monthly visits paid to Hillston, Captain's Flat and Wentworth'. One of the mothers who attended the clinic car in Nyngan in 1949 recalls her experiences:

"I couldn't get anything to agree with my third child, she would put on half an ounce and then take off more. I had seen Sister Toomey from the train before, but my husband suggested I take Arlene to see a specialist in Sydney. I took her back to see the sister first and there she was standing at the door. She said she couldn't sleep worrying about my child. We both came up with the solution of goats milk, and the baby didn't look back from that time onwards. I wasn't any more pleased than the sister-it shows how caring they were.'

In addition to the services provided by the clinic cars, additional field sisters were employed by the Far West to visit areas not covered by the regular services. As well as undertaking regular clinic work they distributed powdered milk and vitamins and visited homes regularly to keep in touch with local children.

The report from Sister Hart in 1947 describes this work:

'This district, with Coonamble as its headquarters, covers a wide and varying area. It extends west of Coonamble to Quambone, through the Pilliga Scrub to the lovely hilly country around Coonabarabran and Coolah.

Work is done mainly in the baby health centres, mothers everywhere showing a continued interest in the baby clinics.

Until May of this year, travelling was done by any means available – and, in spite of its difficulties, it had its extremely pleasant side,



*Sister Graves visits Coonabarabran  
in a utility baby health car  
Cobar Museum*

adventures included. Bumping across a 50 miles track in a three-ton truck, often minus brakes, often bogged to the axle but always relieved by the mailman. Once we were bogged (I climbed out complete in Wellington boots), the mailman always gave me sundry instructions on how to avoid being bogged and how to get out of them. Needless to say sometimes we managed to get out – sometimes we didn't.

The kindness and courtesy of train crews had to be experienced to be believed. Some of my happiest memories always will be of sitting under a tank at the crack of dawn, with engine driver, fireman and guard, with a large mug of black tea in one hand and a large slice of bread and butter in the other – and being hoisted aboard the engine when I was cold – and always the thoughtfulness was there for my welfare.

In May of this year, the first car was put on the road, and I'm the very proud driver. There's truth in the fact that I walk round and admire it each time I get out!

In enabling me to reach the isolated places such as Pilliga and to go into the tiny settlements, the car has served its purpose. The blue Chev with the 'Far West Scheme' on its windscreen is a familiar sight these days. Scales are on board, and babes are often weighed in the car by the roadside, isolated mothers watching for the car to pass or coming down to the gate to meet me.

Since having the car, I've learned that being bogged for hours with the mailman is bad, but when you hear the back wheels settle firmly, and you're on your own, that's worse, However, it's a wonderful place, this west, and always there comes a helping hand.

Fortnightly visits are paid to Coonamble, Gulargambone, Armatree, Pilliga, Baradine, Gwabegar, Coonabarabran, Binnaway, Coolah, Dunedoo, Merrygoen, Biriwa, Purlewaugh, Bugaldie, Ulanambri, Craboon, Mendooran, Gilgandra and Quambone.

A total of 3,786 children attended the various clinics during the year. Of these 2,733 were babies, 807 were under two years of age, and 241 were older children. A mileage of 8,028 was travelled – 3,199 miles by train and 4,829 by car. 120 homes were visited, schools were visited and mothercraft lectures given to 56 girls.

24 children from the district attended the annual camp. 14 children were sent to Manly Far West Home for treatment. Leeton Branch sent many cases of oranges, which were received with great joy.



Above left:  
Sister Fawcett and  
Graves in the 1950s  
Cobar Museum

Centre Left:  
Home visiting  
Royal Far West Children's  
Health Scheme

Top:  
Boiling the billy  
Royal Far West Children's  
Health Scheme

Above:  
Weighing baby in the  
boot of the car  
Royal Far West Children's  
Health Scheme

Left:  
Arriving in the Pilliga Scrub  
Mitchell Library,  
State Library of New  
South Wales.



Orange Branch sent apples for distribution. In addition, clothes and medicines were distributed to needy cases.

Far West committees throughout the district continue to do a grand work, helping all they can. The Junior branches at Dunedoo and Gulargambone endowed a cot.

The work of the Scheme grows daily – it is a very satisfying work.' (Annual Report, Royal Far West Children's Health Scheme, 1948.)



In 1960 the Commissioner for Railways presented the Scheme with two reconditioned carriages. The modifications included an insulated roof, steel sink, built-in cupboards, and a test-feeding corner. During the 1960s new Baby Health Centres were opened at Cobar and Bourke, with the Bourke Clinic sponsored by the Rotary Club and including a special clinic for Aboriginal mothers. By 1964 the baby health sisters (or 'field' sisters as they were called by the Royal Far West Children's Health Scheme) had travelled 23,000 miles and conducted 3,000 clinics. 'The field staff in the clinic cars were the lifelines which radiated from Manly to all the outposts of the West.' (Wearne, 1966)

By the end of the 1960s there was a decrease in the number of clinics conducted by the Scheme, due to the opening of clinics by the Department of Health. In 1974 'in a spirit of full co-operation', the remaining services were handed over to the Health Commission of New South Wales which assumed responsibility for the clinics. The clinic buildings at Cobar and Bourke were sold to the local Shire Councils. The rail car No. 1 became a museum exhibit at Cobar.



Sister Doreen Walsh, who had worked with the Royal Far West Children's Health Scheme for five years, accepted an appointment as a community health nurse in Cobar Shire in 1974, at the time of the handover. In addition to her original role with mothers, babies, toddlers, school age children and some involvement with the general health of the community, her responsibility expanded to include health education program, immunisation, counselling and involvement with the multi-disciplinary community health services.

The inevitable development of the Government's taking over of services originally commenced by voluntary organisations is commented on in the Scheme's 1974 Annual Report:

'It must be recognised that any great voluntary humanitarian organisation has its origins in needs; this applies to Stanley Drummond's scheme. And when the need ceases to exist or is well met by the State or other community services the voluntary organisation is no longer necessary.'

Top:

Mothers and babies at Brewarrina  
are visited by Sister Godfrey  
Royal Far West Children's Health Scheme

Centre:

Sister Hinder in the clinic car  
The John Fairfax Group

Above:

Mothers waiting to see Sister Hinder  
The John Fairfax Group



Reverend John Flynn

## THE ROYAL FLYING DOCTOR SERVICE

The Royal Flying Doctor Service was another voluntary organisation which recognised the needs of country people for adequate health care, including baby health services. The Royal Flying Doctors Service (known then as the Aerial Medical Service) started on May 15th, 1928 at Cloncurry, a small country town in outback Queensland, with one aircraft, one pilot and one doctor. The establishment of this service was the result of the vision of one man, the Reverend John Flynn of the Australian Inland Mission who saw the need for a 'Mantle of Safety' for people of the inland. Flynn had travelled extensively throughout the outback and found medical facilities either totally inadequate or non-existent because of the lack of resident doctors. Flynn recognised that air transport and radio were needed to break the isolation of the inland people, remote from medical and religious care.

An Advisory Committee of the Aerial Medical Services was formed at the headquarters of the Australian Inland Mission in Sydney. This led to the registration of the Australian Aerial Medical Services (New South Wales Section) on 6th May 1936. This name was changed to the Flying Doctor Service (New Section) in 1942 and to the Royal Flying Doctor Service (New South Wales Section) in 1955, when the Royal Charter was given to the Service. In 1938 a base was opened at Broken Hill, the only Flying Doctor Base to operate in New South Wales.

The Royal Flying Doctor Service in its earlier years operated under very primitive conditions. The famous pedal radio of the Service's early years broke the soul-destroying isolation and loneliness of the outback. In the early days of the Service, flying doctor aircraft usually carried the doctor and the pilot. Flight sisters, dentists and other medical specialists and health professionals were added later.

There were three types of flights within the scope of the flying doctor; clinic flights, emergency and mercy flights.

The establishment of a Flying Doctor Base at Broken Hill greatly assisted Bush Nurses. The Bush Nursing Centres at Menindee, Pooncarie, Wanaaring, Louth and Enngonia were within reach of the Broken Hill Services.

The New South Wales Section of the Royal Flying Doctor Service had the distinction of employing the Service's first Nursing Sister. Sister Myra Blanch joined the Section's Broken Hill base in November, 1945. Although often called a 'flying sister', this was a misnomer for although she used aircraft for transport at times, she did most of her travelling by road. Initially, she used any form of transport she could get and that included lifts by station managers and owners and even the mailman. Later, she acquired her own vehicle in which she covered huge mileages.

Sister Blanch was a triple-certificated nurse and joined the Section with an impressive background, both pre-war with the Australian Inland Mission and with the Australian Army's Nursing Service in World War II. After studying preventive medicine in England for two years, she returned in 1953 and started a complete health survey of the outback areas of the Section's network, being particularly concerned with the needs of the outback children.



Housewife on an outback station  
Royal Flying Doctor Service, Australia



Doctor at Mission Station  
Royal Flying Doctor Service, Australia



*Sister Myra Blanch, the first nursing sister appointed to The Royal Flying Doctor Service in 1946. She served with the New South Wales section of the Service and is wearing the uniform of the Australian Army Nursing Service Royal Flying Doctor Service, Australia*

On her surveys she found many children suffering from conjunctivitis, particularly bad during the summer when heat, dust and flies were at their worst. Some of the children suffered from so-called chronic colds, which she found was mostly catarrh caused by continuous irritation of the mucous membranes by dust. At some of the outstations she found the children's diet far from satisfactory.

Sister Blanch, while working for the Section, did a remarkable job. What made it even more remarkable was that she went into the outback without any previous bushcraft experience. When she acquired her own utility truck she had to be not only the driver, but also the mechanic. She carried a radio transceiver in the truck. This was vital for communications, especially as she had to cover unmapped roads in the more remote parts of the State.

The Royal Flying Doctor Service began to use flight sisters on a regular basis in the 1960s. The use of flight sisters had obvious advantages, as part from assisting the doctors they could advise mothers on antenatal and postnatal care and contraception.

The Royal Flying Doctor Service has always been committed to adequate health care for Aborigines; about 45 per cent of all patients attended by all Sections of the Service being Aboriginal. Health care of Aborigines presented far greater problems than that of non-Aborigines because of the gulf that existed between Western medicine and Aborigines' own conception of medical care. There was a lack of the understanding of the intellectual, cultural and social practices of the Aboriginal people which were very different from those of non-Aboriginals.

Doctors of the Eastern Goldfields Section of the Service, following investigation into the health of Aborigines in Western Australia, made these points:

'There is very little difference in birth weights of Aboriginal children when compared to the National Centre for Health statistics survey (1977) but these infants show a significant fall off in growth (weight and height) commencing in the second half of infancy (6-12 months).'

The implications of this study were widespread and the consequences of malnutrition accounted for much of the Royal Flying Doctor Service medical officers' work. Chronic under nutrition in Aboriginal infants and children was closely linked with infectious diseases like gastroenteritis, chest infections and otitis media. The first two disease states were the commonest reasons for admission to hospital where the opportunity was taken to formally monitor the child's growth and educate the mother in diet and hygiene.

From the late 1970s the Royal Flying Doctor Service at Broken Hill was able to provide transport to other health workers including community nurses. They were flown fortnightly to specific locations such as Wilcannia and Ivanhoe to conduct baby health clinics. In addition, the service's own flight sister conducted clinics in other areas such as White Cliffs and Tibooburra visiting mothers on cattle stations, on the air strip, or in local town halls in small towns in South Australia, Queensland and New South Wales.



In 1988, the Service was operating 33 aircraft, 52 full-time and part-time pilots, 25 aircraft engineering staff, 26 doctors, 37 flights sisters and paramedics, 59 radio staff and 51 administrative and other staff. The Service is based in all states of Australia and provides medical services over two thirds of the Australian continent – an area of some two million square miles.

The Royal Flying Doctors Service has developed from largely an emergency air ambulance service to a general health care service; providing regular clinic flights to Aboriginal communities, mining camps, station properties and other Inland settlements, with daily consultations to anyone within radio range in need of medical advice; as well as the emergency services. In addition, the Service provides transport for dentists, medical specialists and other health workers in order to ensure that the people of the outback have access to medical care similar to that enjoyed by urban dwellers.

Like the Royal Far West Children's Health Scheme, the Royal Flying Doctor Service has brought baby health services to mothers in the outback because of its recognition of the need for mobile nurses.



*Inside the Plane*

*Courtesy Sister Monica Harris*

## CHAPTER 6

### CONSOLIDATION AND EXPANSION 1920S-1940S

'Every additional infant unit reproduces another young plant in the State garden, which will one day yield its quota towards the harvest of national prosperity.'

Newcastle Morning Herald, 1915



*Lady Edeline Hospital  
Tresillian*



*Treatment Room, Woolloomooloo  
Baby Health Centre, 1928  
NSW Government Printer*

In 1920 the Labor Party came into power in New South Wales and JJG McGirr was made Minister for Public Health and Motherhood. The debate continued about the level of direct official control which should be exercised over the Royal Society for the Welfare of Mothers and Babies, supported by the Health Minister, who wanted to make it a section of the Health Department.

The summer of 1920 was a bad one for cases of gastroenteritis, the Lady Edeline Hospital having a very high death rate. LR Parker, the Visiting Medical Officer noted that 'this is due either to parents, clinics, or medical men treating 'Greycliffe' as a last resource... In no previous year have I seen epidemic enteritis so virulent and so rapidly fatal.'

The Matron added that of the 220 cases treated, 30 under three months died, eighteen under six months, five under 12 months, and five in the one year to over two group (Annual Report, 1920)

In 1921 things were much better. Of 300 admissions there were only 32 deaths, a considerable achievement, as Dr Parker pointed out, since 'most of our children are, in addition to the acute illness which had necessitated hospital attention, suffering from chronic malnutrition in various forms.'

In the slow process of recovery and nutritional development, he noted 'the mothers of the children are urged to watch the various processes of the infant's management.'

The matron added that 49 mothers had been in residence with their babies, and left 'not only with restored babies but with a good working knowledge of motherhood.' (Annual Report, 1921 p.69)

Despite the epidemic in 1920, the infant mortality rate, as calculated in five-yearly intervals, continued to decline with the Sydney rate for 1916 to 1920 of 68 per 1000 live births dropping to 59 by 1921 to 1925. The State rate dropped from 65 to 58 in the same period.

Dr W G Armstrong became the Director-General of Public Health in 1921, a position he held until 1924 when Dr Robert Dick took over the post ... During 1923 to 1925 the debate about the effectiveness of the Truby King model of infant welfare services in reducing the infant mortality rate in New Zealand continued with Truby King criticising the Royal Society for failing to reduce the infant mortality rate more effectively. Armstrong continued to defend the Health Department and its role in reducing the infant death rate and the Royal Society argued that physical and social differences between New Zealand and Australia accounted for the variation in the statistics. The Minister for Health was obliged to defend publicly both the Department and the Royal Society (Milton Lewis, 'Populate or Perish').

In October 1925 J H Cann, Labor Minister for Public Health, announced that the Government had accepted Dr Dick's recommendation that a medical officer of the Department of Health be placed in charge of infant and maternal welfare work.

The Baby Health Centres Committee had been asked to make a recommendation to the Minister upon the subject of establishing more direct medical supervision over the baby health centres. It proposed that a Medical Officer be appointed under the Director-General of Public Health and that the principle of an advisory committee be maintained. Dr Dick recommended in November 1925 that Dr



Burwood Baby Health Centre, 1927  
NSW Government Printer



Our Babies 1931

E Sydney Morris, Senior Medical Officer of Health, be entrusted with the duties of Director of Maternal and Baby Welfare without any variation in his remuneration of 1,000 pounds per annum.

In 1926 the baby health centres were transferred to the direct control of the Director-General Public Health, thus placing the centres under direct medical control, and the Baby Health Centres Committee ceased to exist. There were then 60 centres operating. Figures for 1925 showed 190,329 attendances and 83,757 visits by nurses to cases in areas served by the 55 centres then operating.

Gandevia argues that Government sponsorship and control of infant welfare organisations was an inevitable development following legislation of public health problems. The role of the Department of Health in directly 'controlling' the baby health centres has remained to the present day although voluntary organisations have continued to play a significant role in many areas of baby health services particularly in the rural sector.

Dr E Sydney Morris had been Director of Public Health in Tasmania before transferring to the New South Wales Department of Public Health as a Senior Medical Officer. He had been winner of a national competition for the best study of the causes of maternal mortality in Australia. Before the appointment, he had spoken at the Country Women's Association conference in 1924 on the value of the baby health centres and enlisted the support of the Country Women's Association. Morris recalls his experiences during this period in an address to baby health centre staff in 1946:

'My advent as Director of Maternal and Baby Welfare had mixed reception. Some resented the change in control. I think even Miss Spencer and Miss Williams, with both of whom my subsequent official relationships were extremely cordial, viewed me with much misgivings and apprehension... The staff in those days was comparatively small and I was able to take personal interest in each individual sister. All were fired with a zeal which was infectious.'

The baby health centres increased in number and Dr Morris' departmental responsibilities increased. Dr Sandford-Morgan was appointed to assist Dr Morris. Morris recognised that 'propaganda publicity' was essential for the progress and success of baby health centres and so Mr White was appointed as publicity officer.

Milton Lewis believes that;

'the success of the infant welfare movement in Sydney had much to do with its capacity to convey simple information on infant care to large numbers of mothers. To avoid confusion, the advice had to be uniform as well as intelligible. The clinics were one means by which to reach a mass audience ... The publications and other publicity efforts of the Health Department and of the Royal Society extended the influence of the movement, reaching mothers not otherwise to be contacted. But the audience had to be reasonably receptive to and capable of absorbing the advice preferred.' (p.159)

Lewis argues that the advent of compulsory education in 1880 created a population of better educated and more responsive mothers early in the twentieth century who sought advice and were prepared to be instructed by experts. So the history of the infant welfare movement reflected this social change by recognising the need for initially, the



*Our Babies* 1957



*Healthy Motherhood*, 1939

distribution of pamphlets in Armstrong's 'Town Hall' campaign and later the clinics followed the Royal Society in using newspapers to provide material to the public. By the mid 1920s the Royal Society's pamphlets were distributed by mail throughout the State, and the Education Department took 29,000 for distribution to girls' schools.

The Health Department gradually took over the Society's role in the publication and distribution of pamphlets on infant care, and the Society's participation in this activity ceased in 1930. Films, radio talks and a major campaign through the newspaper (with 100 newspapers throughout the state receiving regular articles on mothercraft) added to the impact of earlier efforts.

The two major Departmental publications on antenatal care and infant care, *Healthy Motherhood* and *Our Babies*, were commenced and distributed free of charge. The final publication of *Our Babies* was not until 1983.

Morris felt that the publicity and educational propaganda shaped public opinion sufficiently to encourage the Government to continue to provide funds. The support of organisations such as the Country Women's Association and the Bush Nursing Association ensured that the Government would not have to finance the totality of baby health services. Local authorities in the main however, did not assist at this time, arguing that it was national work and exclusively a Government responsibility.

By 1927 there were 35 clinics in the metropolitan area and the Annual Report of the Department of Public Health stated that, where clinics had been established for some time, 60 to 80 per cent of babies attended. Mothers from all socioeconomic levels were attending the clinics as against the earlier focus of Armstrong's campaign aimed at the inner-city, working class mother. Dr Morris wrote in 1927:

'Mother in every grade of life are welcome ... since every healthy baby is equally one of the State's best assets, and any mother may need mothercraft instruction ... In consequence, the mothers who attend the Baby Health Centres are drawn from every class in the community, and the fact that there is no discrimination whatever in the centres emphasises the essential national characteristic of the work.'

Medical experts such as Morris and Harper certainly attributed a large part to the activities of the baby health centres, particularly in advocating the necessity of breastfeeding, to the marked reduction in the infant mortality rate. Comparing the period 1908-12 with that of 1923-27 there had been a reduction of the infant mortality rate of almost 25 per cent. The death rate from 'diarrhoea and enteritis' for the same period had been reduced by more than 50 per cent.

In 1929 Morris reported in the *Medical Journal of Australia* that the 30 per cent of babies who were not attending the baby health centres contributed to more than 80 per cent of the total 'enteritis' cases treated annually in the Royal Alexandra Hospital for Children, the Renwick Hospital for Infants and the Lady Edeline Hospital for Babies (Vaucluse). Morris proposed that the medical profession should universally support the value of breastfeeding, particularly in the summer months, in order to reduce the incidence of gastroenteritis.

Certainly the incidence of breastfeeding was high in 1930; an average of 93 per cent of all babies in the first month attending the 84 baby health centres in the state were fully or partially breastfed. The percentage dropped to just over 90 in the second month and by the end of the ninth month, 70 per cent of all babies attending the clinics were still breastfed. These mothers and babies represented all sections of the population, metropolitan and country, industrial and well-to-do.

Between 1928 and 1931 there were three more years of dreadful epidemics of 'summer diarrhoea'. During this time, of 952 babies admitted to the Royal Alexandra Hospital for Children, 207 died, many of them because help was sought too late. Of the 300 admissions in 1929-30 only 43 had ever attended a clinic, and there were no wholly breastfed children among them. In 1932 Dr Margaret Harper wrote in the Medical Journal of Australia:

'It is again noticed, as in previous years, that only a small number of these infants have attended the Baby Health Centres, in spite of the fact that the districts from which they come have Baby Health Centre with very large attendances. There is no doubt that the mothers who take their babies regularly to the Health Centres and who follow the advice given to them, learn how to protect their babies from flies, to protect food from contamination and to be clean in their households.' (Dr Margaret Harper, Lysbeth Cohen, p.32).

In 1918, the Royal Alexandra Hospital for Children had established a group of little 'Shelters' where Wade House garden is now, for the isolation and treatment of gastroenteritis patients. Provision was made for special treatment and food preparation rooms, and each year these were opened from September until April. By the summer of 1931/32, the number of gastroenteritis cases admitted to the Special Ward showed a considerable decrease, and by 1934/35 it was decided not to open the 'Shelters'. Lysbeth Cohen quotes Sir Lorimer Dodds, who with a sweeping gesture from the window of his office above the Wade House garden, said:

'I cannot help remembering as I look out, all those little shelters each housing two poor sick little babies in cots...It was a terrible thing, gastroenteritis...and now there is this pleasant garden.'

In 1933 the Director of Maternal and Baby Welfare in the Department of Public Health was able to say:

'...the summer scourge of gastroenteritis among infants is becoming a thing of the past...and even when such an epidemic occurs, not only are the breastfed babies almost entirely exempt, but also those artificially-fed ones whose mothers are guided by the Baby Health Centres.' (Annual Report, 1933).

The Lady Edeline Hospital for Babies which had been opened in 1913 for the treatment of babies suffering from diarrhoea and gastroenteritis, closed in 1935 due to the decline in demand and was handed over to the Royal Society for the Welfare of Mothers and Babies to be used as a Mothercraft Home.

By 1935 the infant mortality rate had dropped from 120 in 1885 to 39 in 1935 for children under one year. For the first time in the period 1931-35 the rate for Sydney fell below the rest of New South Wales suggesting that the factors associated with heavy urbanisation had been overcome. The clinics had obviously played a



*Rosalind Black Ward, Lady Edeline Hospital  
NSW Department of Health*

significant part in the decline in mortality due to 'summer diarrhoea'. Wade in 1939 wrote: 'they represent the greatest advance in the concerted care of young children that has yet been evolved.'

During the late 1920s and early 1930s with the decline in the infant mortality rate due to gastroenteritis, there was an increase in concern about the other causes of infant mortality under one year of age. The problem of slow population growth continued to be significant and was exacerbated in the Depression years, when the birth rate was low due mainly to later year marriages. The birth rate fell below replacement levels and did not recover until 1940.

The 1928-34 Annual Report of the Department of Public Health recognised that more than one half of the total numbers of infant deaths occurred during the first month of life, and of that number the majority took place during the first few days. It was identified that the problems of neonatal mortality would only be solved if the factors contributing to maternal morbidity and mortality were overcome; neonatal deaths occurring mainly from trauma after difficult deliveries, among premature infants or as sequels to toxæmias of pregnancy.

In 1926 the increased public awareness of infant and maternal mortality had led to deputations from women's organisations lobbying for more baby clinics and antenatal clinics. In 1928 the Royal Society presented a Report by the Special Committee on Maternal Welfare which, among other issues, reviewed the provision of antenatal clinics. It reported:

'the aim should be that each obstetric hospital should provide an antenatal clinic not only for its own patients but for patients who will be confined outside its own hospital. In addition, antenatal clinics in suitable locations should be run in connection either with the obstetric hospitals, the baby health centres or both. The general adoption of antenatal supervision which will diminish the number of unexpected complications of pregnancy and labour is urgently needed.' (Australia Nurses Journal, 1928, p. 294)

While it had been written into the original statement of the role of the baby health centres that they advise women during pregnancy, this had proceeded on an ad hoc basis since 1914. In 1929 Dame Janet Campbell, the Senior Medical Officer for Maternity and Child Welfare in the Ministry of Health in London, visited Australia and reported to the Commonwealth Government on her impressions of maternal and child welfare in Australia. She felt that many of the deaths associated with injury at birth, debility or prematurity were preventable with better midwifery, supervision of the mother during pregnancy or more skillful care of the 'weakly' infant after birth. She noted the potential for good health in Australian cities, pointing to problems of isolation and primitive conditions for mothers with young families in many sparsely inhabited rural districts. She also acknowledged the work of the Country Women's Association in maternal and child welfare.

Dame Janet Campbell argued that adequate antenatal supervision was one of the most effective means of preventing unnecessary mortality with antenatal care falling into two parts; the medical and obstetric, and the hygienic and social. The obvious nucleus for such clinics was at the maternity hospitals. She felt too that there was a need for the effective supervision of young children, and that dental services needed to be extended to those children and to pregnant and nursing mothers.



*Waiting Room in Baby Health Centre 1930s  
Benevolent Society of New South Wales*



*Rose Bay Baby Health Centre 1929  
Courtesy of Therese Baulman*



*Randwick Baby Health Centre 1935  
NSW Government Printer*

As a result of this debate, the first Government sponsored antenatal clinic at a baby health centre commenced in Newtown in 1919 and by 1931 eight clinics had been opened. The aims of these clinics were the reduction of maternal morbidity rates, fetal morbidity and mortality rates, miscarriage rates and neonatal death rates. The Newtown clinic operated one night a week, with 817 attendances in 1931. Originally the clinics were conducted by nursing staff with periodic supervision but by 1942 all clinics except one, had regular medical supervision. During this period honorary medical officer attending the clinics included Dr Margaret Harper, Dr Lucy Gullett and Dr Grace Cuthbert Browne.

Everything possible was done through the media by way of 'propaganda' to help pregnant women to be more informed and to attend antenatal clinics; through lectures, radio talks, articles in the press; and above all through personal contact by the baby health centre nurses. This included urging midwives to assist, particularly where no doctor was in attendance, in persuading their patients to attend one of the antenatal clinics. However, the number of women who used the antenatal services, either in the clinics or in the hospitals only increased slowly so that by 1931 it still only accounted for one-fifth of confinements. Those 7,000 expectant mothers who did attend for advice unfortunately sought assistance on matters such as baby clothes help in obtaining extra nourishment etc. The majority of mothers, however, continued to come into labour without having received any antenatal supervision whatsoever. (Annual Report, Department of Public Health 1928-34)

Dame Janet Campbell in her report on maternal and child welfare advocated improved education for midwives to secure for the qualified midwife a high professional status and adequate remuneration. She also put forward the concept that training in mothercraft should receive full official recognition and support. She felt that Mothercraft Schools should be expected to conform to certain general requirements which would ensure adequate teaching facilities without imposing unnecessary standardisation of methods.

In New South Wales the Registration of Nurses Act had been proclaimed 1 January 1926 and the accompanying regulations led to the setting up of the New South Wales Nurses Registration Board. The Board had the power to control the training and examination of all types of nurses including the regulation of the practice of midwifery nurses. One immediate result was that many untrained women who had been unable to produce medical certificates of competency were prevented from practicing as midwifery nurses. However, the regulation of mothercraft training would not occur until the 1960s.

Until 1930 premises for the clinics had been provided by the Government or rentals paid by the Department. From 1930 to 1944 no centres were established unless the premises and maintenance were provided by Local Government authorities or local committees.

In 1931, despite financial stringencies caused by the Depression, there were 87 baby health centres (40 metropolitan and 47 country) with home visits being made to nearly one half of the newborn babies in the State. As soon as the registration of a birth was received from the local registrar, the mother was visited by the centre nurse with offers of advice. By 1932, with a reduced nursing staff, a marked decrease in the birth rate and difficulties in transport, the number

of individual babies attending, the new cases enrolled and total of number of attendances was less than previous year (for the first time since their inception). Many other country towns were awaiting the opening of centres which had to be delayed because of the lack of funds. In many instances rooms had already been supplied and furnished by the Country Women's Association.

By 1935 however, attendances had again increased substantially and the number of centres had increased to 140. This expansion was due to the work of the Country Women's Association, which accounted for eight of the nine new country centres opened in the previous 12 months; only one centre in Bulli was supported by the Shire Council. There were 145 nurses employed in the clinics besides two inspector nurses and six supervisory nurses.

The emphasis on preventive methods continued, the centres were becoming successful in establishing breastfeeding when babies were brought in several weeks old having been artificially fed since birth. Only where 'test feeds' conclusively established that the supply of breastmilk was deficient were mothers allowed to either partially or completely use artificial feeding. During 1935, 34,947 test feeds were carried out at the various baby health centres.

Classes were given to Girl Guides, schoolgirls and domestic science students by the baby health centre nurses and the Director of Maternal and Baby Welfare, published articles on mothercraft in the press throughout the State.

From 1930 onwards the infant mortality rate for the metropolitan area was consistently lower than the rate for the country. However, the rapid increase in baby health centres between 1931 and 1937 in the rural areas (an increase of 137 per cent, from 51 centres to 121 centres) was mainly attributable to the funding arrangements. The Country Women's Association was responsible for the upkeep and maintenance of 80 centres by 1937. In other instances, citizens' committees were responsible for supporting centres, while Shire and Municipal Councils had provided equipment, premises and upkeep of some centres.

*Necessities for artificial feeding 1928*  
NSW Government Printer





There were staffing changes in the Division of Maternal and Baby Welfare in the late 30s. Dr Elma Sandford-Morgan had been the first full-time Director of Maternal and Infant Welfare since 1934, and resigned her appointment in May 1937 in order to take up an appointment in South Australia. Dr Grace Cuthbert Browne was appointed in her place, and would hold that position until 1964, during which time she would have a major impact on infant and maternal health services.

In 1939 Miss Lucy Spencer, who was a Nurse Inspector and had been employed in baby health services since 1912, and more recently in administering the baby health centres, resigned to get married.

By 1939 there were 211 baby health centres in New South Wales, with 53 in the metropolitan area.

During the late 1930s a continuing thread in public discussion on children was the concern with the falling birth rate and the belief that Australia would be damaged by failure to expand through reproduction. Two children were not regarded as enough, and some decried the 'age of voluntary parenthood', and advocated a break with the fashion of having small families. 'Motherhood should be seen as a joy and a privilege' according to Dame Enid Lyons, whose views were reported in the *Australian Women's Weekly*. She also expressed dislike of the trend toward seeing the expectant mother as a 'medical case', when in the strictly medical sense the mother is not a patient. Similarly, teething is not an illness and nor is maternity. She advocated fewer maternity cases in hospital, and more home confinements where the baby could immediately be part of the family. (*Women's Weekly*, 3 September 1938)



*Bathurst Baby Health Centres 1926 and 1952*  
Bathurst District Historical Society

The *Women's Weekly* ran a 'Mothercraft Service Bureau' with notes on infant care, such as the encouragement of the baby to suck within six hours after birth, and prohibition of night feeding.

In his 'Charles Mackay Lecture' to the Australian Institute of Anatomy in 1937, Sir Robert Wade talked of the great gap in attention of baby health services to the pre-school child. He believed that 'Women ... should be taught something about domestic life and the care of her children', and felt that the lack of training given at school in 'dieting, feeding and care of babies, or at a later stage in child psychology or nutrition' was a serious omission in the system of education. Acknowledging that times were changing, he stressed that the mother should still bear the child and feed it for the first year and that 'the mother comes into the particular care of her child quite untrained, and with absolutely no knowledge as to her duties as a mother.'

'... Parents know little of the feeding and care of the baby until recently; this is being remedied by the infant welfare centres. The knowledge of the child has not progressed beyond this. There has been an over-reaction against the severity and authority of the Victorian era to undue spoiling and 'self expression'. It is really pitiful to think of the amount of stupid advice the poor young mother receives from female friends and well-wishers, but, above all, from the maiden sisters and grandmothers, who, seeing the child only occasionally and having no responsibilities, spoil and pamper him to their hearts' content.'



Rose Bay, 1929

Courtesy Therese Baulman

By 1941, the early part of the Second World War, concern with professional advice and infant care had coincided with the recognition of a serious shortage of mothercraft nurses. The Sun reported that mothers with sick children often found it impossible to secure a nurse's services, and mothers with new babies needing home visits were refused. Matron Warneke of Karitane said they needed about 80 more nurses, and Dr Morris said demand for Tresillian nurses was always greater than supply, and his department urgently needed about 50 more.

The Minister for Health, Mr Kelly, said maternal and infant welfare was a work of vital national importance, and indicated that the Government might be ready to take greater responsibility for the maintenance of baby health centres throughout the State, which had relied almost entirely on voluntary work. 'I cannot stress too much the importance of prenatal care and the care of young babies and young children,' he said.

In 1942, there were 224 baby health centres in New South Wales. Dr Grace Cuthbert Browne, Director of Maternal Welfare, said they must become the advice centres on problems of antenatal care and babyhood. There were 200 trained nurses in the centres. Wartime shortage had affected supplies of clothing such as winter clothes and napkins, essential antenatal and baby foods such as certain dried milks, cereals and dried fruits, and equipment such as prams and baby baths were hard to come by. The call-up of doctors had removed many family practitioners, and prospective mothers alone were in some cases, having a drastic time. Sister Jacobs from Karitane urged that:

'In all schemes for food control and distribution, our Government must ensure that the expectant mothers and mothers should have adequate supplies, for upon them depends the health of the generation to come.' (Sun, 1 June 1942)

During 1942 baby health centre nurses attended a special course of lectures on the care of pre-school children arranged by the Kindergarten Union and Day Nursery and Nursery School's Association as a supplementary training as the war situation, then extremely grave, made it necessary for children with nurses to be evacuated to remote areas. In fact many mothers and expectant mothers did move out of the metropolitan area in 1942 and attendances at antenatal clinics declined in that year.

When emergency conditions occurred, special pamphlets were produced by the Department for the information of mothers. When oranges were withdrawn from the civilian market in 1944 and a serious outbreak of scurvy threatened, 50,000 pamphlets on the subject were distributed. The propaganda was most effective and the number of cases was reduced to a minimum in a very short period. During the milk strike in 1944, 14,000 pamphlets were issued in the metropolitan area to assist mothers in the rapid changeover from cows' milk to dried milk in the feeding of babies. (Department of Public Health, NSW 1941-46)

The shortages of nursing staff created particular problems for nurses working in the rural sector; particularly Bush Nurses due to lack of relief, etc, and many centres had to be closed. The petrol rationing was a major problem, causing difficulties in obtaining transport. The 1945 Annual Report of the Bush Nursing Association states;

'Among the requests was one for an issue of petrol ticket. As a result of an appeal to the Liquid Fuel Control Board the Association has been issued with petrol tickets to the value of 100 gallons per month. The difficulty of transport for the Bush Nurse to get to her patients and for the patients to get to her has been somewhat eased by this issue. The tickets are sent to the Nurses who are mainly in charge of the centre farthest from the railway.'

Gandevia argues that perhaps 80 per cent of the improvement over 1900-1945 was due to a decline in mortality from infectious diseases, especially gastroenteritis, which was responsible for about a third of deaths. Decline in diphtheria, scarlet fever, measles and whooping cough were also responsible.

As a result of the improvement in the overall infant mortality rates in this period the focus shifted to the casual factors relating to neonatal mortality and thus began an emphasis on antenatal care. In addition there was an emerging awareness of the need to provide services for the pre-school child.

## CHAPTER 7

### POST-WAR BABY BOOM 1944-1964

'Wherever groups of people discover a consciousness of community life, the needs of certain sections within the community tend to receive special emphasis. This emphasis will depend upon the nature of the community, its location, its economic status and its interests ... it is increasingly evident, however, that wherever families live together in close or in scattered communities, more and more attention and interest is being focused on the needs of the young child.'

The Infant Welfare Centre as a Community Service, p.1

#### Standards for Premises for Baby Health Centres in Country and Metropolitan Districts

Premises should provide for:-

1. Waiting mothers with babies and toddlers.
2. Mothers consulting with the nurses.
3. Mothers who are having test feeding.
4. Nursing staff for sterilizing equipment, heating water etc.
5. Nursing staff for changing uniforms, meals, shower rooms, etc.

Provision should be made for parking perambulators and for a space where toddlers can play. Suitable arrangements for heating, lighting, ventilation and sanitation are necessary; this should include separate lavatories for mothers and nursing staff.

The accommodation required is as set out hereunder.

#### Metropolitan Areas and Country Districts

##### A Daily Service.

Rooms	Approximate Size
1 waiting room	14 x 16
2 consulting rooms	14 x 12
1 test feeding room	12 x 12
1 nurses' room	10 x 10
Kitchenette	6 x 8
* 1 Doctor's room	12 x 12

\* (The doctor's consulting room for paediatric and pre-natal supervision should be provided only in a large district in the metropolitan area where a pre-natal clinic is required and after consultation with the department.)

##### 3 to 4 Days per Week Service.

Rooms	Approximate Size
1 waiting room	14 x 16
1 consulting room	14 x 12
1 test feeding room	12 x 12
1 nurses' room	10 x 10
Kitchenette	6 x 8

The war years were particularly difficult ones for the baby health centres due to the volume of work. In spite of war time restrictions and difficulties there was an increase in the number of centres opened and in the volume of work in the baby health centres. There were two major developments which would significantly affect the growth of baby health centres in the post-war years. These were the newfound interest of local government authorities in the development of baby health centres and the new financial policy of the Government in assisting baby health centre development and extension.

In 1942, a new interest developed from local government authorities in the establishment and improvement of baby health centres in their districts. This led to the preparation of lists and schedules setting forth the standard requirements for the premises of baby health centres including the appropriate equipment, maintenance and condition of the centres, the local responsibility, if any, and any other relevant data. There was a particular need to adopt standards for the ongoing maintenance of the centres as recent surveys had shown that the condition of the majority of existing premises needed improvement.

The Concord Municipal Council in 1943 built the first baby health centre to these requirements, entirely at its own expense and handed it over to the Department of Public Health, making an historic occasion. The Strathfield Council opened a similar centre in 1944 and provided the site, the building, furniture and equipment without any government assistance.

In 1944 the Commonwealth Department of Health produced a book on The Infant Welfare Centre as a Community Service. The introduction drew attention to the increasing interest in the needs of the young child:

'the natural result of the ever-increasing knowledge of the importance of the first years of the child's life and the effects, mental, social, physical and emotional, which environment and training can have upon the child, not only during those years, but in all the subsequent years of its life.' (p. 7)

It was stressed that besides providing a health service for mothers and babies, the infant welfare centre should be an educational agency. The object of a fully developed infant and child welfare service was stated: 'to ensure that every mother has an opportunity of receiving sound advice as to the care and management of the normal baby and little children under school age, to maintain health and prevent sickness.' (p.10)



Concord Baby Health Centre 1914



*Pram Area , Concord, 1944*  
NSW Government Printer

The book emphasised the importance of 'infant welfare' centres in the development of community facilities. It outlined the functions of infant welfare services, existing services in each State, the importance role of Local Government, and provided guidelines on the level of service requirements based on population size. The document gave specific proposed plans for the layouts of centres and lists of required equipment for both urban and rural centres.

In 1944 the New South Wales Department of Public Health decided to amend the funding guidelines for the establishment and maintenance of baby health centres.

The new guidelines allowed for the Department of Public Health to have a much greater role in the funding of the centres. The policy enabled the Department to make a baby health service available to an approved organisation (e.g. Local Government, a branch of the Country Women's Association), as long as that authority agreed to provide a suitable building and maintain it.

The Department agreed to provide the staff for the centres, including paying for travel and other expenses, while funding 50 per cent of the capital cost of the building (not including the cost of the site), or 25 per cent of the rental cost if a building could not be erected. All plans had to be agreed to by the Department, and agreement given by the participating organisation to make the centre available at all times for the purposes of baby health services.

Buildings were not to be erected on any standardised plan, and local authorities were encouraged to choose the style of architecture suitable to the geographic location.

In 1950 the funding arrangements were again changed to reflect further the commitment of the Government in supporting the development of baby health centres. The grant of 50 per cent of the capital costs to be provided by the Government was increased to 75 per cent, or a rental refund of 37 ½ per cent.

By 1950 there were 278 baby health centres in the State, of which 76 were in the metropolitan area, 11 in Newcastle and 191 in the country. This was an increase of 31 since 1944, of which 11 were metropolitan centres.

Dr E Sydney Morris summarised the changes in the support of baby health centres as follows:

'Baby Health Centres have now become established as an indispensable necessity with considerable political influence. Public opinion is now so much in favour of them that even local authorities are competing with each other in providing up-to-the-minute buildings and equipment.'

There was continuing concern about the lack of services for the pre-school child after the War. The Commonwealth Department of Health's 1944 report advocated extension of the infant welfare centres to provide a 'Toddlers' Waiting Place' for the occasional care of the toddler, with services to include periodic health supervision and a certain degree of educational development. The importance of suitable toys for different ages, and the role of play as a learning experience and not just a time-filler, was discussed. It was recognised that specialised pre-school officers would be required for this work.



*Test feed, Concord 1944*  
NSW Government Printer



*Pre-Schooler, 1944*  
NSW Government Printer

There was considerable concern that 'much of the excellent work of the Infant Welfare Centres is often lost in the pre-school years.' (p.34)

There had been some initiatives commenced for this age group prior to the war in the centres. In 1939 'zone charts' developed by Dr Clements of the Institute of Anatomy were used to record the history of the child's progress and to impress upon the mother the necessity of continued supervision to school age. The need for suitable advice on nutrition and management was also emphasised.

The 1941-1946 Annual Report of the Department commented on the general interest in the community concerning the needs of the pre-school child, with a marked demand for increased facilities and more frequent attendances by pre-schoolers. As well as advice on nutrition and hygiene, the weight and physical development of the pre-schoolers was checked.

However, by 1947 the Department was unable to sustain this service on a routine basis owing to a serious shortage of staff. In order to staff all baby health centres in the urban and rural areas and provide advice and supervision for mothers with young infants it was decided to discontinue 'temporarily' in the metropolitan area the practice of seeing children aged from two to five years as a matter of routine. Advice would be provided when especially needed. This 'temporary' suspension of services was not in fact re-established for 14 years, until 1961.

In 1950 the services of a medical officer were provided to make regular visits to five baby health centres in the metropolitan areas at fortnightly intervals, to advise on cases selected by the sister from the babies brought to the centres who were not seen by a private doctor. Acutely ill babies or those with infectious diseases were not seen. Advice was given to mothers on nutrition, feeding problems, behaviour problems and management.

During the mid 1950s these clinics increased in number to nine and were variously entitled 'paediatric' or 'well baby clinics' with attendances reaching 1,600 by 1957. However, by 1958 these clinics declined considerably in number to two, located in Balmain and Hornsby, with only 103 sessions conducted. This decline was due to the introduction of the Medical Benefits Scheme, which allowed the public to obtain private specialist treatment more cheaply on a fee for service basis. The service was re-established on a more comprehensive basis in the 1960s.

A small section of the pre-school population did receive regular screening and assessment from the beginning of the post-war period. From 1946 a health service was provided by the Division of Maternal and Baby Welfare to pre-school centres conducted by the two voluntary organisations subsidised by the Government, the Kindergarten Union and the Sydney Day Nursery and Nursery Schools Association. In 1950, thirty kindergartens and fourteen day nurseries were being run by these organisations.



Woolloomooloo Welfare Centre, 1948  
NSW Government printer

The object of this health service was to: 'improve and safeguard the physical and mental health of the children.' (Annual Report, 1950, p.56) Regular visits by specially qualified medical officers were organised with the objective of seeing the children twice yearly. At the first visit the children were screened for physical defects and interviews held with the mother if possible. In this way a total picture of the child's general health, nutritional status, dental health, and social environment, behaviour and intelligence was obtained. The teachers were encouraged to inspect that pre-school children at the centres each morning to prevent the spread of cross-infection. Children were referred to the Dental Hospital if dental treatment was required. When there were behaviour problems which could not be resolved, the child would be referred to a child guidance clinic. Where medical treatment was required, the mother was advised to take the child to the family doctor or to the out-patients of the Children's Hospital.

The period after the Second World War signified major changes in social, economic and political terms. The period of the second half of the 1940s, the 1950s and the 1960s was the generation of the baby boomers. As Helen Townsend writes:



Gladesville, 1950  
NSW Government Printer

'Officially, the term, 'post-war baby boom' refers to the increase in births when Australian servicemen returned home from World War II. It was a time when couples who had deferred marriage got married. They were keen to establish families. Couples separated by war were anxious to complete their families. Post-War reconstruction not only involved large national projects, but dealt vigorously with bread-and-butter issues such as housing for families, child endowment and better maternity hospitals. Australians, having the good fortune to be on the winning side of the war, wanted to settle down to normal, ordinary, everyday living. This normal, ordinary everyday environment shaped the childhood of children born in the 1940s, 1950s and early 1960s.' (Baby Boomers, p.7)

The baby boom reached a peak in 1961. It was a period of rapid urbanisation. Townsend continues:

'The previous generation of Australians had grown up in a period of acute economic depression and then had to face the uncertainty of war. The baby boomers grew up in a period of certainty and security ... By today's standards; they were fairly sexist, racist and very British. Their major pre-occupations were home and family and material comfort. The nation was increasingly middle class, interested in owning homes and cars. Red brick suburbia spread relentlessly ... More than anyone else, Mum, who worked at home, created the environment for the baby boomer childhood. Mums provided basic food and shelter. If your mum wasn't home, the one next door would do. The baby boomer was given the freedom of the suburb because there were mothers on every street, in every house. They created a network where everyone knew everyone else.' (pp. 8-9)

The memories of some retired baby health sisters also show the problems of this era:

'In the 1950s, there were a lot of distressed people, particularly in those new suburbs. They were very isolated. Engadine just grew... the beginning of the urban sprawl. There was no transport and no support services, and they were all young, often living in temporary dwellings. They were garages, and their husbands spent the next 10 years building the house.

The garages got extensions and lean-tos. The mothers didn't see other people. The visit to the baby health centre was the highlight of their week, and they walked miles to come. It was difficult to organise getting them to their postnatal check-ups, because there was no-one to mind their children. The social worker put up a list of people needing help - it was pages and pages - and there was hardly anyone on the list of those able to help. There were stress problems, but they didn't expect too much ... they were very lonely, but they had vegetable gardens, fresh air and took it more patiently.'

Townsend identifies that in this period 'free milk was symbolic of post-war reconstruction, along with baby health centres and immunisation programs.' From 1943 onwards the total number of attendances at baby health centres on an annual basis exceeded the one million mark and would remain at this level until the early 1970s when statistics ceased to be centrally collected.

The improvement in living standards was reflected in the continuing decline in the infant mortality rates. The mortality rate among infants in the first year of life was below 50 per 1,000 live births for the first time in 1930, was below 40 in 1933, 1935, 1940 and 1943, and between 1944 to 1948 did not show any marked deviation from the average for that period of 30. By 1950 the rate had dropped below 30 to 27 per 1,000 live births, and by 1960 this rate had dropped to approximately 21 per 1,000 live births.

Analysis of the figures for 1950 showed that two-thirds of the mortality rate was attributable to deaths under one month, with the majority of these occurring under one week. It was felt that there was a need to focus on the prevention of premature births and the proper care of babies born prematurely. (Annual Report, 1950, pp. 52-53) 1951 figures showed that half of the babies dying within the first four weeks of life were premature.

By 1958, 58 per cent of babies dying under one week were premature babies. A visiting service was established for premature babies in co-operation with seven of the metropolitan obstetric hospitals. The hospitals notified the Division of Maternal and Baby Welfare of the discharge of each premature baby and arrangements were made for a sister to visit the baby in the home.

The Annual Report of the Department in 1958 reported that it was the view of the Director, Dr Grace Cuthbert Browne, that the decline in infant deaths under one week from 1957 to 1958 was due to improved standards of prenatal care. Prenatal clinics were still being run at baby health centres, and the nine clinics accounted for 15,175 attendances in 1958.

During the late 1950s and early 1960s there was an emergence of the recognition of the needs for services for disadvantaged groups such as migrants and Aborigines and people in remote areas. With the wave of post-war immigration to Australia, many of the women attending baby health centres were of non-English speaking origin,

i.e. 'new Australians'. Initiatives in the mid 1950s to cope with these changes included the translation of relevant questions on babies and expectant mothers and on diet instructions for expectant mothers into Czechoslovakian, Dutch, Estonian, French, German, Hungarian, Italian, Maltese and Polish languages to assist new migrants with language difficulties at the centres.



*Consulting the expectant mother*



By 1963 these translations were available in 19 languages. By the end of the decade there was recognition of the limitations of this approach, due to the inability of the sister to understand the mother's response to the written information or because of illiteracy.

'At present the Baby Health Centre Sisters rely on mime plus examples of food such as an orange, a tin of Farex etc. It is very slow and tiring and quite often unsuccessful.' (Annual Report, 1959, p. 74)



*Holsworthy Village Baby Health  
Courtesy Sister Olwyn Hendy*

Strategies which were proposed included recruitment of multilingual nurses (although these were not readily available), preparation of translations of simple statements in relation to feedings and general care of the baby and the possibility of interpreters.

Services were also extended to Migrant Hostels, where immigrants were housed temporarily until they found suitable employment or set up their own homes. Because of the large number of young families accommodated in the Centre hostels, baby health centre services were provided within the grounds of the hostels themselves, with the first weekly visiting service opened at East Hills Migrant Hostel in 1963. It was proposed that a centre would be operating in the new year when accommodation was available. By 1964 there were four centres operating at Migrant Hostels at Bunnerong, Matraville, Cabramatta and East Hills. Suitable premises and furnishings were made available free of charge by Commonwealth Hostels Limited and essential equipment provided by the Department.

In 1964 negotiations were commenced for the establishment of a baby health centre at Holsworthy Army Camp in conjunction with the Department and the Army.

Cabramatta and East Hills Hostels were closed in 1972/73 but reopened in 1975 when people arrived from Darwin following Cyclone Tracy and with the intake of refugees from South-East Asia. These hostels were closed again in 1982/83. The Westbridge Hostel, formerly the Villawood Migrant Hostel, continued until December 1988, and community nurses now conduct a 'Mothers Advisory Service' when required.

The Annual Report for the Department for 1953-57 commented that:

'every effort is made to encourage the attendance of the Aboriginal mother at the Centres, and whenever possible a visiting service to Aboriginal Settlements, at reserves, is arranged.' (p. 83)



The high death rate among Aboriginal babies was a continuing source of concern, with whooping cough being prevalent and causing some mortality. In 1958 a baby health centre service was commenced at three Aboriginal stations – Cowra, Burnt Bridge and Bellbrook. The service consisted of a clinic run in some form of accommodation, either a hall or medical room or in some cases the nurse did a house to house visit in a car. There were problems in the follow-up to the sister's visit, as these were only made fortnightly. In addition, the need to immunise Aboriginal children and give TB tests was quickly recognised, and initially sisters were giving Triple Antigen to Aboriginal children. However arrangements were made to involve local medical practitioners and immunisation clinics were held at Aboriginal settlements when required.



Following a conference held in 1963 with the Department and the Aborigines Protection Board it was agreed that if any improvement was to be effective in the perinatal mortality rate and the health of the Aboriginal mother and her baby: 'the problem must be attacked on a local basis and services expanded in the prenatal and early postnatal field.' (Annual Report, 1963, p. 100)

By 1963, 11 baby health centres were conducted specially for Aborigines at Bellbrook, Burnt Bridge, Caroon, Coffs Harbour, Cowra, Murrin Bridge, Namina, Purfleet, Sand Hills, Three Way Bridge and Wallaga Lake. There were six visiting services at the Aboriginal settlements or reserves at Murie, Condobolin, Peak Hill, Dareton, Balranald and Green Hills. At these settlements or stations a room was made available by the Aborigines Welfare Board.

By the late 1950s there were insufficient funds available to extend baby health services, which were needed due to the population growth and the opening up of new areas for housing and development, particularly by the Housing Commission.

There was also a shortage of trained staff to run the centres, and many centres were cramped and in need of renovations. Through the personal efforts of the Minister for Health, the Honourable W Sheahan, a Loan Vote allocation was made for 1959/60 and 1960/61 which enabled another 32 centres to be opened in these years, together with the refurbishment of inadequate and dilapidated centres. The increase in funding 'transformed the position of the Division of Maternal and Baby Welfare, although there were still over 100 applications for centres all of which were considered eligible with a strict priority list maintained. (Annual Report, 1960, p. 97)

There was a growing recognition of the need to determine priorities for services based on population requirements and the extent of existing service provisions, which was heightened by the program of decentralisation of the Department of Public Health into Health Districts, which was under way at this time.

Attendance figures at centres for 1961 were analysed by health districts, and the results showed that there had been a heavy increase in demand from the metropolitan area and the South Coast; the South Coast being explained by the rapid population explosion in Wollongong and its environs.

A survey of attendances showed that of total births in the state, 70.4 per cent attended baby health centres, while the figure for first births was higher, being 86.2 per cent. However this was even higher for the Sydney metropolitan area where 91.3 per cent of first born children attended baby health centres while in Greater Wollongong the figure was 95.8 per cent. These figures did not include attendances at clinics run by other organisations such as the Royal Far West Children's Health Scheme or the Bush Nursing Association.

The need for services to the remote areas of the state was endorsed and in 1961 an initiative was commenced to fill this deficit.

The arrangement consisted of a base centre located in a major town, with the sister conducting other clinics in halls, shops or station properties or even home visiting if such accommodation was not available. The sister would travel throughout her district by car equipped with a two way radio.



"Concrete Babies", Fairfield Baby health  
Courtesy Sister Olwyn Hendy



*A country get together*

*Royal Far West Children's Health Scheme*



*Visiting a station property*

*Royal Far West Children's Health Scheme*

The first of these circuits was established at Balranald serving the Balranald and Wentworth Shires. The pilot scheme met with immediate success. Based on this experience, a similar circuit was planned for Hillston to be operating by the middle of 1963. Further approaches were made from the Shire Council at Nyngan to establish a similar service based at Nyngan taking in Trangie, Nevertire and Warren and working with the Royal Far West Children's Health Scheme, which conducted a rail car service to the area west of Nyngan.

By 1963 there were ten visiting services within the two Special Itinerant Country Circuits. The Hillston service was established with the 'enthusiastic' co-operation of the Carrathool Shire Council, and from the headquarters of the Circuit at Hillston in the new baby health centre five visiting services were conducted regularly at Carrathool, Roto, Merriwagga, Rankins Springs and Goolgowi. One sister recalls her experiences working on the Balranald circuit:

'At Balranald, the Sister did the day there, then left about six in the morning and did three days outback staying at station homesteads overnight. I had a council car for that. Then I went back Kyalite and set up in the pub, in the saloon – it was the only place. The next week I came back, and went to Wentworth and Dareton, then back to Balranald and started the circuit over again. At one place, where the Sister was relieving, she had to set up on the altar in the Church - at Buronga. The outback people knew the circuit and the days. One day it was hot and Dry, and one day I got bogged. I had a two-way radio and had to wait until somebody could come and tow me out. And one day I got lost – that was when I first started there – I went into this property and saw a mother ... but there were about 10 ways out, and I found myself going the opposite direction to the way I wanted to go. Fortunately there was a station along the road, and I called in and said, "Oh God! I haven't got enough petrol. Can you give me some?" And he said, "The boss is away, I'll give you some," and away I went.

Staff shortages experienced in the late 1950s were due to the fact that the average age of the nurses was 54 years and to the existence of 'compulsory country service', where all sisters were required to do periods of country service of three years duration in any part of New South Wales. In order to attract staff, a country allowance of 100 pounds per annum was introduced, paid at the end of each six months of completed country service, and a new Bond Scheme for the training of nurses was commenced. Nurses with a General Certificate could undertake the Mothercraft course of four months training under bond to the Department, where they were paid full salary while training and agreed to work for 18 months after completion of their course in baby health centres. Temporary officers were also employed. By the early 1960s the staffing shortage had been overcome due to these initiatives.

One sister recalls her experience of being a 'casual' baby health sister:

'When you were married and lived in the city, you could elect to stay in the city, but you had casual status – even when you were in charge of a health centre. There was a daily average of 65 at Revesby, but I was still paid as a casual. You could be at one centre at lunchtime and they would call you up and send you to another one in the afternoon. You often got a call late in the afternoon sending you anywhere in the city and you had to travel by public transport.'



*Nyngan Baby Health Centre  
Courtesy Sister Doreen Walsh*

Nurse Inspectors were also encouraged to inspect centres and make contact with staff and with the process of decentralisation of the Department the appointment of Nurse Inspectors to specific Health Districts was commenced. Previously the three Nurse Inspectors operating from Head Office had only been able to make visits to the country centres infrequently. In-service training was also available for baby health sisters, both during the first weeks of service and at other courses such as the in service training course for public health nurses. Sisters' discussion groups and baby health centre sisters' groups were organised to provide a medium for communication and exchange and updating of ideas. Participation was entirely voluntary.



*Late Sister V. Keith  
Courtesy Sister Wilma Newman*

By 1964 the growth and development of the service had continued and was now available free of charge to mothers, irrespective of social or economic status, throughout most of the state. It was seen as a service which was aimed at advising and encouraging mothers of the state in the care of their babies and themselves with developments having occurred from basic education in hygiene and infant feeding to embrace all aspects of infant care. The role of the centres had changed however, in that nurses frequently worked in a centre alone, and it was only in the large regional areas with extensive housing development that two sister centres were provided.

So much of the work was carried out within the baby health centre and mothers were encouraged to attend; the baby's growth and development were monitored with weight, length and head circumference measured at regular intervals and recorded. When there was undue delay in attaining milestones the baby was referred for medical advice. Home visiting was still an important part of the baby health centre service and staff were made available to home visit on priority basis. The priorities were:

1. Premature babies and multiple births.
2. Babies discharged from hospital with feeding difficulty.
3. Babies with apparent handicaps, physical, mental or socioeconomic.
4. Mothers with family and other problems who are in need of help.
5. All patients referred by hospitals and medical practitioners or Child Welfare Department Officers.
6. Mothers with social problems who are need of guidance and supervision.
7. At home visit is made when a mother reports management and feeding problems which the sister considers may be due to environment factors.
8. Routine visiting to newborn babies on notification of registration if the mother has not attended and subsequent visiting to mothers who have not re-attended to ascertain the mother's need for assistance.' (Annual Report, 1964, p.65)



*Measuring Baby  
NSW Government Printer*

The need to contact mothers soon after the birth of the child was resolved by initiating hospital visiting. Baby health centre sisters made regular visits to the obstetric teaching hospitals, to the obstetric units attached to suburban and country district hospitals, and where requested, to private obstetric hospitals.

The purpose of hospital visiting was to acquaint new mothers with the baby health centre service and the advice which they would receive from specially trained mothercraft sisters when they left hospital. This service is still carried out today.

The shift in focus during this period from the infant to the mother, and then to the family unit as a whole resulted in initiatives to provide additional support and education to the family. Mothers' discussion groups in conjunction with the Mental Health Association were started in 1961 and were held in nineteen baby health centres, proving very successful. Mothercraft classes, designed to assist expectant mothers to learn about Baby Care, were also introduced.

'Any expectant mother may attend these classes and learn from the demonstrations, the techniques used in bathing a baby and how to make up a baby's cot. Advice on the purchase of the layette is also given.' (Annual Report, 1963, p. 101)



*Prenatal Class*

Prenatal classes continued to play a significant role in the baby health services, aimed at the prevention of factors contributing to maternal and infant deaths. The need for a service for women who could not attend their obstetric hospital for antenatal care due to the distance from the hospital with the rapid growth of the population was recognised.

Senior Specialist obstetricians attached to teaching hospitals, acting in an honorary capacity, started a pilot scheme in two outlying centres; Parramatta and Blacktown. This involved an extension of the services and facilities previously available at the baby health centres. Full examination of the mother was necessary including routine blood tests and x-rays. Difficulties were overcome with the cooperation of the obstetric hospitals concerned, the district hospitals, the Red Cross Blood Transfusion Service and the Institute of Clinical Pathology at Lidcombe.

These clinics were seen as the best time to introduce the mother to all aspects of parenthood and it was planned that special evening classes would also be held due to the importance of including the father. The need to supply other services available at obstetric hospitals such as physiotherapy and education on 'Preparedness for Child Birth' was also accepted.

By 1964 there was an organised program for 'Preparation for Parenthood' at the baby health centres, in which Divisional Medical Officers participated.

The promise of services to the two to five year old age group eventuated to some extent in 1961 with the reopening of the 'Well Baby' Clinics, relocated in some instances, with the new title of 'Preschool Clinics'. No treatment was carried out at these clinics and so referrals were made where necessary to medical practitioners; as a result their role was one of assessment and counselling. These clinics were staffed by medical officers of the Division of Maternal and Baby Welfare, and five of the Well Baby Clinics at Dulwich Hill, Glebe,

Auburn, Granville and Newtown were conducted by medical officers in charge of child health centres as an extension of increased services provided by the school medical service to pre-school children. The purpose of these clinics was to study the normal range of physical and emotional development in the three to five years age group.

Confusion about the titles and roles continued. In 1962 they were again retitled as 'paediatric' clinics. As the basis of these clinics was the care of the well child, the word 'Paediatric' had previously been avoided.

The sisters referred any child about whom they were concerned to the paediatric clinics or when the mother requested an examination. By 1964 a two tier service had been established.

Two types of paediatric clinics were set up, the Well Baby clinic and the Paediatric Referral clinic, with two district purposes. The Well Baby clinics were able to provide a medical assessment of children referred by the sister which was of importance in detecting certain defects, i.e. difficulties in hearing and speech etc. The importance of assessing the child as a whole, and as a member of the family and its' emotional inter-relations was also emphasised. The cases beyond the scope of the medical officers were referred to the Paediatric Referral clinic or other suitably selected agencies.

The Paediatric Referral clinics had consultant status. Referrals to these clinics came not only from the Well Baby clinics, but also from general practitioners, as well as special cases from the baby health centre sisters. The type of case which the sister referred directly concerned feeding or thriving problems or difficult management problems in the young baby.

It was proposed by the Department that these services should be available not only in Sydney but in Newcastle, Wollongong and other large towns.

Additional surveys were carried out and greater use made of published and broadcast material to expand the educative role of the service in the late 1950s and early 1960s. Broadcasts were made weekly by sisters at Goulburn, Grafton, Wagga Wagga and Wollongong in the late 50s and a campaign was organised in 1963 to lower the incidence of poisoning of young children. Medical officers from the Division appeared on television and gave broadcasts on this subject. Standardised advice on immunisation was made available to all baby health centre sisters.

'Our Babies' and 'Healthy Motherhood' were both revised. 'Our Babies' had commercial advertising removed and was rewritten to stress the modern problems associated with the rearing of babies, particularly the emotional development of the child and the mother-child relationship. 'The rigid doctrines were eliminated in favour of a more permissive attitude towards the child.' (Annual Report, 1962, p. 85)

'Infant feeding notes' were a summary of the basic principles and methods of infant feeding according to the teaching in the Training Schools of the Royal Society for the Welfare of Mothers and Babies and the Children's Hospital and were supplied to each sister and to selected groups and individuals. These were revised in the early 1960s to ensure that advice to general practitioners and baby health centre sisters was consistent.



Canley Heights Baby Health Centre, opened 1961

Courtesy Sister Olwyn Hendy



Waiting Room in the 1960s

NSW Government Printer

Surveys were conducted on the extent of breastfeeding due to concerns that the number of mothers breastfeeding had fallen.

The results of a survey in 1960 showed that while threequarters of mothers in a sample of baby health centres throughout the state were breastfeeding with babies at one month, this had dropped to 30 per cent for mothers of babies aged six months. The policy of the service had also changed in that; 'It is also essential that the choice of either breast or bottle feeding a baby remains with the mother, this is her right. No pressure should be exerted to force breastfeeding for this is repugnant to some mothers.' (Annual Report, 1962, p. 83)



*Sister Mabel Douglas, 1950s*

*Courtesy of her sister, Kathleen Crago*

A survey was conducted in 1963 investigating the incidence of phenylketonuria, which involved a state-wide Urine Testing Survey using Ferric Chloride. This method of the detection of errors of metabolism leading to 'mental deficiency' was instigated on a more routine basis in 1964.

By 1964 there were 415 centres throughout NSW with a total attendance for the year of 1.15 million mothers. 1964 was the year of the Golden Jubilee of the service dating from the establishment of the first baby health centre in Alexandria in 1915. To commemorate this date, a new centre was built at Alexandria in conjunction with the Council of the City of Sydney and dedicated to the three nurses Miss Lucy Spencer, Miss Edith Pike and Miss Irene Williams, who began the service 50 years previously.

'In 1963 Council's Parks and Recreations Department had suggested that the Baby Health Centre be relocated from the very dilapidated building it had resided in for nearly 50 years, to a new building to be erected on the corner of Renwick Street – Dadley Street, Alexandria. The chosen site was then a children's playground.

The Council of the City of Sydney designed the new building as a brick octagon with a curved entrance via the corner of Renwick and Dadley Streets. More than a quarter of the building was set aside as a play area and there was ample space to park prams; the building contained a waiting room, a consulting room and a test feed room as well as an amenities section and a small garden court.' (Council of the City of Sydney Archives) 1964 also marked the retirement of Dr Grace Cuthbert Browne, who had been Director of the Division of Maternal and Baby Welfare since 1938. The Annual Report states: 'It is in large measure due to her guidance and leadership that maternal and baby welfare services of the Department have become so widely recognised and accepted by the medical profession of the community.' (p. 11)



*Alexandria Baby Health Centre, 1989*

*Royal Prince Alfred Hospital  
Audio Visual Department*

Dr Cuthbert Browne's work and the services she administered played a significant role in reducing the infant mortality rate in that period from 41 of every 1,000 live births to 19.9 per 1,000 live births. The introduction of antibiotics, meticulous medical antenatal supervision, improved teamwork among the medical and supporting health professions and the transformation of the mother from just another case number to a central figure all contributed to this decline.' (The People who made Australia Great, p. 94)



*Dr Grace Cuthbert Browne*  
*John Fairfax Group*

Dr Cuthbert Browne had been directly responsible for introducing changes in maternal and infant care and continued to emphasise the preventive rather than therapeutic role of the Division of Maternal and Baby Welfare. She is known to have insisted on a homely atmosphere for the baby health centres which played a large part in the cottage-style architecture which was used in the post-war period. At her retirement, when interviewed, Dr Cuthbert Browne stated:

'I am proud of the mother-nurse relationship which has developed through the Baby Health Centres, and which (I feel) is part of the Australian pattern of life. Our objective as far as the Baby Health Centres are concerned is to present the mother with all the modern paediatric knowledge we can. (Sydney Morning Herald, December, 1964)

In 1988 Dr Cuthbert Browne was named one of the 200 Australians who had made Australia great and died that year at the age of 88.

'The inclusion of Dr Cuthbert Browne among those representing outstanding human endeavour and achievement was a final honour in a long career which had already been recognised through awards for excellence.

The University of Sydney, where she completed her medical studies in 1924, honoured Dr Cuthbert Browne in 1986 by conferring upon her the degree of Doctor of Medicine 'as a distinguished graduate who has contributed notably to the advancement of public health and to community appreciation of the status of womanhood generally'.

Dr Cuthbert Browne's medical achievements were recognised by her election to Fellowships of the Royal College of Obstetrics and Gynaecology and to the Royal Australian College; by her admission as a Fellow of the Australian Medical Association and by the award of an MBE.

In 1986, she was appointed a Consultant Emeritus in Obstetrics and Gynaecology to the Royal North Shore hospital. She had no children of her own. 'I have devoted my life to other people's children she once remarked. (Quotes taken from the Obituary, Sydney Morning Herald, Dec. 1988).



## CHAPTER 8

### MOTHCRAFT HOMES AND MOTHCRAFT TRAINING

'The approach to mothercraft, which is now more truly familycraft, has been changing over the years. No longer is the emphasis mainly on infant feeding and a good weight gain. The complexities of family life today are such that a doctor or a nurse or a social worker or any professional in the Family Health Care Services need to have a good working knowledge of family dynamics and interactions both normal and abnormal.'

McDonald, Tresillian  
Annual Report, 1982.



Frank Guthrie, Alison Cox and Bob Elmslie  
outside Margaret Harper Clinic, Wollstonecraft  
Tresillian

### TRESILLIAN

By 1930 the Health Department had taken over a large part of the former educative role of the Society. The Royal Society for the Welfare of Mothers and Babies continued to influence the community through its nurse training programs and advice and help given to mothers attending the mothercraft home. In addition, Tresillian became training centres for medical and nursing students, nursery school trainees and social studies students.

'At all three homes, refresher courses have been arranged for trained nurses since 1935. Observation visits are arranged for Girl Guides, Red Cross voluntary aids, kindergarten trainees, overseas visitors and school girls. Fifth-year medical students from Sydney University have been given lecture demonstrations at one of the Tresillian homes since 1926. A demonstration of the work at Tresillian has been arranged in connection with a postgraduate course for doctors since 1934.' (Fifty Years of Service, p. 180)

Major changes were made under the Presidency of Sir Charles Clubbe between 1927 and 1931. One of these changes was the reorganisation of the Society. In order to centralise administration, the unwieldy Executive Council was replaced by a General Committee, while an advisory body was formed to appoint new General Council. Committees of Management were appointed to each of the three mothercraft homes.

The Depression years were a period of stringent cuts in Government subsidies to Tresillian with a resulting reduction of approximately 8 per cent in salaries. Very little maintenance and building development was possible during these years. However public support and donations continued due to the fundraising efforts of the Committees of Management at each mothercraft home.

During the 1930s the Society opened the training mothercraft home at Vaucluse, formerly the Lady Edeline Hospital, which was an acquisition from the Government. Dr ES Morris, Board Member and Director-General of the Department of Public Health since 1934 was largely instrumental in securing these new premises for the Society. Dr Morris also made recommendations that the Society should administer Carpenter House in Wollstonecraft after Sir William and Lady Carpenter donated it to the State in 1940.

One woman recounts her experience as a client at Tresillian in the war years:

'I had my first baby in Sydney during the war. I had gone to Tresillian after the birth of my child and remembered the night that a Japanese submarine entered Sydney Harbour. All the mothers were told to pick up their babies and sit on the steps in the stairwell. They weren't told what was wrong, but they realised it was some kind of emergency. I was impressed by the calm and collected way in which this was done.'

The educative role of the Society continued in the post-war period, working in close cooperation with the Minister for Public Health and in particular with the Division of Maternal and Baby Welfare in organising campaigns and lecture tours all over the State. Displays were arranged in the Sydney Town Hall and at the Royal Agricultural Show until 1955.



*Sister Gwen Young, Tresillian Petersham, 1944  
Courtesy of her husband, P C Young*

In 1956 Tresillian became involved in the production of educational films for parents, students, teachers and nurses. The first of these were two films *Care of the Premature Baby* and *The Natural Feeding of Infants*, which were made in conjunction with the Royal Hospital for Women under the auspices of the Post Graduate Committee of Medicine, University of Sydney. Both received awards from international film associations. More recently, a series of four films on child development were produced in 1980-81 by Barbara Chobocky. Like the previous films, they were accepted for exhibition at international festivals, and used in nurse education programs and other educational centres.

Major changes occurred in the type of training received at Tresillian mothercraft homes by students undertaking both the basic mothercraft course and the post-basic course. Many of these changes also applied to the training programs offered by the Australian Mothercraft Society.

The initial specialist training initiated in the 1920s was undertaken for the duration of four months, unpaid, with lectures primarily in the nurses' free time as they continued working in the centres. It equipped the sisters more thoroughly with knowledge of sanitation, food handling and vermin control along with giving information on how to support the mother in areas of child health and management such as feeding discipline and establishment of routines.

By the 1940s Dr Kate Winning and Dr Margaret Harper had established the first main syllabus for the training of mothercraft nurses. In 1953 the Nurses Registration Act 1953 – Mothercraft Pupil Nurses Six Months Course was defined, and from this document it was possible to determine the area of practice of mothercraft nursing. It enabled the nurses' role in a baby health centre at this time to be identified. It also illustrated the expansion of this role since the first inception of home visiting for the supervision of breastfeeding.

Since the earliest days, the mothercraft sister had as her first goal the prevention of problems through 'active and positive' undertakings. This initially included guidance, counselling and modelling for mothers, but the emphasis was changing from a largely practical focus of caring for the baby and toddler to the nurse having a broader spectrum of care. A far more holistic view of maternal and child welfare was developing.

The nurse not only guided the mother in aspects of feeding, bathing, suitable clothing, toileting, sleep, play periods, 'sunkicks' and 'tucking up' (Nurses Registration Act 1953) but this broader spectrum involved antenatal care, development of the fetus, 'the occurrence in the pregnant woman of attitudes towards pregnancy and the expected infant' and looking at the family to a greater degree (family finance and budgeting). More emphasis was placed on the education of parents and its presentation through posters, pamphlets, strip films, slides, etc and the nurses themselves were looking at their interaction with the mother and its effect upon child development. As the nurse's role became less isolated and was incorporated into community health programs the relationship of community health services to the mother and child was studied.

Perhaps the most noticeable development was the Sister having to deal with, and try to prevent, behavioural problems of a psychological nature in the mother and child.



*Cleaning the bassinette, Tresillian Vauclose  
Tresillian*

To do this, topics covered were emotional development and behaviour patterns in young children, mother-child relationships, the development of trust, independence, affection and a sense of security and sense of identity in the infant and child and factors affecting these processes; maternal deprivation and its effect on children and behavioural problems associated with eating, sleeping, elimination and the control of behaviour. (The Changing Role of the Nurse in Baby Health Centres, 1982) Infant Feeding Notes were a summary of the basic principles of infant feeding according to the teaching provided by the Tresillian training schools and the Royal Alexandra Hospital for Children. A Special Committee on Infant Feeding was set up in 1962 to review these notes. On the Committee were representatives of the various organisations responsible for the teaching of medical students and nurses. These included the Professor of Child Health, University of Sydney, the Professor of Paediatrics, University of New South Wales, and the medical representatives of the Nurses' Mothercraft Training Schools, assisted by officers of the Division of Maternal and Baby Welfare.

From the diverse material in use, both for the training of medical students and nurses, basic principles were evolved. Agreement was also reached that preparation of material for use for the different disciplines and in different situations would vary considerably to meet the variety of needs and purposes.

In this way the confusion and difficulties arising from diversity of practice and divergence of some basic principles were eliminated and the teaching of medical students, nursing students in mothercraft courses for general trained nurses and mothercraft nurses no longer differed basically. The most important result was that the baby health centre sisters were no longer at variance with general practitioners in advising mothers on infant feeding.

Revision of the Departmental Infant Feeding Notes for the guidance of Baby Health Centre Sisters, was then undertaken.

This initiative signified the level of co-operation which had developed between the relevant training authorities associated with mothercraft training. This developed even further when from 1976 the Tresillian Mothercraft Training School participated with the Karitane Mothercraft Society in the development of a joint curriculum and in joint trading.

The regulation of the training and examination of nurses by way of legislation had been implemented in 1924 with the passing of the Nurses Registration Act 1924. The accompanying establishment of the New South Wales Nurses Registration Board led to the registration of general, mental, midwifery and infants' nurses in 1926. However, it was not until 1964 that a law came into effect for the registration of a new category of nurse, the mothercraft nurse. Two mothercraft training schools, Tresillian and Karitane, were invited to assist a sub-committee of the Board to develop a curriculum. This was the first new category of registrants since the original 1924 Act. Registration began in 1965 and by the end of 1966, 488 mothercraft nurses had been registered. The length of post-basic training in all mothercraft schools was extended at the same time to six months. Students from Tresillian, Karitane, St Anthony's Home at Croydon and the Waitara Foundlings' Home were all eligible for examination and registration, according all students the same status.



*Student Mothercraft Nurses, Tresillian, 1984  
Tresillian*



*Tresillian Mothercraft Graduates, 1988  
Tresillian*

There was debate at the time as to whether mothercraft nurses should be registered or enrolled but it wasn't until 1987 with further amendments to the Act, that mothercraft nurses were placed on the Roll. This enrolment was a reflection of the length of their training and it was emphasised that it did not indicate a decline in their status in the community or with the profession. From 1987 nurses who had undertaken a post-basic course in mothercraft training following general training had this recognised as an additional qualification and were given a certificate of recognition.

Changes also occurred in the services provided by Tresillian in the 1960s and 1970s. A baby health centre which had been operating in the grounds of the Tresillian Mothercraft Home since 1926 under the auspices of the Royal Society was closed as a more central location for the baby health centre services at Petersham was required.

'The Department of Public Health acknowledge the co-operation of the Society in the running of the centre as honorary medical staff had held a clinic at the baby health centre each week.' (Annual Report, 1963, p98)

The closure of Vaucluse occurred in 1969 following more than three successful decades of service. Its isolated location was a contributing factor to its increased cost of operation, having incurred difficulties of staffing and decreased demand for accommodation.

1970 was the year of the Jubilee of the Society and the 1970s and onwards was a period of considerable growth and change.

The Guthrie Neighbourhood Children's Centre opened in 1981 named after Mr Guthrie, who together with Dr J Quoyle was instrumental in setting up the centre after protracted delays by the Federal Government's Department of Social Security which provided funding through its Office of Child Care. Non-residential care for mothers and babies was provided in the Margaret Harper Clinic at Carpenter House, Wollstonecraft from October 1980.

Tresillian was now in a position to 'influence the antenatal, neonatal periods and the first five years of a child's life'.

By the 1980s the different syllabus requirements in the training of mothercraft nurses reflected significant changes in the needs of society. The content of courses and method of training had altered considerably with the emphasis now on family care and support services for mothers.

In the early 1980s there was an increasing demand by parents for the services of Tresillian, and a waiting list for student nurses. To June 1983, 3,858 general trained nurses had completed mothercraft training at Tresillian, as had 1,147 mothercraft nurses. Since the commencement date of the mothercraft functions of Tresillian, there had been approximately 29,000 mothers and 40,500 babies admitted to Tresillian.

In 1985, Tresillian, Petersham commenced a non-residential unit and Tresillian, Willoughby changed from a seven-day to a five-day program in February 1986. An outreach program was also commenced in 1985. This was a crisis-oriented unit whose aim was to resolve family crisis through early and rapid intervention or to provide interim care until admission to residential or day stay services could be arranged.



*Dr Charles Scarf, Tresillian  
Tresillian*

In 1987-88 funds were provided by the Department of Health to establish and operate an integrated and expanded telephone counselling service.

Following major renovations of Tresillian Willoughby, the state's first residential support unit for families with toddlers was opened in 1988.

In June 1987 funding became available to Tresillian to develop, implement and evaluate a pilot group treatment program for postnatally depressed women.

In 1987-88 the Council commissioned a review of Tresillian's operations and structure to determine their effectiveness and examine options for future service developments.



*Tresillian, Petersham  
Tresillian*

Tresillian Family Care Centres are now located in three areas of Sydney - Willoughby, Wollstonecraft and Petersham. Tresillian is classified as a Third Schedule Hospital and has developed close working relationship with two Area Health Boards restructured recently - Central Sydney Area Health Service and Northern Sydney Area Health Service.

The 1987-88 Annual Report of Tresillian summarises the current services provided by this organisation and the goals for the future:

'Tresillian's aim is to provide quality nursing care, social work and medical support to families experiencing difficulties with children aged 0-5 years.

There are now two residential homes with nurse training schools, two day stay family clinics, outreach, a home visiting service, an occasional child care centre and a long day child care centre, a formal telephone counselling service and the postnatal depression program.

On a daily basis nursing staff deal with a wide range of family problems - from basic parenting skills, unsettled babies, feeding and sleeping difficulties to recognition of complex psychiatric disorders and assessment of child neglect and abuse.

Staff endeavour to promote confidence and self esteem by assisting in the determination and application of appropriate mothercraft techniques, as well as providing individual, joint or family counselling when necessary.

During their time at Tresillian family groups participate in relaxation and educational programs.

In addition to specific clinical work, staff are involved in the education of students from Tresillian's own school, Colleges of Advanced Education, Social Work departments of universities and medical students from the University of Sydney.

Staff are involved not only in the training of students but also in addressing community and nursing groups.

As one of the few hospitals specialising in non-acute care, demand often exceeds capacity. Some families travel from as far away as Dubbo in Western New South Wales for care.

In situations when the waiting list is unacceptably high, short-term intervention and assistance for these families is sought from other community resources. Extensive liaison with agencies such as community health centres, the Department of Family and Community Services and early childhood health centres is an integral and important part of the service.

At the local level within each of the Tresillian family care centres there are plans to develop specific programs for families as priority needs are identified. For example, groups are to be expanded for first-time mothers and parents of toddlers. It is anticipated that a special family group will be conducted at night to enable fathers to participate and to encourage fathers or support partners to be admitted with their families on a routine basis.

It is proposed that the 15 month course will be restructured to become a mothercraft module or a new Enrolled Nurse Program to be run by TAFE. Plans are also being developed to allow Tresillian to offer a post-basic mothercraft course for enrolled nurses. Tresillian also acts as a major provider of clinical experience for nursing, medical, social work, child care certificate and work experience students. 1988-89 will see Tresillian consolidating its existing service while extending the reach of its educative role in the community.' (Annual Report, 1987-88)



*The Plunket nurse pays a home visit  
Karitane Mothercraft Society*

## KARITANE

The advent of the 1930s saw the Australian Mothercraft Society pursue a somewhat different direction to the Royal Society, although it continued to play a prominent role in the training of the Plunket and Karitane baby nurses and in the services offered at the Karitane Sydney Mothercraft Training Centre at Woollahra.

The initial clinic at Elizabeth Street was attracting so many referrals that it was decided to open a second clinic. In 1930 the second clinic commenced in Buckingham Street in the Sydney factory of the Karitane Products Society, which made preparations for modifying milk mixtures for artificial feeding. This Society had its headquarters in New Zealand, as part of the Plunket Society and as such was not directly affiliated with the Australian Mothercraft Society. However, due to high tariffs on importation of its products from New Zealand, Sir Truby King organised the establishment of a second factory in Sydney. Any profits from the sale of the products made in Sydney were recycled back to the Australian Mothercraft Society. Sir Truby King, at his own expense, rented two rooms on the same floor as the factory and organised the refurbishments for the clinic.

This clinic actually closed in 1932, but other clinics were opened and by 1938 13 clinics were operating, two in the city, one at Newcastle and others in the suburbs of Sydney, with an emphasis on preventive medicine. Most of the clinics were only operated on a part-time basis and were located in different types of venues, including local council rooms, a Scout Hall, a School of Arts, a large hall donated by Woolworths, a pharmacy, mothers' homes and a church hall.

In addition a district visiting service was established where friends of the Society drove nurses to mothers' homes when it was inadvisable for the mother or baby to visit the clinics due to health reasons. This work was extended by the provision of a Travelling Clinic in 1933, where visits were made to homes and to pharmacies.

Farmer and Co. Limited provided support to the Australian Mothercraft Society by holding demonstrations on mothercraft in the Toy Department of the city store.

This proved so successful that by 1933 a permanent clinic was set up on the fourth floor of the city store which continued to operate until 1954 when it was closed due to space constraints and re-established at Bondi Junction. The clinic was run by Sister Thomas, a Karitane trained nurse, and foods and clothes (a complete layette) were on display. Facilities were provided for weighing the baby and test-feeds. An article from an internal store publication made the comment; 'we certainly start looking after our customers early!'

By 1938 the visits to the Karitane clinics had grown from 700 in 1923-24 to some 48,600 visits in that year.



*Terry Hills Karitane Clinic held at Mrs William's Home, 1939  
The John Fairfax Group*

The educative role of the Society had also been pursued since its establishment. Weekly talks on Mothercraft had commenced in 1930 and by 1932 Radio 2UE was offering a weekly program broadcast by Miss Truby King, the daughter of Sir Truby King. The 2UE Mothercraft Club was established and operated with the help of 'Auntie May' and its aims were to support the Australian Mothercraft Society financially. It supported the clinic, entitled the 2UE Truby King Mothercraft Centre, at Woollahra, and provided baby clothing for expectant mothers and 'actual' mothers in distressed circumstances:

"Lectures were provided to various organisations and clubs and a correspondence service was run by Sister Jacob with letters coming from as far away as China, India and Borneo. Orders were also received for mothercraft books, Karitane products, baby patterns, enamel measures, bottles and other goods.' (Annual Report, 1930, p 11)

A weekly letter was written for 'The Country Woman' a supplement to the Land Newspaper, for the benefit of mothers in the country.

A Rest Tent for mothers and babies was provided annually at the Royal Agricultural Society's Easter Show, which often included demonstrations of work done by the Society.



*Goats' milk was used for babies at Terrey Hills  
John Fairfax Group*

In 1939, the Sydney Morning Herald Women's Supplement reported on a clinic held by the Gordon branch's Karitane nurse at Terrey Hills twice a month. 40 unemployed families from city slum areas had established a 'bush settlement' at Terrey Hills on land made available by the Government at the rental cost of a pound an acre per year, with building materials provided by the Government with a minimum repayment of six shillings a week.

These 'pioneer conditions' came to the attention of the Gordon branch of the Australian Mothercraft Society which arranged for a clinic sister to hold a clinic at the settlement:

'The first clinic was held under a tree, four mothers and nine children attending ... nothing daunts them. On clinic day they trudge with their children, pushing go-carts and encouraging weary little legs, through the boiling sun and heavy rain. Some of them walk more than three miles over the hills, pushing their prams over the bad roads, cheerfully negotiating ruts and wash-outs, very often tired with family duties before setting out on their long trek.' (Sydney Morning Herald, 4September 1939)

Lack of milk was a serious problem at the settlement until the Mothercraft Society recommended the use of goats' milk, and so a herd was established.

In June 1941, the building of a new wing was commenced at Karitane, Woollahra which was officially opened in 1942, with the Patron of the Society, Her Excellency the Countess of Gowrie officiating. With this additional accommodation, the home was able to assist twice the number of mothers and babies. At this stage the Society was operating 15 clinics in Sydney, one in Newcastle, antenatal classes well as providing the more traditional advice on mothercraft.

The war years had created difficulties in the building of this accommodation with problems in obtaining materials and labour, due to the national emergency. Some of the fundraising clubs had had to shut down due to members doing war work, the baby cupboard which had provided babies layettes to mothers in need was closed due to rationing and the weekly talk on Mothercraft on Radio 2UE had to be discontinued temporarily due to the space needed for various appeals and war activities. Clinics also had to be rescheduled and reduced due to the evacuation of mothers from the Double Bay area as well as general transport difficulties and shortages in some foodstuffs. There was however increased pressure on correspondence as mothers evacuated to country districts wrote regularly for advice and to report on their babies' progress.



Karitane, Woollahra  
Courtesy Sister Marion Hawley

At the same time there was a greater demand for services due to the absence of husbands at war, and the number of 'difficult' cases increased at this time. At the Annual Meeting of the Australian Mothercraft Society in 1942 attention was drawn to the fact that war work must not lead to the neglect of mothers and babies. Women were in need of sympathy and moral support as well as physical guidance. At the Silver Jubilee of the Australian Mothercraft Society in 1948 the objectives of the organisation were summarised as follows:

'The Society's main object is the care of the expectant mother and the care of the child during infancy a trust which it fulfils without conflict with others sharing those responsibilities and with whom it is always eager to cooperate. During that time, the infant mortality rate has dropped greatly, and new and sturdy generation has arisen who regard prenatal and infant welfare care as the right of all people in a civilised country.' (Annual Report, Australian Mothercraft Society, 1948, p 3)

In the post-war years the social problems of mothers received greater attention, with the recognition of the part played by the economic and social conditions of living in the failure to breastfeed. A survey was conducted of mothers attending the clinics in 1948 to determine the proportion of mothers breastfeeding. While 79 per cent of mothers were breastfeeding up until the baby was one month old, by the time the infant was six months old only 21 per cent were breastfeeding. The Sister-in-Charge of Clinics writes:

'Had Sir Truby King been alive, I feel he would have been disappointed that breastfeeding is still at such a low ebb, even though baby clinics have become so well established in the community.' (Annual Report, Australian Mothercraft Society, 1948, p9)

The Karitane Mothercraft Home had established a pattern of use where for most of the time the number of infants in the home for



the regulation of feeding on foods other than breastmilk exceeded the number of infants admitted with their mothers. Mothers of the artificially fed babies were given demonstrations in the management of their babies, including bathing, preparation of foods and feeding procedures before the babies were discharged.

The Australian Mothercraft Society continued to experience financial difficulties in the 1950s and 1960s. A fee was introduced for women using its services in 1948, with mothers paying one shilling per visit and expectant mothers two shillings and sixpence. In 1953 the Society applied for Government assistance and it was proposed that the home be registered under the Third Schedule of the Public Hospitals Act. While this application was deferred in 1951 due to an improvement in its financial position, the Society did finally accept financial support from the Hospitals Commission in 1958 after 34 years as a voluntary organisation. However, the clinics did not receive financial assistance until 1967.

The number of clinics run by the Karitane Society declined from the post-war period onwards due to financial strain, difficulties in recruiting staff (as experienced by the Government clinics), the cost of travelling to the clinics and the increasing accessibility of the Government baby health centres.

However, a major new initiative was started in 1951 with the commencement of a mobile clinic to serve the northern suburbs. The Ku-ring-gai sub-committee used its funds to purchase, equip and maintain a travelling clinic to serve the outlying districts of Pymble. By the 1960s the Sister operating this service averaged 200 miles a week - Collaroy Plateau, Frenchs Forest, Belrose, Terrey Hills, Berowra, Mt. Ku-ring-gai, Mt Colah, Asquith, Normanhurst, Dural, Galston, Arcadia, Northmead, Toongabbie, Seven Hills and Dundas. When a Government clinic opened, the mobile clinic moved on to some other area in need. A clinic was even conducted in a bus waiting shed. Mothers queued up - some pushed prams more than two miles to come. The Sister organised help for needy cases, and home assistance through an emergency housekeeping scheme.



*Mobile Clinic, Berowra, 1956  
Courtesy Sister Marion Hawley*

In 1968 the Society bought and equipped a van to use in the new outer Western suburbs, where no permanent health clinics were yet established. Prior to this the Society served some of the Western districts from local chemist shops or community halls. A sister set up the clinic at a prearranged site each day, and parked at shopping centres following the same route each week. Advice was given on growth and development, care and feeding, community services and child behaviour. Pamphlets and booklets issued by the Department of Public Health were distributed. There was no charge, though mothers often gave a small donation.

During the sixties the role of Karitane started to change with the emphasis on the mothercraft section starting to give place to the needs of the community for assistance in the social welfare field. Requests were received from social workers for the admission of babies while mothers were admitted to hospital for treatment. Help for unsupported mothers and deserted fathers was given with some babies and children taken in full time for short term and others taken as day boarders while the mothers/fathers became established.



*Interior, Mobile Clinic  
Karitane Mothercraft Society*

The mothercraft home became recognised as a Public Hospital under the 3rd Schedule of the Public Hospitals Act.

From 1968 additional roles were added with the admission of adoption babies, infants of psychiatric mothers and social problems. Antenatal classes had increased to 20-24 classes per year. Parent education increased. Premature babies from intensive care units mid nurseries were admitted with their mother so that the mother was able to handle and care for her baby sooner. Day care children were taken in special cases while Sydney Day Nursery closed down at Christmas and New Year.

In 1969 the name of the Society was changed to the Karitane Mothercraft Society. A Karitane Nurses' Bureau was run by the Society to provide Karitane nurses to work in private homes to support the mother and assist in the care of the baby.

In 1973 at the time of the Golden Jubilee Matron Hawley said that 'more attention was paid to the environment than in the past'. There was also a team approach to Karitane with a social worker operation two days a week, and a team focus on 'the total family picture'. Fathers were encouraged to learn how to handle and look after babies.

Babies were at Karitane for social, medical, legal and economic reasons. Matron Hawley emphasised that originally the Society was started to help mothers breast feed. Now they took problem children up to three, and 'environmental problems dominated'. Mothers came from hospital and premature babies from intensive care. In 1974 the Karitane Mothercraft Home moved from Woollahra to Avoca Street, Randwick, its current address.

There were changes in the training of the mothercraft nurses in the early 70s with the cessation of the charging of fees to student nurses. Despite the charging of fees since 1924, demand for Karitane mothercraft training had always exceeded supply with a constant waiting list of two years. The course in Plunket nursing had become a six month post-basic mothercraft short course and the Karitane baby nurses were now trained in a basic mothercraft long course of 18 months duration.

In 1980 the objectives of the training programs were as follows:

'Students are to:

1. Observe and become involved in the cycle of crisis related to the learning of parenting skills, and to help in the adjustment of the new and different demands of a family with its inherent problems.
2. Learn to encourage, support and guide the parents through the transition period of early parenthood, and in the learning of new parenting skills.
3. Develop an awareness of the continuing and extended role of the mothercraft nurse in the preventative and educative aspects of maternal and infant care and in the nursing management of the mother and infant in whom there has been atypical development and/or nutrition.
4. Observe different techniques of management and routines suitable and appropriate to a variety of babies.



*Karitane Graduation  
Karitane Mothercraft Society*

5. Observe and gain knowledge in basic maternal and infant care.
6. Gain knowledge of the principles of normal infant feeding.
7. Gain an understanding of the problems associated with infant feeding and their management.
8. Gain observational experience in assessment and evaluation of an infant's developmental stage and progress.
9. Observe and gain knowledge in the physical and psychosocial factors which contribute to normal and abnormal developmental progress.
10. Gain understanding of the many ways in which unsatisfactory development can manifest itself.
11. Observe the baby's 24 hour patterns of activity (e.g. feeding, sleeping, etc) and how these differ between individual babies, and in different age groups.
12. Participate in the 24 hour care plan for the mother and baby.
13. Develop skills in working with others within the health team for the improvement of the health or the community.'(History of the Karitane Mothercraft Society Hospital, pp 5-6)

In 1973, a special course of training was introduced for six Aboriginal student nurses to learn community health and mothercraft. This initiative was due to the Matron at the time, Matron Hawley, who had a particular interest in Aboriginal education.

An unpublished history of the Karitane Mothercraft Society written in the early 1980s emphasised the unique role of mothercraft homes such as Karitane:

'Many of the problems with which it deals are of an interactional nature between the mother (and/or father) and their children up to three years. While many of the problems with which Karitane deals have a medical basis, all of these problems manifest themselves behaviourally. Karitane provides a total environment where such problems may be isolated and treated under expert mothercraft care and medical supervision.'

The emphasis on the family unit as a whole and the importance of the pre-school child was reinforced when Clovelly House was founded in 1985 as a day unit to help with parenting problems, feeding, sleeping and toddler management. It was a free clinic at Avoca Street, Randwick.

Both parents were encouraged to join, with the emphasis on the family unit. There were nurses, a social worker, visiting paediatrician and a child and family psychologist provided to staff the unit.

By 1987-88 the Karitane Mothercraft Society was still operating four early childhood centres (formerly baby health centres) at fixed locations (Randwick, Sylvania, Guildford and Roselands) and two Mobile Clinics to the Western and Southern suburbs. In addition the educative function of the Society had continued with the dissemination of information and education of parents on parenting, and baby care, both antenatal and postnatal.



*Sister Coffey, Roselands Clinic  
Karitane Mothercraft Society*

Changes with the introduction of the Amendments to the Nurses Registration Act in 1987 led to the situation where the basic mothercraft ceased as a registrable qualification. From 1989 onwards enrolled nurses are able to undertake a post-basic program in mothercraft and family nursing of 16 weeks.

The post-basic course is continuing to be offered by the mothercraft homes, but in 1987 ceased to be a registrable qualification. The course title is now 'Infant and Family Nursing Studies' and is an additional qualification following the initial training.

National recognition of the Karitane training has been demonstrated by past and present students travelling from all states of Australia and New Guinea to undertake their mothercraft training. Up until 1987, 1,726 nurses had graduated from the Karitane Mothercraft Society training school.

The Karitane Mothercraft Society's current aim is to produce a centre of excellence in care, training and community support.



*Dr Harris teaching Karitane Students  
Karitane Mothercraft Society*

'The residential units of Karitane and Tresillian have become 'centres of excellence' in parentcraft. They provide a third tier in the system of family care which has, as its first tier the early childhood/ community nurse and general practitioner, and as its second tier, particularly in metropolitan areas, family care cottages or day stay units. Thus these residential units play a specialised role in family care, taking on those clients whose problems are unable to be resolved through lower level interventions.' (Tresillian Strategy Review, p7)

These services have continued to play a unique role within the health system with the availability of an in-patient service and a professional training capability expanding to meet the changing needs of society. The ongoing commitment with strategic planning programs and role feasibility studies indicate the flexibility of these organisations in meeting the needs of the future.

## CHAPTER 9

### BABY HEALTH AND COMMUNITY HEALTH - 1965-1980

*'Today's children carry with them the hopes of tomorrow. It would seem appropriate that at a time when resources are limited, priority be given to this area of health care. It is an investment for the future.'*

Degeling, Health in New South Wales, 1979



*Carrington Baby Health Centre  
Courtesy Sister Annette Lynch*



*Vision Screening  
Royal Prince Alfred Hospital  
Audio Visual Department*

1965 was a watershed year for the administration of health services in general and maternal and child health services in particular. In that year the whole of New South Wales was divided into geographic areas known as Health Districts, with a Medical Officer of Health in professional and administrative charge of all Health Department staff, operations and equipment. The Medical Officer was responsible for the School Medical Service, Maternal and Baby Welfare Service, Tuberculosis and Infectious Disease Control amongst other responsibilities, as well as advising and assisting local authorities in their health functions under the Public Health and Local Government Acts.

The Medical Officer for Health had a general responsibility for the prevention and control of disease and the maintenance and promotion of health, particularly in the care of the aged, community mental health and welfare, and social medicine. This led to a greater emphasis on community health education while continuing to focus on more traditional areas of health work such as environmental sanitation and community hygiene. The introduction of a Medical Officer of Health in each Health District resulted in 'a greatly increased tempo in all health matters in country areas.' (Health in New South Wales, 1965)

In January 1965 the Division of Maternal and Baby Welfare was amalgamated with the School Medical Service to form the Bureau of Maternal and Child Health. The aim of the bureau was to provide a continuing, complete preventive service to prospective mothers and all children from conception to school leaving age.

The Bureau consisted of three sections, a Section of Maternal and Infant Care, a Section of Child Health and a Section of Special Services, each under the administration of an Assistant Director. Dr N Solomons was appointed the Director of the Bureau of Maternal and Child Health and retained this position until 1967 when Dr A Douglas was appointed. Dr Maureen Gratton-Smith who had been Assistant Director under the old Division of Maternal and Baby Welfare was made Assistant Director of the Section of Maternal and Infant Care.

The Section of Maternal and Infant Care provided preventive health services to prospective mothers and mothers and children up to the age of two years; the Section of Child Health covered children from two years to school leaving age, and the Section of Special Services provided specialised services for the investigation and evaluation of children with problems of any kind. It gave advice to the other two sections and to other agencies interested in the welfare of children.

Recognition was once again made of the lack of adequate preventive health services being provided to the pre-school child aged from two to five years. During the late 60s and early 70s a concerted effort was made to increase services to this age group with the expansion of Well Baby clinics and Paediatric Referral clinics by utilising medical officers on the establishment of Child Health. By 1974 there were 42 Well Baby clinics operating in the metropolitan area for infants and children. Problems in feeding, sleeping, behaviour and general development including hearing and vision defects were assessed after referral by general practitioners or baby health nurses. Routine pre-school medical assessments were also carried out at the request of parents.



*Baby being tested by Sister Margaret Piper at the Tweed Heads Early Childhood Health Centre, 1982. The \$400 hearing detection device was donated by the Tweed Heads Quota Club and can detect hearing disabilities in a two week old baby*

*Courtesy Sister Margaret Piper and the Daily News Goldcoaster*

By 1968 attendances at the baby health centres had increased for children over two years of age and proposals were made to medically screen all three year olds in the community. The previously limited provision of preventive health services to pre-school kindergartens and nursery schools conducted by the Sydney Day Nursery and Nursery Schools Association and the Kindergarten Union in parts of the metropolitan area of Sydney was expanded with the aim of offering these services to all such facilities in metropolitan and country areas. During 1970 the screening of these pre-school children for deafness was introduced, and in 1974 this service became the responsibility of the child health centres.

The need for the evaluation of the hearing of infants as early as possible had been recognised in the mid sixties. Following consultation with the Commonwealth Acoustic Laboratories and Ear, Nose and Throat Specialists a set of tests, to be used by the nurses following a short course of training, was introduced to evaluate the hearing of children at six months. Secondary screening was initially carried out by Paediatricians in Well Baby clinics. The age for screening was changed to eight months in 1970 and the hearing screening tests became a routine procedure of the baby health centre service. Special nurse audiometrists were subsequently used as secondary screeners.

Other measures were introduced, such as the survey of Inborn Errors of Metabolism, where urine tests were carried out on all babies aged six weeks or over with the testing material distributed free from all baby health centres in New South Wales, and from clinics conducted by the Karitane Mothercraft Society; the Australian Capital Territory Health Service Office, the Royal Far West Children's Health Scheme, the New South Wales Bush Nursing Association, the Royal Flying Doctors Service (New South Wales Division), and the cot rooms of the Sydney Day Nurseries.

In addition, following a survey of the immunisation status of children in 1970, supplies of sabin vaccine were kept at some baby health centres and the sisters dispensed the vaccine as required.

The attendances at baby health centres and the advice that they provided changed in the 1960s. The type of care they provided was peculiar to Australia and New Zealand where a nurse-mother relationship was developed with only limited medical supervision, and was regarded as the most satisfactory was of maintaining supervision of the well babies in the community. The duties of the nurses included interviewing mothers at the centres combined with hospital visiting to inform mothers of their services and home visiting on a priority basis.

The 1968 Annual Report of the Department of Public Health supported the priority systems of home visiting.

'To home visit 81,000 families even once is a mammoth task, particularly in terms of the nursing staff available. Even if staff were available much time can be wasted by visiting the homes of capable and knowledge mothers; further, many Australians resent the continued intrusion into their privacy although most accept one visit and more if there are problems. Priority visiting is the most efficient and effective answer.' (p.70)

The number of births in New South Wales had been steadily dropped since 1962 and then rose again from 1968 to 1972

when it peaked at just over 95,000 births. Attendance patterns showed a major variation in that while the number of total attendances had fallen slightly, the number of individual mothers attending baby health centres had increased.

By 1966 it was claimed that this fall off in total attendances was not accidental:

'This is interpreted as an indication of the continued popularity of Baby Health Centres as a source of advice. With an increased confidence on the part of the mother in her own ability to handle her child, the number of visits she makes has been reduced. The new attitude towards feeding schedules resulting in less regimentation and less dependence by the mother on the sister appears to be showing results.' (Annual Report, 1965, p. 69)

Mothers had become more independent in the management of the children and were visiting the centres when necessary and not routinely. Dr Angel-Lord, who joined the Department of Public Health in 1962 as one of its Paediatric Specialists writes of this era:

'the end of an era of total rigidity, spawned – in good faith – by Truby King. Mothers had to be taught, were presumed to know nothing, therefore whatever went wrong was their fault. Sisters were not aware of the fact that they never heard the truth because mothers were afraid of their wrath and emotionally quite unable to follow their unreasoned dicta e.g. strict four-hourly feeds, no more than one hour playtime in the afternoons, no dummies, etc.' (Changes in Community Baby and Child Health, historical perspectives, p. 2)



Sister Elizabeth Williamson  
Courtesy Sister Williamson

The development of prepackaged and fast foods in the 1960s also gave the mother more flexibility in the feeding of her children, due to the extensive variety of canned infant foods which came onto the market.

While there had been a gradual decentralisation in the administration of health services, staffing and finances remained under the central control of the Bureau for some time. A Visual Control Panel was kept in Head Office which consisted of every Baby Health Centre in the Metropolitan area, showing days of opening, services operating and the placement and names of all baby health centre sisters situated at each centre, including full time and part time officers. Staffing difficulties continued during the 60s and it is argued that this was due to the inflexibility of the centrally organised administrative system, and the particular problems caused by the requirement for nurses to agree to a three year period of country service at whatever location was selected. Dr Angel-Lord recalls:

'All minor deviations from accepted routine had to be notified to the Nurse Inspectors Office in writing. One funny incident which occurred as a result of this ruling – a maniac invaded Glebe Park and started to shoot through the Centre windows. The Sister-in-Charge rang the office shouting "I am being shot at, help!" and got the scathing reply from the somewhat deaf clerk, "Put it in writing Sister". Luckily a passer by called the police and the Sister is still with us whole and hearty.'

Initiatives were trialled in order to overcome the staff shortages; these included a pilot scheme to employ mothercraft-only trained nurses in multiple-staffed centres, recruitment to specific country circuits so nurses were employed in their local residential areas, and the greater

recruitment of part-time staff. Some of the inflexibility in staffing arrangements was also attributable to the fact that the nurses were employed as Public Servants and hence came under their regulations.

The focus on the need for antenatal services operating from baby health centres continued due to concerns about the maternal and perinatal mortality statistics. While they reflected a high standard of care of the mother and infant compared to other countries, there were still areas of improvement to be achieved with antenatal care (particularly in country areas) falling below the required standard with the resultant high prematurity rate still being the major cause of death in the perinatal period.

DIVISION OF HEALTH EDUCATION - HEALTH COMMISSION OF N.S.W.


# Preparation for Parenthood Classes

## at your local Baby Health Centre

**General health and nutrition in pregnancy**

**Physiotherapy-  
Breathing control and relaxation to help you in labour**

**Labour ward procedure-  
A doctor talks about normal birth**



**Parentcraft-  
Bathing your baby  
Cot making  
Baby clothes**

**Caring for your new baby**

**Film evenings and discussion groups for both parents**

Ask your doctor or ring the sister for further information. Nearest class is at: Baby Health Centre

NSW Department of Health

By 1970 there were 13 antenatal clinics with a social worker attending some of the clinics at Manly, Dee Why and Liverpool, and by 1972 these totalled 17. Demands for 'preparation for parenthood' classes continued and evening sessions were held to cater for both partners. Consultant antenatal clinics, previously entitled 'consultant obstetric clinics', were still provided in outlying areas.

The decline in the importance of infant mortality due to the great improvements which had been brought about earlier in the century was arrested somewhat with the results of studies which showed that the post-neonatal mortality rate (one month to 12 months) had shown little improvement in the late 60s. The greater proportion of deaths, 68 per cent, occurred between four weeks and 20 weeks, which clearly indicated the vulnerability of the infant in the early



months of life. The need for ongoing preventive services for this age group was emphasised, with additional factors such as the apparent increase in mental illness in adults and children identified as possible causes. Improvements in communication between the many services, both governmental and voluntary, was recognised as one way of improving the current structure of services.



*Baby Health Clinic in the 1970s*

There was a move towards the integration of the various sections of the Bureau in the late '60s, with an emphasis on the need for a continuation of service provision to protect, promote and maintain the mental, physical and social health of the family unit. Staff, particularly medical officers, were used interchangeably within the different sections. It was proposed that the baby health centres could be used where appropriate in size and situation to accommodate school health teams and by 1971 plans were under way to integrate the two Sections of Child Health and Maternal and Infant Care. Dr Angel-Lord talks of 'the real unity of ideologies and purpose and close personal working relationships which were achieved, only to be fragmented by Regionalisation.'

In 1970 the focus of the baby health centre was broadened even further; 'with the objective of maintaining the total health of the family and the community at the highest possible level.' This included the encouragement of the use of Baby Health Centre premises for additional services. (Annual Health, 1970, p. 13)

'A further Community Aid Service for the middle-aged commenced at Kingsgrove Baby Health Centre; other community health services have been established in the Baby Health Centres at Brookvale, Narrabeen, Seaforth, Alexandria, West Pennant Hills and Willoughby; The Spastic Centre of New South Wales has established; physiotherapy clinics for cerebral palsied children at Seven Hills, Gymea and Green Valley Baby Health Centres; and the Family Planning Association of Australia is conducting a family planning clinic one evening each week at the Green Valley Baby Health Centre. In addition the Chatswood Child Health Centre has established assessment services and speech therapy clinics in the Baby Health Centres at Artarmon, Northbridge and Willoughby. The Section of Maternal and Infant Care has received the utmost co-operation from the local government authorities in the establishment of these services.' (Annual Report, 1970, p. 111)



This expansion in the use of the centres for other purposes continued; in 1971 the Association for Mental Health established adolescent and mental health advisory services; community aid services; a day centre for elderly persons; and a regular immunisation clinic held by local government were other innovations. Services for Aboriginals and migrant families were also expanded in the late 1960s and early 70s. A Commonwealth grant for Aboriginal Health Services was made in 1968 through the Office of Aboriginal Affairs of the Prime Minister's Department as part of an overall grant of 13 million dollars for Aboriginal health, welfare, housing, education and research. New South Wales proposed that funds be made available to voluntary and religious organisations active in Aboriginal health and welfare, and that a group of community nurses be provided to supervise Aboriginal health in the western district of the State. Nurses were located at Wilcannia, Wentworth, Bourke, Moree and Walgett and in addition some of the funds were used to provide medical sessions in certain of the western shires for the antenatal care of Aboriginal mothers and the immunisation of Aboriginal children.

A second stage of the proposals was concerned with the training of Aboriginal nursing aides, with a view to the aides working in country hospitals or returning to Aboriginal stations and settlements to assist the community nurses. Funds were also provided to undertake more research into the ill-health, morbidity and mortality of Aborigines in New South Wales.

In the early 1960s there was a great deal of concern expressed in the Parliamentary Debates about the 'alarmingly high infant mortality rates' among Aborigines in New South Wales (Second Report from the Select Committee of the Legislative Assembly upon Aborigines, 1981. p.34).

Due to the support for the concept of assimilation for the Aboriginal people, statistics had not been separately collected on their health status. However, what information was available, pointed to the social and economic deprivations of the Aboriginal people being responsible for their unsatisfactory health status. Even as late as 1981 a paper presented to the Chairman of the New South Wales Health Commission stated that there was no overall objective by Government regarding Aboriginal environmental health.

The services for Aboriginals set up as a result of the Commonwealth funding were established under the Bureau of Maternal and Child Health. In 1971 a Health Education Officer and Liaison Officer for Aboriginal Health was appointed to the staff of the Bureau, to support the community nursing program for Aboriginal health. This

Aboriginal health program led to improvements in the health status of Aborigines.

By 1973 the Department of Health was reporting that:

'Improvement in general level of health is already being reported in areas where community nurses have been operating for two to three years. e.g. Dareton, Wilcannia, Moree and Bourke. Admission rates of Aboriginal children to hospital have fallen as has the infant death rate. Medical practitioners have made important contributions to the improvement in health in some areas as has improvement in housing and employment.

Additionally evidence that Aboriginal people have a diet deficient in vitamins, minerals and protein has been provided by a Commonwealth team which carried out a survey in Collarenebri during the year. An intensive nutritional health education program will be set up during 1973-74.' (Annual Report, 1973.p. 45)

However, reports of a high infant mortality rate for Aboriginal children continued, with the infant mortality rate for rural Aborigines in New South Wales in 1978-79 estimated to be 52 per 1,000 live births compared to 12.2 in the total population. The level of Aboriginal childhood mortality was of the same order as countries in the 'transitional stage' of development. The Aboriginal Medical Service initially established in 1971 at Redfern was set up and administered by Aboriginal people, with the aim of providing primary health care coupled with preventive health care. Statistics provided by the Sydney Metropolitan Medical Service show that:



NSW Department of Health



'in the year 1976-1977, 70 per cent of children under five years of age who attended the clinics had weights below average, and 25 per cent were suffering from growth retardation due to malnutrition. In this latter group, 80 per cent were under three years of age and over one quarter of this group had lactose intolerance and could not drink cow's milk.'

Statistics were also collected on the poor health status of Aboriginal women.

'The extent of malnutrition in young children is connected with the poor nutrition and health of pregnant women. Crown Street Women's Hospital indicates that approximately 50 per cent of its Aboriginal patients suffer from complications in pregnancy and labour. The most common difficulties are nutritional anaemia, pre eclamptic toxæmia and post-partum hæmorrhage.'

(Second Report from the Select Committee of the Legislative Assembly on Aborigines, p.397)

The Aboriginal Medical Services assisted mothers and others responsible for infants' preventive health care in such matters as immunisation and nutrition.

Continuing concern for the low level of the health status of Aboriginals, paralleling the poor health status of infants from low socioeconomic levels earlier in the century, led to additional funds being made available in the early 1980s for the expansion of Aboriginal Medical Services and for the continuation of the Aboriginal Health Services offered by the Department of Health.

A Health Education Program for Migrants was initiated in 1972 by the Department to make services accessible to migrants with little or no English. Initially monthly sessions for migrants were arranged to be held at baby health clinics throughout the metropolitan area where there were high density populations of various ethnic groups. Selected migrant health educators, after training, commenced translating in Arabic, Greek, Italian, Spanish, Portuguese, Turkish and Yugoslav languages. Attendance by migrant mothers increased rapidly and has continued to increase. (Health Education Program for Migrants)

Factors which determined the selection of baby health centres where sessions were to be held included requests for assistance from centres where there had been problems of communication between migrant mothers and sisters and the location of centres in areas where there were high density populations of certain ethnic groups. Between 1972 and 1974 a total of approximately 12,340 migrant mothers received assistance from the service and sessions were provided weekly. From 1975 efforts were made to establish an interpreter service in hospitals and community health centres, and this resulted in the setting up within the Health Commission of the Central Migrant Resource Unit, and the subsequent establishment of the Health Care Interpreter Service in 1977.

Redfern Baby Health Centre was one of the first centres to become involved with the Health Education Program for Migrants. The centre was originally established in 'temporary' accommodation in Redfern Park 1949, and was not relocated to permanent premises until 1972 at a new site in the park. Justification for the new premises included proposals for the location of a community nurse providing services specially to Aboriginal mothers and children, preparation



NSW Department of Health



Waiting Room, Redfern, 1989  
Royal Prince Alfred Hospital Audio Visual Department

for parenthood classes, a 'well baby' and immunisation clinic and an antenatal clinic. (Council of City of Sydney Archives)

Sister Marjorie Biddington was the nurse at Redfern Centre for 26 years, retiring in 1986. She is claimed to be one of the great innovators in baby health services and was responsible for the establishment of the first playgroups run at a baby health centre.

Arabic (initially mainly Lebanese women), Greek and Turkish interpreter sessions were run at the Redfern Centre and the women attending the migrant health education sessions were involved in developing the playgroup. 'People can remember Sister Biddington teaching large groups how to cook, how to sterilise, but she is remembered by the Lebanese in the community for her famous porridge and custard.'

Interpreters are now made available at regular sessions held at baby health centres to assist the nurses with ethnic clients on a one to one basis. Sister Pam Townsend and Sister Molly Martin who work at Cabramatta Early Childhood Centre claim that they now see the highest proportion of non-English speaking clients of any centre in New South Wales, with 80 per cent being of non-English origin:

'We are booked out 10 days in advance. While we have some sessions for English-speaking mothers, never a day goes by without someone coming who can't speak English.'



*Sister Biddington with Mrs Laurence Mansour  
Interpreter at a special Migrant  
Health Group Meeting  
Redfern Baby Health Centre, 1979.*

The sisters use the Migrant Health Interpreter Service which they feel is excellent but which slows down their work, as they are always arranging for their services or having to conduct a three-way conversation by phone with the interpreter and the client.

In 1973 the New South Wales Department of Public Health became the Health Commission of New South Wales. 14 geographically defined regions under the administration of 13 Regional Offices were established. Maternal and child health became the responsibility of the Regional Director of each health region. The baby health centres were incorporated into the larger service called "Community Health". At the level of central administration, the Health Commission retained clinical directorates including the Division of Maternal and Child

Health, where the director and his staff had a state-wide advisory function in respect of both hospital and community services:

“The principles on which the baby health centres were established, i.e. focusing on preventative measures, and going out into the community to meet its needs adequately, are those on which the community health program is based.’(Health in New South Wales, 1979).

When the system of baby health services was initially established it was the only community-based health service other than general practitioners. The growth in district nursing services due to the needs and numbers of frail elderly and the provision of the Community Health Programme under the Whitlam Government in 1973 meant a great increase in the numbers of and variety of community health services:

‘Baby health sisters are now a part of a large and diverse community health service provision which is funded and administered by a wide variety of institutions. In some regions baby health sisters have been encouraged to integrate with other services and in other regions have been left to continue their traditional role. The concept of the generalist community nurse has also developed and been implemented in several regions. Some now see baby health services at the crossroads, where they can continue to provide their present services, specialise even further in the provision of infant health services or broaden their role to include the functions of a generalist nurse’ (Corn, 1980).

The baby health service was the only community nursing service in New South Wales which required nurses to possess an additional specialist certificate to their basic nurse training in order to practice. Other forms of training were also available to the baby health sisters. In 1960 an in service course leading to a registrable Community Health Diploma commenced. This was mandatory for child health nurses and also attended by many baby health centre nurses and other disciplines. It ceased in 1975 with the introduction of the Diploma in Community Health Nursing at the New South Wales College of Paramedical Studies (later the Cumberland College of Health Sciences). This was a tertiary diploma course, and the first intake commenced in January 1974.

Degeling summarises the role of the baby health nurse which emerged in the late 70s:

‘Present-day maternal and child health practice however, has grown and diversified to meet the needs of a larger and more complex society. As a health educator and health supervisor, the baby health centre nurse has the following functions:

1. Supporting, guiding and advising parents to be confident and competent in their parenting role.
2. Identifying children with physical, mental and sensory problems, and referring them to the appropriate service, usually the family doctor.
3. Advising on the feeding and daily care of young children.
4. Educating parents in normal child growth and development through an understanding of child behaviour.
5. Facilitating the use of other community resources as the need arises.



*Redfern Early Childhood Health Centre 1989  
Royal Prince Alfred Hospital  
Audio Visual Department*

6. As a result of the reduction in infectious conditions, emphasis can now be placed on developmental, educational and social paediatric practices.' (Degeling, pp. 20-21)

Demographic trends changed in the 1970s. The marriage rate dropped from 1971 after peaking at 9.1 per 1000.

Delayed marriage meant delayed childbirth. Childless families increased with greater movement from involuntary to voluntary fertility. (Burns et al. 1983, p.55)

The needs of the family unit were becoming more varied.

'Rapid urbanisation and the resultant breakdown of the extended family left many young mothers isolated and far removed from traditional sources of support and information.' As well there were many different types of families, e.g. with a single parent or with both parents working.

'Advice today on how to bring up one's baby come from many different sources - books and television, doctors and baby health nurses, neighbours and grandparents. This is often very confusing to new mothers, as people have very different opinions on just about everything to do with babies. Even the experts disagree.' (Degeling, pp. 21-22)

In the 1970s the baby health centres/community health centres were still offering services such as Preparation for

Parenthood classes, Mothers' groups, Parent Effectiveness Training for parents of older children and 'well baby' clinics.

Maternal and child health education about parenthood and children was no longer exclusively the work of health professionals. Various community-based voluntary groups including the Childbirth Education Association, Parents Centres Australia, the Nursing Mothers' Association of Australia, the Australian Multiple Birth Association, the New South Wales Association for Mental Health and Family Life Movement developed programs and services to meet the needs of prospective parents and the family.

A study of Maternal and Child Health Practices in the Illawarra Region conducted by the Division of Health Services Research in 1976 focused on the use made of all health services by mothers and children including the baby health service. The report showed that 95 per cent of mothers surveyed had taken their children at least once to a baby health centre while 87 per cent were regular users of the service. The main reasons for a mother not attending regularly were difficulties with transport, and general self-sufficiency. The major characteristics of mothers who did not attend were those with older children, mothers of an older maternal age and mothers born in non-English speaking countries. About half of those who had never attended had been visited at home by the baby health sister.

For the 87 per cent of mothers classed as regular attenders, the normal pattern was weekly for the first six weeks, fortnightly stretching to monthly until the child was nine months of age and then bi-monthly or when necessary. This coincided with the guidelines of the Bureau of Maternal and Child Health at that time.



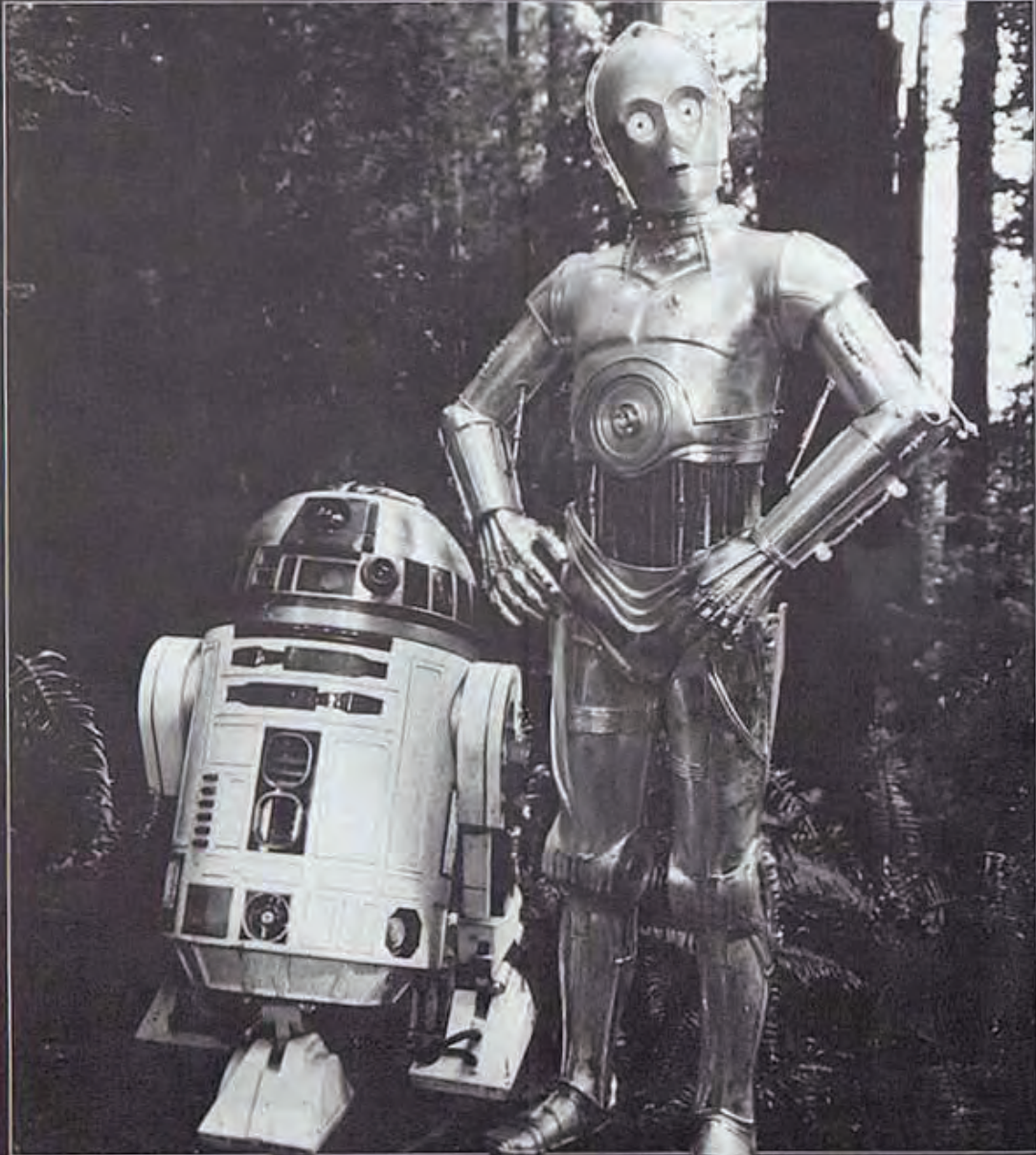
*Redfern Early Childhood Health Centre 1989  
Royal Prince Alfred Hospital  
Audio Visual Department*



*Kotara Baby Health Centre  
Courtesy Sister Annette Lynch*

Baby health services had almost come full circle from the turn of the century when the mothers' instincts were first rejected as inadequate due to ignorance or the basic principles of mothercraft to the situation where the health professionals were there 'to primarily advise and support parents in their parenting role.' (Degeling, p. 22)

**PARENTS OF EARTH  
ARE YOUR CHILDREN FULLY  
IMMUNISED**



NSW DEPARTMENT OF HEALTH  
HEALTH INFORMATION AND TRANSLATION SERVICES

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## CHAPTER 10

### BABY HEALTH/EARLY CHILDHOOD HEALTH TO 1989

'The Baby Health Centres have made a great contribution to the welfare of the nation. They are, perhaps, one of the most outstanding examples of preventive medicine and everyone who is actively concerned in this work can legitimately feel that their efforts are valuable not only for the immediate present but still more so for the future. It is a great opportunity and a great responsibility.'

Morris, *Infant Welfare in New South Wales*, 1946, p.4



*Royal Prince Alfred Hospital  
Audio Visual Department*

By the early 1980s there were 500 community health services in the state for parents of babies and children under five years of age. Most were still held in established baby health centres, although some formed a component of the service available in community health centres and other community health facilities.

The Bureau of Maternal and Child Health had ceased to function as a separate entity in the 1970s following the process of regionalisation of its services. By 1984 a Senior Specialist in Family and Child Health was responsible for policy advice in this area, as part of the Health Services Unit in the re-formed Department of Health.

A survey of baby health services in four health regions was undertaken by Juliet Corn in 1980. Her conclusions were that the changes brought about by regionalisation and the community health program had resulted in a 'management vacuum for the Baby Health Services and that in very few areas had there been re-assessment of the form the service should take, despite considerable agreement that the role of the Sisters had changed from a procedure oriented role to a counselling role.'

In the early 1980s, recognition was given to the fact that baby health sisters had become isolated from other health professionals and had the image to some, of a service which had continued virtually unchanged since 1914. This was despite the innovations which had in fact occurred. It was also identified that, despite the continuing use and popularity of the service, that very little work had been undertaken to document the actual services provided.

A Baby Health Activity Survey was therefore initiated in 1984. The results of this survey indicated the role of the baby health nurse was very much one of the preventive health activity, in terms of frequency of activities. General Health appraisal and promotion was the major activity, accounting for 54 per cent of all episodes of service. Parent counselling was involved in just over 30 per cent, screening checks in 29 per cent, individual counselling in 11 per cent and administration in 18 per cent of all episodes.

The conclusions of the survey were that the major factor affecting the activity patterns of baby health nurses appeared to be the socio-economic context in which they worked. This influenced the type of service delivery, the distribution of time, the time involved in each activity, the nurse's perception of local needs and her response to these needs.

The nature and distribution of activities was also influenced by rural and urban factors and some more minor differences related to the organisation and classification of nursing staff.

While the differences identified between urban and rural areas were minor, more time was spent on each individual consultation in the country, phone services were not common in small country clinics that only operated for limited sessions and more time was spent in travelling between centres, on home visits or in-service training. Socioeconomic context was a major factor affecting the development of the service. While the traditional one-to-one drop-in or appointment service was well utilised by more middle class Australian-born families, those families who were poorer, migrants, lone parents, or families 'at risk' were more likely to respond to services oriented towards their particular needs (i.e. groups and community work).





The survey was able to identify special needs groups for all of the areas surveyed; including young single mothers, isolated mothers, families under stress and lacking support, migrant mothers with language difficulties, low income/unemployed families, working mothers, and those with drug/alcohol/psychiatric problems. Isolation was also recognised as a problem in most areas.

One nurse who was interviewed talked of her experience of current social problems:

'People did not have the overwhelming debt that they have now. They weren't as stressed about money, even though they were quite hard up. They didn't have the overdraft. They didn't try to have the big house and the two cars. The stresses are different, and often the mothers are in more of a mess now. Most grandmothers are out at work now, too, so they don't have their support.'

Due to the results of the Baby Health Activity Survey and further work undertaken in reviewing the role of the baby health services, policy guidelines entitled 'Early Childhood Services' were prepared and endorsed by the Policy Review Committee of the Department of Health, NSW in July 1987.

At the same time it was decided to change the terminology associated with Baby Health Services. The term 'Baby Health' was changed to 'Early Childhood Health', Baby Health Sisters were to be called 'Early Childhood Nurses' and Baby Health Centres called 'Early Childhood Health Centres'. (Circulars 87/159, 87/156)

It was felt that the term 'Baby Health' implied young babies, whilst the term 'Early Childhood Health' implied all children from birth to school age. There was a need to encourage young families and young children to attend an early childhood health centre until school age. Yet another concerted effort was being made to emphasise the importance of the preschool child. Local Councils were informed of the change and requested to include the change in the name on the outside of the clinic when building new centres or refurbishing old centres.

In summary, the policy document states:

'The early childhood health service is the central component of the network of community health, Hospital and other services for children aged 0-4 years and their families. At a time when extended family support is declining, unemployment and lone parent numbers are high, and child abuse notifications increase annually, the need for a service which supports and educates parents in the care and management of young children is obvious. The primary point of access is the early childhood nurse, who is part of a community nursing team and is supported by other community health professionals.

The program is intended for children aged 0-4 years and their families; 7.5 per cent of the New South Wales population being aged 0-4 years.

Infant mortality has declined significantly largely due to improved social conditions, better knowledge of hygiene and nutrition, immunisation and antenatal care. Following a decline from around 140 deaths per 1000 live births in 1910 to 20 per 1000 live births in 1971, infant mortality has been reduced even further (10/1000 live births in 1982), through improved antenatal care, antenatal diagnosis and neonatal care.' (Early Childhood Health Services Policy Statement, Department of Health, NSW, 1986)



*Sister Saw Cheng Khor, Alexandria, 1989  
Royal Prince Alfred Hospital Audio Visual  
Department*



*Gloucester Early Childhood Health Centre  
Courtesy Sister Leonie Bell*

The policy document identifies that the standard of maternal and child health is influenced by a number of factors associated with poor socioeconomic status. These include low income, poor nutrition, inadequate antenatal care, poor housing, smoking and drugs. Low birth weight is positively correlated with poor socioeconomic status, and its effects. The higher level of infant mortality observed in Orana and Far West region is associated with the generally poorer socioeconomic and health status of Aboriginals, as well as factors relating to isolation and difficulties in access to health care.

The report emphasises the fact that early childhood health services should be flexible enough to deal with specific local problems and demands as necessary. The identification of children at risk of abuse, and of parents needing more intensive support, was also recognised as increasing the requirement for domiciliary nursing services. Early discharge of mothers from obstetric units increases the need for advice and support from community nurses who offer advisory services to mothers in some regions, and from early childhood nurses.

Since the policy guidelines were developed there have been further changes in the structure of health services of New South Wales. In 1986 the Area Health Services Act was introduced establishing Area Health Services under the Regional administrative structure in the Metropolitan Sydney, Hunter and Illawarra Regions. The Area Health Services have responsibility for managing the range of hospital and community based services for a population in a defined geographic region. By 1988 the regional structure had been removed and there are now 16 Health Areas and Regions in the state.

The policy document referred to innovative services, such as family care cottages which have been established in the 1970s and 1980s. The Report and Guidelines on Family Care Cottages 1986, summarises these developments:

'One of the first Family Care Cottages to begin operation was in the Western Metropolitan Health Region, at the Mt Druitt Polyclinic in May 1975. This was as a result of an influx of young families into new housing development estates. These families were frequently isolated from family and friends and being in a newly developed area, did not have any community support services to rely on. Since then similar units have been established in other health regions. The centres are set up primarily as a level of support additional to that provided by baby health and generalist community nurses to care for families with children aged 0-5 years, where there are parenting difficulties. The centres are oriented towards behaviour/management and socially based problems rather than acute physical illness.

The centres are set up to deal with 'normal' family problems, and are not generally equipped to deal with the specialised problems such as drug dependent, alcoholic or psychiatrically disturbed parents. The mushrooming of family care cottages over the past 10 years is an indication of their value and acceptance within the community.

Most family care cottages operate as part of the community health network in close co-operation with other early childhood health services and staff, including trained nurses with mothercraft qualifications, parent support workers and a social worker or psychologist.' (Report Guidelines, Family Care Cottages, Department of Health, NSW, 1986)



*Family Care Cottage  
Courtesy Mount Druitt Polyclinic*



*Family Care Cottage  
Courtesy Mount Druitt Polyclinic*



*Eileen Ashton catching a ferry to Scotland Island to hold her monthly Early Childhood Clinic. This service commenced in April 1989*

*Courtesy Sister Eileen Ashton and the Manly Daily*



*Alexandria Early Childhood Health Centre*

*Royal Prince Alfred Hospital  
Audio Visual Department*

Other innovations have occurred in terms of the types of specialist expertise now available to support early childhood nurses. An Australian Lactation Association Consultants Association has been established which operates as multi-disciplinary organisation which educative, research and supportive roles. The objectives of the Association are to impart information about the effective management of breastfeeding, examine and interpret research relating to infant nutrition, breast milk and the lactation process, and to foster mutual support for those involved in caring for breastfeeding mothers. There are five early childhood nurses in New South Wales who hold the qualification of the International Board of Lactation Consultants having passed the fully accredited examination set by the Board, and these nurses use this expertise in the running of seminars and the screening of relevant materials for mothers.

In 1989, the year of the 75th Anniversary of the service, an initiative has been organised by the Department of Health, New South Wales under the coordination of the Primary Health Care Unit of the Program Development Branch. This involves an analysis of the changing role of the Early Childhood Health Service with a view to planning for future services.

As part of this initiative, detailed guidelines are being prepared on different sorts of services provided within the umbrella of early childhood services.

## CONCLUSIONS

The major role of the organised Infant Welfare Movement in reducing the infant mortality rate at the turn of the century and in the twentieth century cannot be underestimated. This represented one of the most significant public health initiatives in this era, with a continuous emphasis on education and preventative measures to overcome the major problem of infant mortality.

During the 75 years that Baby Health Centres/Early Childhood Health Centres have operated under the aegis of the Department of Health in New South Wales, there has been a constant acknowledgement of the need to further educate the mother, as women are not 'natural' mothers. The continuing eagerness of mothers to seek help with their infants, whether as a mother in the bush in the early part of the century or as a single parent in the 80s indicates that they have recognised the benefits of this service.

There has been a major emphasis on the mother-child relationship, from the commencement of organised infant welfare services, with the importance of the role of the father first recognised as early as the 1920s. Now there is continuing emphasis on the role of the family in the wider context of the community.

There has been a continual emphasis since Armstrong's Town Hall Campaign on the importance of breastfeeding as the best method of feeding for infants although recognition has always been made of the value of artificial feeding under optimum conditions when breastfeeding could not be established.

The role of the voluntary sector including the early pioneers such as the Bush Nursing Association, the Country Women's Association, the Royal Far West Children's Health Scheme, the Royal Flying Doctor Service, the Royal Society for the Welfare of Mothers and Babies



Windsor Early Childhood Health Centre  
 Courtesy Olwyn Hendy

(Tresillian), and the Karitane Mothercraft Society in providing services to areas where they previously did not exist and in recognising the needs of the mother for education and support, has proved invaluable.

Due to constraints on Government funding, these services would otherwise have been unavailable and their establishment delayed by many years. In addition Local Government has provided a helping hand to the Service, particularly with the support given in the post-war period in establishing facilities.

However, it was inevitable that the Government would gradually assume a more significant role in the provision of infant and child health services due to the financial constraints in the voluntary sector and the need to ensure services which offered quality, accessibility, continuity and efficiency. The cycle has now almost been completed with the re-emergence of voluntary organisations such as the Nursing Mothers Association which play a major role in supporting the Government services.

A special recognition must be given to the 'Baby Health Sisters' who have continued to provide a most important service often under difficult conditions and continuing pressures due to staffing shortages and incredible demands for their services.

The significance of the Baby Health Service as previously entitled, and the Early Childhood Service as it is now called, to health care cannot be overemphasised.

'There is no other period in the human life span when beliefs, customs and values affect health and health care as much as they do at the time of pregnancy, childbirth and childhood.' (WHO Sixth Report on Maternal and Child Health – New Trends and Approaches in the Delivery of Maternal and Child Care in Health Services, 1976).

## CHAPTER 11

### ADVICE TO MOTHERS



*Before the Baby is Born: Advice to Expectant Mothers. 1914 Government Press Commissioner*

Methods of advice to mothers, and now families, on the care of infants and children, have obviously changed remarkably over the period of the provision of organised children's health services. (Almost as much as the terminology!)

This chapter is a summary of the methods of child care that developed from the turn of the century together with descriptions of the various forms of advice that were given on mothercraft.

#### TURN OF THE CENTURY - 1910S

##### AUSTRALIAN MEDICAL GAZETTE

'There are, no doubt, two important factors which conduce to this infant mortality. The first is the separation of the infant from its mother, or at any rate the difficulty in securing the proper nursing of the infant by its mother. Unfortunately, in a large percentage of cases the children are illegitimate; their death is a relief to the mother. Hence there is no earnest attempt on the part of the mother to nourish and cherish their children, and the infants suffer in consequence. Artificial food is at best a poor substitute for the mother's milk, and cannot, of course, supply that other important factor, namely the cherishing care of a true mother toward her child; and in spite of all the care the delicate digestive tract of the infant becomes the seat of chronic disease, and the child dies from 'marasmus'. But another factor, which we venture to think has been to some extent overlooked in the past, and which conduces to excessive mortality among infants, collected together in large numbers in institutions, is that fact that the disease which attacks the digestive tract, the gastroenteritis which leads to marasmus, is undoubtedly due to one or more microorganisms, and is really a contagious disease.' (Australian Medical Gazette, March 20, 1903, p.116)

##### ALICE RAWSON SCHOOL FOR MOTHERS

'In many young mothers there is a decrease in breast milk when they first get up after confinement, due to the disordered condition of the house, which is usual when the mistress of it has been laid up, and the difficulty of doing the housework and cooking, with the additional work that the young infant always entails. This is the time that injudicious friends usually persuade them to wean the baby or give it biscuits; but if they can be induced to keep the baby on the breast and give one or two bottles of milk and water a day as a help instead of weaning it, in a short time they become more used their altered conditions of life, the milk improves and they are able to discontinue the bottle altogether.' (Isla Bloomfield, on the services provided by the Alice Rawson School for Mothers, Australian Nurses' Journal, Jan. 15, 1912, p.8)

'With the bottle fed infants Glaxo and Lactogen seem to give the best results; Albulactin is often found to be a most valuable addition to either of the above, or in fact to any of the artificial foods, particularly so in the case of Condensed Milk where it appears to supply an element otherwise lacking.' (Nurses A M Dollard and Edith Pike, The Terminal Report of the Alice Rawson School for Mothers, 1913-1914)

##### BABY CLINICS - 1914

'District visiting is bearing fruit. When after the lapse of a year or two a home is revisited on the birth of a new infant, we often find the mothers are carrying out instructions given during our previous visits. The child is fed regularly, bathed and put out in the sun. We also find that the majority of mothers have got over the prejudice of allowing the infant to sleep alone. We have always been welcomed in



*Healthy Motherhood  
NSW Department of Health*



Health Week Exhibition, Sydney Town Hall 1917  
NSW Department of Health

the home and even the mother is glad of advice. Another matter for congratulations is that soothing syrups are on the decrease. Efforts were made in 1914 to get in touch with expectant mothers, but with not very good results during the first four months of this work ... Where insanitary conditions existed at the home, reports were made to the local authority. Instructions are always given to the housewife with regard to proper care of the garbage tin, and the menace of an ill-kept one; and also for the necessity of protecting all food from flies.' (Report on Health-Visiting and Baby Clinics For the Year Ended 31st December, 1914, C M Burne, Nurse Inspector, Annual Report of the Department of Public Health, NSW 1913-1915, pp. 43-45)

### INFANTS PARTLY OR WHOLLY ARTIFICIALLY FED

'Return showing the nature of the food used; Allenbury's Food, Arrowroot, Barley Water, Benger's Food, Biscuits, Bread sop, Condensed Milk (and Albulactin, Barley Water, Malt) Cornflour, Cow's milk, (and Barley Water), Glaxo, Groats, Horlick's Malted Milk, Lactogen, Mellin's Food, Keave's Food, Nestle's Food, Sago, Whey, Condensed Milk showed the greatest usage.' (Report on Health -Visiting and Baby Clinics For the Year Ended 31st December, 1914, C.M. Burne, Nurse Inspector, Annual Report of the Department of Public Health, NSW 1913-1915, pp. 43-45)

## 1920S

### BABY WEEK

'Within a few weeks an organised effort will be made in Sydney and other centres of NSW to focus public attention on a highly important chapter of sociological medicine, the proper care of infants. From March 29 to April 3, 1920, a Baby Week will be held throughout the State of NSW. ... During the course of Baby Week an endeavour will be made to inform every man and woman by demonstration, by lecture, by picture and by pamphlet how the preventable maladies of infancy can be avoided and what organised effort is capable of achieving in the nurture of healthy youngsters. The moral aspect will be attacked, as well as the physical, for the two overlap. If women recognised that it is morally inexcusable to feed a baby artificially, save under exceptional circumstances, there would be an enormous saving of tears at the graveside.' (Medical Journal of Australia, Feb. 1920)

### KARITANE

'The Society feels that the result of giving the Expectant Mother correct knowledge in the care of herself and her baby is at the same time rendering a service to the State in preventing the production of C class citizens.' (Australian Mothercraft Society, Annual Report, 1928)

*'Whale's milk for the baby whale.*

*Rabbit's milk for the baby rabbit.*

*Cow's milk for the calf, and*

*Mother's milk for the human baby! ...*

When for any reason breastfeeding is impossible, fresh cows' milk is "humanised" to resemble it as closely as possible by adding the extra sugar required for the nourishment of the human brain as opposed to the calf's, a specially-prepared sugar manufactured under the Karitane label of 'Karilac'. This humanised milk is given in conjunction with 'Kariol', an emulsion, which supplies the necessary fats and vitamins.' (The Lamp of Life, Daily Telegraph, 13th June, 1929)



Source: Plunket Society New Zealand, 1940.

'What is a ... "Truby King Baby"'

How can a mother prove a statement she is often heard to make – 'Of course, mine is "Truby King Baby"?'

1. By observing all the simple rules of healthy living in the important prenatal period.
2. By feeding it for the first few months of its life as nature intended her to do. (Sir Truby King was ever insistent that no food substitute could ever take the place of the mother's own milk, and his slogan was always "Breast-fed is best-fed").
3. By partially breastfeeding it if she cannot wholly feed it herself, realising that every ounce of the natural food is a safeguard to baby and helps in the digestion of the artificial food.
4. To follow along the lines Nature has laid down, and if natural feeding is impossible, to use the best substitute – a milk mixture resembling as close as Nature's food – and modified to suit the individual baby's needs. (The quite common idea that a Truby King baby is one that is fed on Humanised Milk is absurd!)
5. To see that baby receives all those 'Twelve Essentials' for good health which Sir Truby King stressed as necessary for every baby's needs, whether well or ill.
6. To faithfully follow out the instructions given to her by those Truby King experts, whose experience has proved the soundness of the principles taught by the Founder of our Society.
7. To give to her baby, in addition, that wise and loving care and management that seals the indefinable bond that can only exist between and mother and her babe.'

### TRESILLIAN

'DON'T take any notice of those who tell you that the baby should not be put on the breast until the third day.

DON'T imagine that babies should be fed every two hours in the daytime for a month or so, and every four hours at night. This is quite wrong.

DON'T overfeed baby.

DON'T suppose that a child of three months weighing, say, only eight pounds can assimilate as much food as a child of the same age (three months), weighing 15 pounds.

DON'T give more than two ounces of milk per day for each pound of weight

DON'T think that a baby should not be roused if he happens to be asleep when feeding time comes round. This is a serious and wide-spread fallacy. A feeding 'timetable' should be made out and strictly adhered to.

DON'T fall into the error of imagining that when a baby cries the natural and proper course is to give him the breast, or a bottle, or a 'Comforter' to pacify him. There is no surer way of ruining a baby's digestion and converting him into a fretful, exacting little tyrant, who knows he can get his way by merely crying. Feed by the clock.

DON'T forget that in general, anything beyond human or cow's milk properly modified should be regarded as harmful, not beneficial, for the first nine months of life.

DON'T imagine that if mixed feeding is resorted to some of the feedings should be given entirely by bottle.

DON'T give baby 'what's going' during the second year.

DON'T fall into the error of 'swabbing' out the baby's mouth with water two or more times a day to prevent the risk of Thrush.

DON'T believe those who tell you that 'night air' is dangerous for babies.

DON'T cover baby's face with a handkerchief or piece of muslin when in his pram.

DON'T worry. If you are in need of advice and so situated that you cannot obtain it, write to the Royal Society for the Welfare of Mothers and Babies, which will direct you to the proper sources for information.' (The Errors of Maternity – DON'Ts for Babies)

## 1930S

### BABY HEALTH CENTRES

The objective of the Health Centres is to keep the 'well' baby well.

Specimen baby clothes are kept at all Baby Health Centres for the benefit of mothers, and patterns may be obtained at cost prices, viz., six shillings per packet. These garments are inexpensive and easily made. They comprise: petticoat, dress, nightdress, jacket, woollen vest, cotton shirt and bootees.

Each baby who visits the Baby Health Centre has a chart upon which has weight is entered at each visit.

Cot-making No. 1. The proper way to make baby's cot is demonstrated mothers at the Health Centres.

Cot-making No.2. Baby sleeps much better when the cot is properly made.

Cot neatly made, Baby is snug and warmly tucked in for the night.

Breast milk alone is perfectly adapted to the needs of the child. Nothing else furnishes all the elements of nutrition perfectly blended and properly balanced. Breast milk is more easily digested than any other food. It is entirely free from germs of disease; it is supplied to the child at the correct temperature; it is more economical of time and money than anything else; and it offers a measure of resistance to disease that cannot be obtained by any other means. Therefore, unless natural feeding is impossible, mothers should regard it as their duty as well as their privilege to feed their little ones as Nature intended.

While there are certain fairly definite indications of overfeeding, and less commonly, underfeeding, the only accurate means of determining the actual amount of food a breastfed baby is receiving is a test feed. Therefore, where it is difficult to determine whether a baby is being overfed or underfed, the best thing to do is to have 'test feeds' carried out at the local baby health centre.



Layette, Millers Point 1928  
NSW Government Printer



Cot Making, Burwood, 1927  
NSW Government Printer





*Cod Liver Oil*

For this purpose the baby must be carefully weighed on specially accurate scales both before and after taking the breast. His clothing must not, of course be changed in the interval, so that the gain in weight will represent the amount of milk actually obtained. This procedure removes the element of doubt, and affords mothers accurate information, instead of their having to rely upon guesswork.

The result of test feeding, however requires to be interpreted in light of many other factors ... Age, weight, progress from birth, must be taken into account in recommending a suitable diet. That is why mothers faced with this difficulty should consult sisters at the nearest Baby Health Centre.

The 'Clinic' cod liver oil emulsion, specially prepared for the Health Centres, is entirely free from impurities or drugs, and can be safely used for any baby from birth.

The Toddler – But even after the perilous first year is over, there is still a long way to go and many difficulties to surmount before the child can be regarded as no longer needing help of the mothercraft experts ... The toddler's midday meal – vegetable broth, brains, rice pudding of stewed prunes and milk. The toddler's tea – milk pudding, toast, butter, jam, milk or cocoa.'

(The Baby Health Centres – What They Are and What They Do, Department of Public Health, NSW. 1933)

#### ROYAL FAR WEST CHILDREN'S HEALTH SCHEME

'Recipe for Healthy Baby

1. Wake baby, if necessary, in order to feed him regularly by the clock.
2. He must have no night feeds after 10 p.m.
3. He must sleep alone.
4. Keep him out in the fresh air as much as possible.
5. Give him boiled water daily.
6. Give him sun kicks daily.
7. Get up wind after feeding.
8. Do not give oils unless ordered by the physician
9. Do not give a dummy.



*School Mothercraft Project  
Courtesy Mandy Schmid,*

**DAILY ROUTINE FOR A YOUNG BABY**

6.00 a.m.	Waken. Feed. Hold out.
6.30 a.m.	Tuck down to sleep – in fresh air, if possible.
9.30 a.m.	Bath time.
10.00 a.m.	Feed. Hold out.
10.30 a.m.	Tuck down to sleep in fresh air.
2.00 p.m.	Feed. Hold out.
2.30 p.m.	Tuck down to sleep.
4.00 p.m.	2 ozs. boiled water or orange juice. Take out for walk or nurse
5.30 p.m.	Sponge face, hands and buttocks. Put on night clothes.
6.00 p.m.	Feed. Hold out.
6.30 p.m.	Tuck down to sleep.
10.00 p.m.	Waken and feed. Hold out. Tuck down to sleep till morning'

*(Royal Far West Children's Health Scheme Hand-book on Health and Motherhood, published in war years.)*

**1940S-1950S**

'In selecting playthings for children, they should be tested by the following standards:-

1. Are they suited to the child's stage of development?
2. Are they interesting to the child?
3. Are they helping the child in his or her development by developing body control and good posture, by developing imagination, by training for creative activity, by developing interest and ability along useful lines?
4. Are they helping the child establish worthwhile habits such as concentration, tidiness, resourcefulness and reasoning?
5. The wrong playthings help to develop bad habits such as laziness, carelessness and extravagance.' (The Infant Welfare Centre as Community Service – Commonwealth Department of Health, 1944)

As one of Helen Townsend's informants remembers:

'Babies had flannel. My baby brother had flannel singlets, flannel nappies, English flannel pilchers and flannel jackets. They let him out when he was about two.'  
(Baby Boomers, Helen Townsend, 1988, p. 45)

'Experience, too has demonstrated that maternal instinct alone is insufficient equipment for a mother to undertake the responsibility of feeding and caring for a baby. Mothers are slow to accept this. The tendency is to regard maternal instinct as all-sufficient. But in every



NSW Government Printer

sphere of human endeavour it is training that counts. Motherhood is no exception to the rule'. (Our Babies, Department of Public Health, NSW)

Injury due to use of strollers for young babies. The common use by mothers of push-carts or strollers instead of prams for babies under 12 months old cannot be condemned too strongly. The former are not sprung to prevent jolts and there is no protection for the baby's legs from cold winds in winter. Moreover, being wheeled in the upright position is injurious for young babies and the use of these push-carts is likely to result in postural defects which may handicap them for life.

### OLD WIVES TALES

When a baby's cord is healed up he will need binders no longer. The advice of ignorant women – that baby's back – (as some say) or stomach (as others say) needs the support, has no foundation and should not be listened to. If baby is a boy, do not listen to the utterly untrue tale that baby boys must not be allowed to cry for fear of rupturing themselves.

### TOILETING

Make up your mind to have a 'clean' baby, and hold him out (not for longer than five minutes) on a little chamber or basin after every feed after the sixth week. Not only will you save many wet and dirty napkins, but you will train baby's bowels to act so regularly that the foundations of future good health will thus be laid down.

### THE DANGEROUS DUMMY

Why baby should not be given a dummy

1. The 'dummy' cannot be kept clean or away from dust and flies.
2. The action of sucking a 'dummy' is totally different to the active healthy movement of jaws and muscles in breast feeding.
3. Sucking at the breasts is a vigorous and beneficial exercise. When a breast fed baby is given a dummy his energy is expended needlessly, so that when he is put to the breasts he is tired, quickly becomes exhausted and falls asleep.

If parents could only be brought to realise that serious and far reaching injury frequently results from the use of the dummy, it is safe to say that no baby would ever be given one.

Perhaps the recent death of a baby by choking, caused by a dummy, may warn parents of another danger accompanying the use of a dummy.

Fathercraft – The New Science. 'The major part of the responsibility for the care and management of baby inevitably falls upon the mother. But the father is not without his share of this responsibility. He has the choice between helping his wife to be firm in managing the baby and in carrying out the Baby Health Centre Sister's advice or ridiculing it and making it extremely hard for the mother'



*That dirt-collecting toy –  
banish it forever*

## 1960S-1970S

'I am a woman of two worlds, with one child a Spock and one a Truby King, who reigned supreme back in 1953 when my daughter was born. Truby, if my memory serves me, was a New Zealand doctor who revolutionised what child care existed in his day by advocating the sterile conditions of an operating theatre in which to rear infants. His methods did cut infant mortality, but at the price of woman mortality. By the time Spock arrived on the scene in time for my son, I was but a shadow of the formerly lusty female.' (How Spock saved us from terrible Truby, newspaper article – no source)

### OUR BABIES, HEALTH COMMISSION OF NSW, 1975

'In the first few weeks of life when mothers are getting to know their babies it is better not to follow rigid feeding schedules, but to let the baby regulate his own feeding times. It will take some time for the mother to learn to interpret her baby's needs and also for the baby to adjust to the new environment. It is wrong to let a young baby cry for long periods. It is better to pick the baby up, soothe him and if necessary feed him. After a little while baby will develop a sense of security, because his needs are met and he will settle into regular feeding times.

### OBSERVATION FEEDING

When feeding difficulties occur the cause can very often be found by the Sister observing the baby during his feeding.

The following valuable information can be obtained by this observation –

1. How the baby sucks.
2. How he is being held during the feeding.
3. Whether the flow of milk is satisfactory.
4. Whether his breathing is being impeded, e.g. by very large breasts
5. The posture of the mother during feeding and how she feels about handling the baby.
6. How much milk he gets at the particular feeding, by weighing him before and after feeding without changing his clothes.

### CARE OF BOTTLE AND TEATS

After each feed, the bottles must be rinsed in cold water, and then cleaned with hot water and bicarbonate of soda, or a little soft soap and a bottle brush. (Where emulsion is given in the feeding, soap must be used to remove the grease)

After each feed the teat should be rinsed well under the tap and then rubbed inside and out with common salt.

### HOW YOUR BABY ACQUIRES BOWEL AND BLADDER CONTROL

Some parents worry about establishing regular bowel movements in a young baby and try hard to get baby into routine habits before his first birthday. Bowel and bladder control by the baby does not, as a rule, happen until well on onto baby's second year. A mother can, however, generally get her baby into a routine during the first year.



**YOUR BABY IS GROWING UP**

There are many roads to good health, but the principle factors upon which the health and physical wellbeing of young children depend are security and happiness, suitable diet, sufficient restful sleep, plenty of fresh air and sunlight, proper clothing, clean habits, exercise and play, and acquiring self-control.'

**1980S**

'Preparation for parenthood programs have been conducted in selected centres since 1964. They are designed principally, but not exclusively for couples having their first child. Sessions are conducted in an informal manner so that a social setting is provided which promotes the formation of supportive peer-relationships among attenders. Programs aim to prepare people for the physical and emotional experiences of pregnancy and childbirth and the physical and emotional needs of parenthood. Areas which are usually covered in the program include the following:- pregnancy, labour and child birth, physiotherapy, family nutrition, infant feeding, care of young babies, needs and normal development of infants, healthy parent-child relationships, family planning and an orientation visit to the local hospital's maternity unit. Each program comprises some four to six sessions and involves the participation of a team of health personnel.' (Department of Health, NSW Internal Document, 1982)

'Babies teats should be well washed in hot water with detergent added, rinsed well and sterilized by any of the usual methods. Salt and sugar should not be used.' (Department of Health, NSW Circular, 1986)

**OUR BABIES, DEPARTMENT OF NSW, 1982**

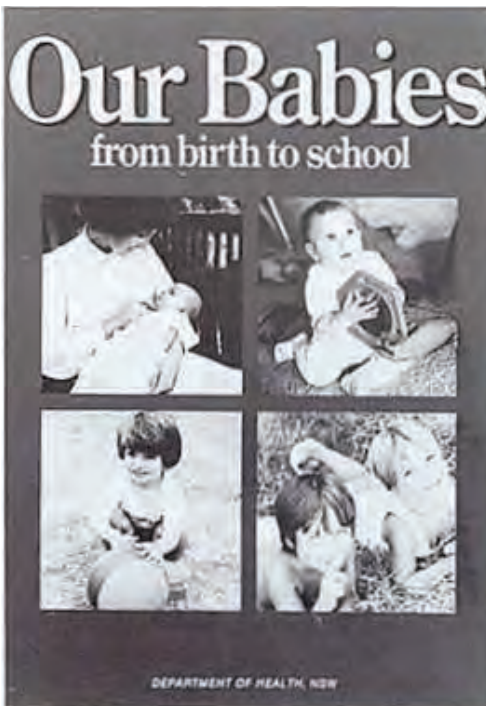
'Parents vary in the ways they feel about their newborn babies. Some mothers feel an intense love the moment they first see their baby, and can easily express this love by touching, cuddling and talking. Others may feel overwhelmed at first and need time for their love and its expression to grow.

If parents continue to think of natural behaviour as normal, then there will be fewer examples of angry 'naughtiness'. If young children's feelings are accepted, they will be secure enough gradually to develop a concern for the needs and feelings of other people. They are less likely to feel angry and rebellious.

**DUMMIES**

There are lots of arguments for and against the use of dummies. If your baby uses one, remember the following things:

1. After use, clean thoroughly in hot soapy water.
2. Sterilise by boiling or in cold sterilising agent.
3. Check that the dummy has not deteriorated. Replace it as needed.
4. Never attach it to the baby's clothes by ribbon or cord, or tie it around the baby's neck. An accident could happen.



### I'M NOT READY YET

Bowel and bladder control doesn't usually happen until well into the baby's second year, and often later. Very gradually her nervous system develops enough so that she can consciously hold back or push out a bowel movement. She doesn't do this until she has enough experience to connect the feelings inside her bowel and bladder to the potty into which her mother wants her to pass her motion or urine.'

### PERSONAL HEALTH RECORD

#### Breastfeeding

Breast milk is the best milk, particularly for babies under six months.

1. It contains the best ingredients in the best proportions and is the easiest milk for baby to digest and absorb.
2. It contains many protective factors against infection, allergy and perhaps other diseases of later life.
3. The close physical contact when feeding helps bonding between the mother and infant.

## REMINISCENCES

The following excerpts were taken from oral or written histories given to us by sisters both current and retired, CWA members and mothers.

### SISTER RAE BURGESS

'Whilst doing my duties as a clinic sister I had a working arrangement with the Burrowa police that if I thought the taxi driver was too drunk to drive me home to Yass I was to put my hand up as I passed the police station.'

### SISTER ANNETTE LYNCH

'Lots of people had Sister Farthing Stories. The only one I remember was told to me by a lady who was one of the Sister Farthing mums. She had seen Sister returning from Sydney after receiving the QBE or MBE. She remarked how nice she looked in a hat as she never wore one. Sister Farthing said she bought a hat especially go to Government House for the medal, but when she got to Central Station she forgot it and walked off the train without it. When she remembered, it was too late so she popped into St Vincent de Paul and bought another hat, receiving her OBE/MBE in a second hand hat.'

### SISTER JENNY ROSE

'Hillston Baby Health Centre opened in 1963 and its travelling clinic circuit over the years served a large area including Rankins Springs, Roto, Ivanhoe, Carrathool, Goolgowi and Merriwagga.

I left Hillston on Wednesdays and did the Roto clinic on the way. It was held fortnightly in a CWA room which was also the Post Office and telephonist room. No-one ever attended except the telephonist's three year old daughter. So I put the scales in the car and home visited four to five Aboriginal families in the area. If any babies were ill, I transported them to the doctor in Hillston on my return trip from Ivanhoe. They stayed in hospital two weeks and I took them home next Roto clinic day if noone had collected them in the meantime

I left the car at Roto Post Office and wrote myself a first class return train ticket to Ivanhoe (had a book of tickets in the glove box of the car). I was met at Ivanhoe by the CWA lady on roster and always stayed the night with a local lady. She charged \$4 for dinner, bed and breakfast. Home visits were done on foot often several miles. Caught the train back to Roto and drove back to Hillston, home visiting at the station homesteads on the way.

In 1970 I travelled 1,000 miles per month and the Shire provided us with a car complete with a two way radio. The Shire workers looked after us very well and sometimes provided an escort when the weather or road was doubtful.

One day I had three flat tyres and was rescued promptly due to radio contact.'

### SISTER DULCIE WILSON

'I was in Walgett in 1971 relieving the community health nurse when the floods came. The whole town was surrounded by levy banks and both Aboriginal settlements were brought into town where they lived in tents – it was like a tent city. I prepared babies bottles at the baby health centre and took them around to the families every day. Everyone was very helpful. One child became very ill and I was upset and crying and an Aboriginal elder put his arm around me. The child subsequently died.

We always wore uniforms in Sydney. On my first day in Nevertire I turned up wearing a uniform and starched veil and one of the

mothers said 'Good God, Dulcie, what are you doing with that on your head, nobody wears them here'. I took it straight off and never wore one after that. In 1960 when the nurse inspector came to visit me, I told her that I normally did not wear a veil but had brought it today only because she was coming. She accepted this; but I always wore a uniform dress as it kept me clean. The regional nursing sister at Trangie developed a pant suit uniform which we often wore in winter. The first community health nurse in Aboriginal health at Bourke was told not to wear a uniform, but after four to five days she rang to ask if she could. Evidently the Aboriginals thought she was the welfare officer and the door was shut in her face. As soon as she wore the uniform she was their nurse and all was well.'

#### SISTER DOREEN WALSH

'I joined the Far West in 1969 and was based at Cobar serving a large area including Nyngan, Nymagee, Girilambone, Coolabah and Hermidale. I was responsible for preventative medicine for mothers, babies, and school age children. I spent a week in Cobar and a week travelling nearly 400 miles a fortnight. The roads were bad and I was not a good driver but was grateful when the Apex Club of Cobar presented me with a car with air conditioning. I held clinics in hotels, churches, homes and at the side of road. The scales were heavy and clumsy, and I used to leave them at various places when I had other jobs to do. One day in Nymagee I was wearing my nice white uniform and fell through the floor. My pride was hurt more than anything.

I got to know the people very well in the country and used to mind babies sometimes until midnight in my flat. All outside the line of duty. One woman was getting married for the second or third time asked me if I could mind her baby during the ceremony. I said 'cut it out, I'm not minding children all around the countryside'. Anyway she dumped the baby on my doorstep at 1.00 pm one Sunday, got married and returned to pick it up and 10.00 pm that night. I did hearing and vision screening in schools and had to send the audiometer back to Sydney for testing as so many children were deaf. One Saturday I took antibiotics 200 miles to a child. Someone had to do it but the Department did not make it compulsory. The Department of Health took over from the Far West and 9.30 am on a Monday morning in 1974. The takeover was badly organised, I resented it very much and cried for a week.'

#### SISTER ELIZABETH WILLIAMSON

'In 1964 I was sent to Albury. In those days it was very difficult to get sisters to work in country centres. Sisters had to be sent to relieve in holiday periods and we in the country would not know until the day before our holiday if we would be having a relief. We had to wait 13 months for our rostered holiday to come up. In order to encourage sisters to the country a bounty of 50 pounds every six months was paid. We had to do a minimum of one year but headquarters hoped we would stay three. On arrival I liked the look of this big delightful river town and thought I would settle here but did not let headquarters know my private thoughts. I thought they might dock the 50 pounds each six months.

There were two baby health centres in Albury and we had our country centres to attend to, sometimes not returning after 8.30 at night. It was often very wet and home visiting in rubber boots was a must. Special permission was sent from Railway Headquarters in Sydney to allow an extra train stop to be made at Uranquinty.



This town had a pub, a shop and a silo and we had to cross the main highway to the station master's office to use the toilet.

Albury was one of the first towns in New South Wales to settle Aborigines and we encouraged them to come to the centre. The Aborigines had a day of their own.

In the days before 1974 the Nurse Inspector from Sydney would come three to four times a year to go through our books. Also we would send our record cards to Sydney three times a year for assessment. Nowadays no information is kept, just a tick made. We worked nine to five with lunch from one to two but had to be at work 15 minutes before 9 am and 2 pm Sydney Headquarters would always phone 15 minutes before closing time to see if we were still there.

#### **MR WALLACE SNELSON – HISTORIAN, COBAR**

'There was no baby health centre in Cobar in the early 1930s and mothers brought their babies back to the hospital for advice. My wife was a sister in the Cobar Hospital and the first time she arrived was by steam train. A Jackeroo was there to drive her to the hospital as there was no taxi. The Matron thought she might like a bath and handed her a nice white towel. She turned on the taps and red mud water came out. The rain water was kept for babies and drinking water. The Municipal Council did not have the money to buy lime to clear the water.

Here are a couple of stories my wife recounted from her days at the hospital. A woman was returning to Nymagee with her new baby and her husband came to take her home in an open utility. It was raining when she was discharged and she was given an umbrella to hold over the baby and herself for the 60 mile journey.

One woman took her newborn baby into the bush when she was helping her husband with the sheep. She put the baby into a wool bag and it fell sick with Pink disease. The baby's nails fell off, and it spent six months in hospital.'

#### **SISTER MARY DEBENHAM**

'I joined the Far West in the 1930s and as well as working on the clinic car did a lot of travelling by road. In each town there was someone who looked after me. In Coonabarabran it was the doctor and his wife who came right down the railway track and found me stationed amongst all the goods trains. Usually someone took me home for the night but often I slept in the clinic car as it was safe in those days and people did not fear muggings etc. Afterwards in the 1940s I was on a bigger car that had a kerosene refrigerator, gas to cook by and a little tiny bath. It was a lonely job, I always worked on my own, but it was never lonely in the towns. I belonged to a number of libraries who sent me boxes of books and I went to conferences in Sydney.

I took my bike on the train and did a lot of visiting by bike. This is how I discovered a very poor family down on the riverbank in one town – the baby was 12 months old and weighed only nine pounds. There were many such children in pitiable conditions with bad eyesight. I reported them to the local branch of the Far West who followed up what was to be done.

I was taken around by road by whoever would help, usually a commercial traveller. I travelled to Wentworth with a chap at

4.30 am. They would wake me and we crawled outside in the cold with no breakfast to an old, completely open Rolls Royce car with no windscreen. We'd hike away down the Darling River stopping at small places on the way. At one place we broke down about 20 miles from anywhere and had to wait until a man came along in a horse and cart and went and got assistance. The clinic was held in an old hall where the locals had stitched up hessian on the walls and given us a few chairs and a table.

On the whole the mothers were sensible and we sisters knew that the mothers did not always do what they were told. However, the majority of babies were healthy. One thing that was bad at the time was that they were still mixing up flour to make food for the babies and you had to get them off that and on to Lactogen which we used a lot. We encouraged breastfeeding but even in those days mothers wanted to put their babies on the bottle. They were worried if their babies cried a lot and were glad to know they had rules to go by for a month or so. They had a long way to come to the clinic and could not come that often so they were given diet sheets that would last a long time.

I worked during the war where petrol restrictions limited my ability to get around and I often needed to travel all night. The effects of the war were very obvious. I left the Far West in 1945.

#### **CELIA DUNCAN, ERICA GALWEY, HEATHER RICE, MARJORIE SIMPSON**

'Nothing in our training taught us how to interview, consult or counsel people. There was no teacher-type training. We were hospital nurses. You had to be able to deal with domestic violence and child abuse, too. There was no particular expertise to refer to. One sister noted that through all her nursing and mothercraft training, she never felt she was equipped for the job she had to do. They agreed it was good practical training, but quite inadequate for working in the centres. If there was good sister in charge of a new sister, it was a help to learning the job.

Social work wasn't what we were supposed to be doing. It wasn't written into the job. We were supposed to be writing out instructions for feeding ... You'd tell the mother 'I'm not supposed to be giving you advice about that, but if you come back in my lunch hour, I'll tell you what you need to know and who to go to'. You weren't supposed to do this over the desk.

Inspectors could pop in at any time. At Revesby for example, there was no telephone, no time for lunch hour, desperate mothers and test feeds. The waiting room was full and flowing onto the steps and into the garden, and the sister had a mother to help with breastfeeding. The mother had scales at home so that she could weigh her baby. The baby was thriving. The Inspector arrived and blasted the sister for letting this mother have scales at home. The inspector wasn't at all interested by the crowding and busy state of the centre.

The expectations of head office were absolutely unrealistic. When they inspected you, they inspected you as if it was a perfect world and the work could be done by the book with perfect babies and mothers. The rules were very strict; the job was nothing like it. The sisters agreed: '...nearly everything you did was sort of done rather furtively'; you tried to keep to the basic rules, but you had to make them apply'; 'the mothers had problems you weren't told about, and if you weren't living through it yourself you probably didn't have much understanding of

it'; 'and you couldn't change the system – they always told me I was going to be thrown out because I used to write letters and ring up people and try to change things'. The centres had food orders, and the families sent in for orders. Sometimes the sisters had to buy the food themselves, because if there were cash orders the husband might spend it. There were always requests for food, money, blankets ... They gave them powdered milk, Lactogen etc. if they had nowhere to keep fresh milk. This was in the 50s ... it depended on the area. There were deserted wives and a lot of people in their own flats.

Country people did a lot to keep their services. They looked after you. The CWA, Red Cross, the hotel people were good. You met other country travellers – the bank boys and the reps. Some places were not so good: 'At Wentworth I used to stay in this old pub and it had wooden walls, and I can remember one night I had one fellow one side and one on the other, and they were both snoring. I'd get up and get a shoe and throw it at one wall ... and then a shoe at the other wall ...' Sometimes we would sleep on a hotel's enclosed verandah with louvre windows, which was noisy. The bathroom might be a community bathroom, with men shaving etc. At Roto, on the Hillston circuit, the toilet was a pit in the bush. One sister stood up on the seat of the old wooden toilets; another poked around for spiders and snakes first. There were no lights -often a box of matches, and no candles.

We had to travel in our own time to different centres – there was no travelling time allowed to get there at nine. To get to Byron Bay from Lismore, you left very early, but almost the whole of the CWA met the sister. They provided morning and afternoon tea. There was no overtime, but an allowance was paid – 20 pounds a day if you had to stay at a hotel.

The mothers were a lot more regimented. The babies were fed only three or four-hourly, and you weren't supposed to pick them up much in between. They weren't to be over handled, only at a set time of day – the mothering hour in the late afternoon. Then you could play with them and take them for a walk. One sister noted that the problem of poor sleeping in children was pretty common. The philosophy was that the baby with a definite routine felt more secure, and that disturbances in that routine created insecurity. You couldn't disturb the baby to go out, for example- After the six o'clock feeding time you hoped that the father would not overstimulate it before it went to bed. The mothers took notice of the strict routine. We were the trained nurses and we did it with our own children. People took a lot of notice of the baby health sisters in those days ... we were held in pretty high esteem.

Once all these prepared foods came out, mothers started to go back to work, and the American ideas took hold – Americans didn't breastfeed – we had to encourage them to breastfeed. Cutting out the 10 o'clock feed at night was a disaster for breastfeeding. The pill was a disaster for breastfeeding too. They went for their check-up at six weeks, and their obstetrician put them on the pill. A lot of the doctors would not believe it, but down went the breast milk, sometimes almost overnight. If they persevered it sometimes came back, but they never really lactated as well. Then the mini pill came in and it reduced the milk although they said it wouldn't. We kept on saying, but for years they didn't believe us, 'If anything wrecked breastfeeding it was not baby health sisters and policies, or going to work or anything else, it was the pill.'

### SISTER ELORA LAMBETH

'I would like to recount some of my experiences in the country. For example, one sister would go home visit in the morning and in the afternoon. When the sister came back, she did the test feeds. There did not seem to be the same necessity for test feeds in the country. I don't know if it was the lack of the rat race or what it was. The mothers seemed to be calmer.

Floods were sometimes a problem in the country – you couldn't get out. Once in Forbes, there were four blocks in the centre of town, surrounded by water. The rector lived on the other side of the canal. He came to me and told me he was going home while he could still get there, and he left me in charge of the parish hall where some of the people had been billeted over the weekend. Whatever was happening, the sister was part of it.'

### RUTH CARTER – URUNGA CWA BABY HEALTH CENTRE

'After much planning and waiting, Urunga CWA is happy to announce that the baby health clinic opened in the CWA Rooms, Urunga, November 1976. Mr Driscoll, the friendly family chemist donated one dozen tins of baby powder and one dozen cakes of baby soap for the first 12 babies enrolled at the clinic. Mrs Dianne Wake donated a foam filled baby mattress and covers, and the CBA bank 20 money boxes.

The Urunga Urban Committee supplied cupboards, filing cabinet, baby scales, pillows for the baby scales and hand towels. Padded keepers to hold the baby firm in the scales were made and donated by one of our members, Mrs Lasker. An electric jug and bottle warmer were in the rooms. Tea, sugar and biscuits were available for Sister Young, and Mrs Lasker donated a small teapot.'

### JOAN ROOTS – WOODBURN CWA BABY HEALTH CENTRE

'The Woodburn Country Women's Association's rooms and baby health centre were opened in 1948 and a visiting sister came down from Lismore once a week. We have maintained the centre for the past 41 years, an effort of which we are very proud. During this time we have suffered seven floods all of which went into the building, the worst one to a depth of three feet and each one taking its toll on our floor coverings and building structure. The 1989 flood was almost too much. The water came in, we cleaned it out and were waiting for it to dry when the water came up again and remained for a week.

We have coped with the whims of various sisters, one wanted the entire centre painted white, one wanted it multi-coloured, one wanted carpet (which we didn't agree to, not with the history of our floods), one wanted pictures on the walls and one wanted the walls plain. All in all it has been an interesting experience.'

### ARMIDALE EARLY CHILDHOOD CENTRE

'The Armidale Early Childhood Centre is unique in New South Wales as it is not owned by the CWA, the Council, or the Department of Health. The land was donated, funds were made by public subscription and the building was opened in 1934. The centre is administered by a group of trustees who act on the advice of the mothers group who maintain the building. In the early days the group paid for everything but today the state government pays power, sisters' wages and the telephone bills. The mothers' group membership comprises mainly of young mothers, who meet

regularly to organise fund raising and social activities. Funds raised help maintain the centre and support has also been given to the maternity ward at the Armidale Hospital and to a child in the Philippines. A newsletter, the Baby Elf is produced monthly.'

#### **CAMPBELLTOWN BABY HEALTH CENTRE**

'Up until 1939 there was no baby health centre in Campbelltown, the population being about 5,000. A group of concerned mothers felt a service was needed and approached the Department of Health who agreed to provide a trained sister for one day a week if the group could find suitable premises. The Department of Justice agreed to provide two rooms in the local courthouse but it was necessary to move the sister and equipment to the Soldiers Memorial Hall once every three months when Petty Sessions were held.

Maurya Hutton was one sister who found the facilities at the Courthouse rather primitive. She remembers standing on the table, taking out the light globe and inserting the electric jug plug for a cup of tea. It was freezing in winter and very hot in summer. The women's group was told there was no way that new premises could be built and funded by the Department of Health, so they formed two committees to raise funds and build a new centre. The main functions held were gymkhanas at the local showground which incorporated barbecues, bike races, lunches, teas and chocolate wheels. One of the mothers (whose husband ran a local hotel) provided whisky and cigarettes as prizes for the chocolate wheels. These items were really scarce in the war years and illegal to use as prizes. A strict church member reported this and two members of the committee were summonsed to appear before the Chief Justice in Sydney. After telling them it would be cold in Long Bay he dismissed the case.'

#### **MRS R PARISH, WOOLGOOLGA CWA BABY HEALTH CENTRE**

'The Woolgoolga Branch of the Country Women's Association was first formed in 1933. The baby health centre was inaugurated at the Returned Services League Hall on the stage. We owned a white painted table, a cupboard, two chairs and a set of scales. After a couple of years the sister wanted the hall floor scrubbed for health reasons but the soldiers objected as it was their dance floor. To keep everyone happy we looked around for another building and were offered half of a shop so we moved the centre there.

After two or three years our membership dwindled to almost zero so the then president and treasurer kept the baby health centre going by paying the rent of 5 shillings a week and buying the sister's requirements until our funds were exhausted. We then called an urgent meeting saying that unless the meeting was well attended the branch and baby health centre would have to close. There was a good response, our membership grew, more babies attended the baby health centre and we were on our way again.

After a while the sister became dissatisfied with the shop premises as she thought the naphthalene used in the shop was affecting the babies. We looked around for a block of land and Dorriggo Shire Council offered us a corner of the Recreation Reserve but it didn't suit our requirements. Two of our members attended several sittings of the Land Board until the block that we now own became available at the cost of 48 pounds which we paid off in instalments, the 1st instalment being in 1947. We had the ground

for several years before we had the money to build. We raised money by catering for balls, children's frolics, weddings etc and held tennis tournaments and street stalls. Our junior members deserve a special mention for selling tickets for competitions.

The building was opened in July 1955 and cost 2,270 pounds. Donations to the building fund came from the Health Commission (500 pounds), the Shire Council (100 pounds) and various organisations and individuals. A retired sea captain donated a polished oak table and six chairs.

In 1954 we joined in the Coronation celebrations for Queen Elizabeth by entering a decorated float in the procession down the main street. A local mother acted as the clinic sister, and our then president, a baby and small girl rode the float. They borrowed the centre's scales without permission and got into trouble for doing so. The little girl was supposed to be sitting on the potty but insisted on putting it on her head instead. However, we ended up winning the prize for our float.

#### **IRENE LAMB – MOTHER, 1940S**

'I remember the clinic car coming to Cobar in 1936. It was stationed at the end of the platform and usually stayed a week. Word used to pass quickly through the town and mothers walked in from surrounding area to see the sister. Two shillings was put in the box – it was not asked for but donated. Sometime shunting occurred while the mothers and babies were in the carriage and they had to wait until the car was returned to the platform before they could alight.'

#### **MRS WILLARD – MOTHER, 1940S**

'Due to the dangers of living in Sydney during the Second World War, I was sent to Cobar to stay with relatives. My first baby was born prematurely and we asked the local clinic sister for help. She would ride on her bike to our home, constantly offering advice and we treated her like one of the family, first names being used.

One day she was visiting and there we were, baby with a dummy in her mouth. My sister-in-law was making strange signs telling me to hide it and we finally did in the machine drawer, the closest place. I'm sure the sister never noticed – nowadays babies are allowed to have dummies in hospital – times have changed haven't they?

#### **ELSIE WALSH – MOTHER, 1930S**

'I first attended the clinic car in 1933 with my first baby. With the excitement of having a baby I completely forgot there was a clinic but knew one existed because my sister had attended one. Anyway my baby seemed to be crying all the time and I thought about the clinic and took him there for a test feed. It was found that I was overfeeding him as his birth weight was 10 pounds and I was feeding him every three hours. The sister told me to give him tablespoon of boiled water before each feed and that was the beginning of the crank becoming a marvellous baby.'

#### **EMMA FREEMAN -MOTHER, 1920S**

'I had 17 children and took the first two to the clinic car. When my third one was born I decided I didn't need help from anyone, but Sister Webb called and insisted. After that I went with all my children up until the very last one. The sisters gave mainly information about feeding but I didn't have much time to breastfeed

my babies. As we had plenty of cows and goats sister suggested I use goats' milk and two of my children were reared on goats' milk. The others were fed on cows' milk apart from the eldest who was fed on Glaxo. Does anyone remember Glaxo?'

### MOTHER OF THE 1940S

'In hospital they got you up on the eleventh day for an hour to have lunch and on the twelfth day you went home. They would not allow you to handle the baby in those days so you didn't know how to bath it or put a nappy on. You had been lying in hospital for 12 days, were weak and stiff.

Nowadays, they allow you to get up and walk around. Some young mothers didn't know a thing, they never had anything to do with children and this was where the clinic sisters were useful. Some mothers lived on their own out in the bush with just their husbands, they learned by trial and error and they survived.'

### RUTH OLDHAM – MOTHER, 1940S

'I thought it may be of interest if I told you of my experience of rearing babies in the bush. I had absolutely no experience with babies. My first baby was born in 1942. Fortunately the baby sister at the hospital got me off on the right path - showing me how to feed and bath the tiny babe, and then I was on my own.

We lived in a cottage a mile from my husband's parents – with no phone, no car, no electricity. This was during the war years – when the petrol ration was four gallons a month. Grandfather just had to go to bowls every Saturday, so there was no petrol to go to the baby clinic. Somehow – I forget how – I was fortunate enough to find out about the correspondence course run by Truby King. This was a big help – as I was instructed about the mysteries of weaning a baby and when to introduce the baby to Farex (does Farex still exist?). How to make the milk mixture gradually stronger - taking half an ounce of water out each day and strengthening the powder specially made by Truby King – till the baby was on full milk. I used to have a piece of paper stuck on to the kitchen mantle – with the day's mixture written on it. I had three babies in two years and 10 months. God was good to me - He gave me two healthy sons and a daughter.

When I was bathing my second baby of three months – the elder one - who was drying himself by the wood heater – lent forward and burnt his bottom, on the heater. The skin was hanging in shreds. Had I been in town – I would have picked the child up and run screaming to the doctor. Instead I placed the young baby on the floor and dunked the burnt bottom in cold water with soda-bicarb in it. Why the soda I don't know! I put the child to bed eventually with wet bandages round his bottom and got up at two hour intervals to wet the bandages again. In the morning all the redness had gone and he was happily playing and I had black circles!

Babies are tough – they have to be to survive inexperienced mothers. I remember going out to the cosyby (did they go out of fashion too?) and there was big brother generously feeding his little baby sister chocolate – bite for bite! She survived!

We all boiled the nappies in a half kerosene tin on the wood stove and boiled the bottles for half an hour. I would do it all again!'



Courtesy Tresillian

## CHAPTER 12

### SETTING HEALTH GOALS FOR BABIES AND CHILDREN

The nurses' role had become more dynamic, with more involvement in home visiting, group education and support programs, and identifying families who needed special care.

#### 1989-1995

Between 1914 and 1980, there were dramatic improvements in the health of mothers and babies in NSW. Improved hygiene, sanitation, nutrition and a range of other important public health initiatives had made a significant impact on early childhood mortality. A further factor in the achievement of some of these great child health gains was the success of NSW child and family health services.

The Australian report about maternity services, the 1989 Shearman Report, found that as many as 80 per cent of mothers across the State were attending a baby health clinic at least once during the first year.

The report also noted that the role of child and family health nurses had changed significantly over the years. While many of the health issues plaguing children over the past century had become a distant memory, new health issues were emerging, and the work done in child and family health services was shifting in response to these changes.

Early childhood health nurses, as they were now known, had moved beyond their original role, which had focused on reducing infant mortality and disease by educating mothers about health and hygiene. Their role now encompassed education, health promotion, health and developmental screening, monitoring family wellbeing, and providing guidance, counselling and support to families with young children. In rural and some metropolitan areas, several early childhood health nurses were now offering immunisation services. They now worked as members of a multidisciplinary team that included obstetric hospitals, paediatricians, general practitioners, social workers, psychologists, nutritionists, family care centres and other health and welfare professionals. The nurses' role had become more dynamic, with more involvement in home visiting, group education and support programs, and identifying families who needed special care.

At this time in the late 1980s, childhood health issues that are still of concern today began to emerge – in particular Sudden Infant Death Syndrome (SIDS) and preventable diseases. Partly as a result of the success of childhood immunisation, there was a growing suspicion in parts of the community about the value of vaccinations, prompting fears that diseases such as whooping cough, diphtheria, tetanus and polio could rear their heads again.

Asthma was the most common cause of hospital admissions for children, according to a report in The Sydney Morning Herald in 1989. SIDS peaked in 1986, claiming the lives of about 200 babies a year, and it was now that alarm bells began to ring about childhood obesity.

#### INFANT DEATHS – TURNING AROUND A CRISIS

By the end of the 1980s, SIDS was the most serious issue impacting infant mortality. With about 200 babies dying in NSW due to unexplained causes every year, most families knew, or at least had heard of, someone who had experienced this devastating tragedy. But despite considerable work to identify causes of SIDS, there was still no real understanding of its aetiology beyond the identification of risk factors.

In July 1991, the Australian Rotary Health Research Fund, in association with the Sir Robert Menzies Memorial Foundation, hosted a meeting of Australian and international SIDS experts over



two days in Canberra. In attendance was an eminent group of 33 people representing State and Federal Health departments, the Royal Australian College of Obstetricians and Gynaecologists, the Royal Australian College of General Practitioners, the Australian College of Midwives and the Australian College of Paediatrics, along with representatives of national and State research institutes.

The assembled group discussed the growing body of evidence suggesting that the prone sleeping position was a key risk factor for SIDS. The group also discussed other possible risk factors implicated in the literature, such as maternal smoking, non-breastfeeding and overheating. The participants agreed the evidence against prone sleeping was compelling, and they recommended a population-based intervention.

The response in NSW was to rapidly carry out a survey of infant sleeping positions, breastfeeding and exposure to cigarette smoke, as well as to conduct an information campaign directed at health professionals. This comprised an information bulletin about SIDS and its risk factors, a seminar attended by more than 200 health professionals from all over the State, and an updated departmental information booklet on SIDS.

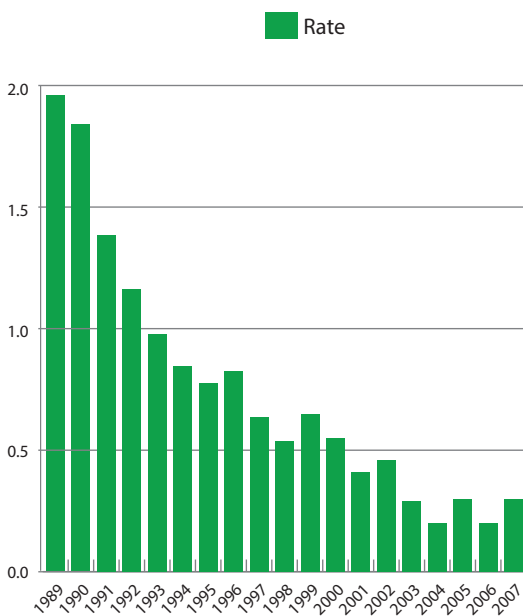
The most important outcome of the Canberra meeting was the roll-out in 1991 of the Reducing the Risk of SIDS education campaign. With epidemiological evidence still equivocal as to the best position for babies to sleep – other than to recommend against the prone position – the policy for the first half of the 1990s was that babies should be placed on their side or back.

Reducing the Risk of SIDS became one of the most successful public health education campaigns in Australia’s history. Alongside a wide-reaching public relations campaign, health services strongly promoted safe-sleeping messages. As new parents heard these messages from nurses and other trusted health professionals, as well as through the media, the practice of placing babies on their back to sleep became more widespread and SIDS rates began to fall. Between 1986 and 2003 the death rate from SIDS dropped by 86 per cent and there were a number of changes in the profile of SIDS deaths, with male infants, those outside capital cities and Aboriginal and Torres Strait Islander children most at risk.

With the advent of further evidence about the risk factors for SIDS, Reducing the Risk of SIDS was followed in 1997 by the launch of the Kids and SIDS: Three Ways to Reduce the Risk program, which recommended that parents place infants only on their backs to sleep, allow infants to sleep with their heads uncovered, and keep infants smoke-free before and after birth. A further campaign followed in 2002 – SIDS and Kids: Safe Sleeping.

Around this time there was also a change in terminology. Recognising that not all sudden deaths in infancy were attributable to SIDS, there was some impetus to broaden the definition and capture a greater range of infant deaths. Sudden Unexpected Deaths in Infancy, or SUDI, is a term introduced in the mid-2000s that includes deaths due to SIDS and other undetermined causes. A death is generally classified as SUDI if it concerns an infant younger than 12 months, is sudden in nature and is unexpected.

SIDS Rates Per 1,000 Live Births 1989-2007



Source: SIDS in Australia 1981–2000: a statistical overview, Australian Bureau of Statistics on behalf of SIDS and Kids.

A 2005 review of SUDI in NSW, Sudden Unexpected Deaths in Infancy: The New South Wales Experience, found the success of these national prevention campaigns was largely due to partnerships between the community, the SIDS associations, researchers and health professionals. "These partnerships have produced sound evidence for decisions, wide participation in programs and the provision of consistent information," the report noted.

NSW Health was tasked with leading the response to the recommendations of the report, and action was renewed in three areas. Prevention of sudden infant death by addressing the risk factors was still a top priority, and SIDS and Kids NSW continued to lead on prevention activities and promotion. Another priority was education of health and other professionals to better promote safe sleeping, and new guidelines on promoting safe sleeping in health services were developed.

Finally, a new and very different multi-agency response was developed to manage instances in which an infant dies suddenly and unexpectedly, which was endorsed by the heads of each agency involved. The new management policy contained some changes for police, coroners and other services, but involved a vastly different role for Health. For the first time, infants who died and their families were routinely brought to the emergency department and received a health response. A health and medical history was taken, which aided in providing the best healthcare and support to the grieving family, as well as collecting key information to help determine cause of death.

However, deaths were still occurring. An analysis of the NSW Child Death Register in 2005 found that in almost 90 per cent of SUDI cases, modifiable risk factors were present, including unsafe sleeping positions, exposure to tobacco smoke during pregnancy and/or after birth, head coverings, and co-sleeping in combination with smoking and/or substance use. This study concluded that information campaigns may not be reaching some groups and should be modified to target specific sectors of the population.

In addition, benefits would be achieved by refocusing prevention efforts to stop the practice of putting infants on their sides to sleep.

As a result of these findings, the NSW Government and SIDS and Kids NSW began to implement prevention strategies targeted at specific high-risk groups and to place greater emphasis on the risk associated with the side-sleeping position. The NSW Government has now adopted an integrated, multi-agency response model to sudden and unexpected deaths in infancy. This model aims to achieve a balance between care and investigation, and ensures that comprehensive information is collected and recorded; that trained personnel are involved; and that there is multi-agency monitoring and research – all with the family as the central consideration.

An important part of reducing SUDI deaths in NSW has been the constant updating of policies and guidelines as new evidence becomes available. The Child Death Review Team reviews every death, including what happened and what risk factors were present, such as babies falling onto their fronts, overheating or becoming trapped. This work continually informs policy, which is rapidly passed to maternity and child and family health nurses, for whom discussing safe-sleeping practices is a crucial part of their routine work. Safe-sleeping is listed

in the Personal Health Record (PHR, or the Blue Book), providing a guide for staff to raise this topic for discussion at each health check, based on material sourced from SIDS and Kids NSW.

### **A SECOND SUCCESS STORY – IMMUNISATION**

The burden of death and disease in Australia has been dramatically reduced by vaccination. The first disease to be prevented by widespread childhood vaccination was diphtheria in 1932. This was followed by vaccination against whooping cough in 1942, tetanus in 1953, poliomyelitis in 1956, measles in 1970 and Haemophilus influenzae type b (Hib) disease in 1993. The most important and easily measured impact of vaccination for these diseases has been on deaths, which declined by more than 99 per cent, from 9300 in the decade 1926-35 to 64 in the decade 1986-95, despite the Australian population increasing 2.6-fold over this time.

However, in the late 1980s, vaccination – or lack of – was emerging as a major population health problem.

A report in The Sydney Morning Herald on 15 November 1989 highlighted the “gross negligence” by some parents in failing to immunise their children against diseases such as whooping cough, diphtheria, polio and tetanus, and reported the concerns of some health policymakers that NSW would see a return of these communicable diseases.

Up to a third of children aged one to five were believed not to be fully immunised, and “health officials suspect that one of the main reasons why people are not immunising their children is that they belong to a generation which has not witnessed the ravages caused by these diseases in the past,” the report said.

While vaccination had seen a successful decline in infectious diseases across Australia, in the early 1990s the vaccination program in Australia was uncoordinated. In NSW, child and family health nurses were often responsible for providing vaccinations in rural areas, but in the cities it was not routinely considered part of their core work, with vaccinations more often administered by general practitioners, local hospitals or by the council.

“Each State and Territory followed their own immunisation schedule and the availability of vaccines was variable and funding arrangements complex,” says Sue Campbell-Lloyd, Manager of NSW Health’s Immunisation Unit.

“Live vaccines such as measles, mumps, rubella and oral polio were free, but triple antigen – for diphtheria, tetanus and whooping cough – was not free until 1999. Parents needed to pay for this vaccine on prescription, and general practitioners were required to collect the live vaccines from the local council. The number of doses was often restricted because there was only so much fridge space. It was not at all efficient.”

In 1988, NSW was the only State to conduct a Bicentennial Measles Campaign in child care centres and then primary schools, with additional catch-up clinics and promotional activities conducted throughout 1989.

**NSW HEALTH ENCOURAGED ALL HEALTH PROFESSIONALS TO ASSESS EVERY CHILD’S IMMUNISATION STATUS TO TAKE ADVANTAGE OF EVERY OPPORTUNITY TO IMMUNISE CHILDREN WHEN THEY VISITED A HOSPITAL, COMMUNITY HEALTH CENTRE OR DOCTOR.**

Linked to this campaign was the introduction of the Personal Health Record in January 1988. It was hoped that its introduction would improve the uptake and documentation of all childhood immunisations, including measles. The Personal Health Record was, and remains, popular with parents and health professionals, and is best utilised by child and family health nurses. It contained the minimum recommended schedule of child health screening and surveillance health checks, and at each check, immunisation status was reviewed and complete immunisation promoted.

Programs aiming to increase immunisation included the Fairfield Immunisation Taskforce, formed in 1993 to increase immunisation in southwest Sydney, and the development of an immunisation kit for Aboriginal communities, *Immunisation: Telling It Right* by North Coast Public Health. However, with the introduction of the measles, mumps and rubella (MMR) vaccine in 1989 and Haemophilus influenzae type b (Hib) in 1992, it became apparent that the Commonwealth needed State and Territory cooperation. As a result, the coordinated process that still exists today was implemented.

NSW Health encouraged all health professionals to assess every child's immunisation status and, unless contraindicated, to take advantage of every opportunity to immunise children when they visited a hospital, community health centre or doctor. This policy aimed to achieve 90–95 per cent coverage and to overcome barriers to immunisation, including misconceptions about its safety, a failure to administer vaccines simultaneously, and a failure to assess children's immunisation status and provide needed vaccines whenever children accessed the health service.

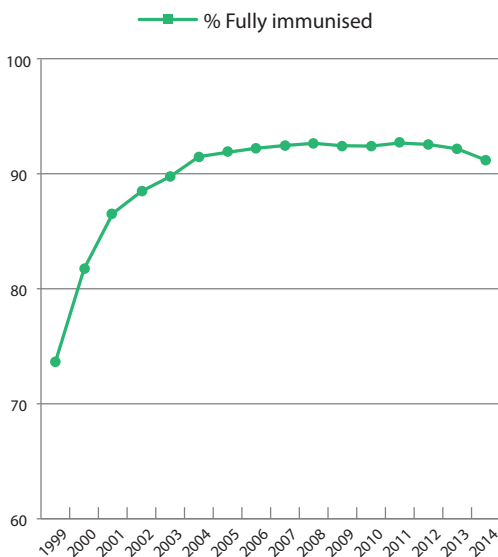
The NSW Health Department joined other States and Territories in working collaboratively with the Commonwealth through a National Immunisation Committee. With pressure from State representatives concerning the chaotic system of vaccine provision, the Commonwealth reviewed its funding arrangements, culminating in the provision of free, Commonwealth-funded vaccines for all parents from the late 1990s.

The NSW Public Health Amendment Act 1992 required, for the first time, school principals to request parents to provide their children's vaccination status. Those who failed to do so would be regarded as unvaccinated and excluded from school during disease outbreaks, a process that began in 1994. Also under the new Act, NSW required GPs, hospitals and other health professionals to notify the government of adverse events related to vaccination.

In the early 1990s, the only data available on immunisation rates was gathered by the Australian Bureau of Statistics. Although it was based on parental recall, and therefore likely to be unreliable, the data suggested the coverage rate in Australia was only 54 per cent.

With vaccination rates still perceived to be unacceptably low by 1996, the Commonwealth launched a two-year pilot managed by the Health Insurance Commission to record the vaccination status of all children under the age of seven. This Australian Childhood Immunisation Register (ACIR), managed by the Health Insurance Commission, recorded data on immunisation coverage and generated a reminder system to allow active follow-up of susceptible children. All babies born after 1 January 1996 were automatically entered

Percentage of fully immunised children in Australia by calendar year 1999–2014, Cohort: 2, 24–<27 months



Source: Australian Childhood Immunisation Register - Annual Coverage historical data, *Immunise Australia Program*, Department of Health, 2015.

**ALL BABIES BORN AFTER 1 JANUARY 1996 WERE AUTOMATICALLY ENTERED INTO THE AUSTRALIAN CHILDHOOD IMMUNISATION REGISTER FOLLOWING REGISTRATION WITH MEDICARE.**

**WHILE THE LATE 1980S SAW EFFORTS FOCUS ON SUDI AND VACCINATION RATES AT A GRASS-ROOTS LEVEL, WORK TO IMPROVE CHILD HEALTH WAS UNDER WAY AT A BROADER NATIONAL STRATEGIC LEVEL.**

into the register following registration with Medicare. In NSW, all maternity hospitals were required to enrol babies with Medicare before discharge to ensure they were registered on the ACIR.

The following year, in 1997, former GP and then Federal Health Minister, Michael Wooldridge, implemented Immunise Australia, a seven-point plan to improve immunisation rates. It formalised ongoing funding for the ACIR and offered a \$6 incentive per vaccination to providers to collect data on immunisation, which was cost-shared by NSW Health. For child and family health centres, which were still providing immunisation in rural areas, this fee soon built up and enabled the purchase of better fridges and storage facilities, ensuring the potency of vaccines.

The plan also saw the establishment of the National Centre for Immunisation Research and Surveillance of Vaccine Preventable Diseases (NCIRS) to conduct immunisation research and evaluate national disease surveillance data; incentive payments to parents; and the National Measles Control Campaign in 1998, which saw the vaccination of 1.7 million (96 per cent) primary school age children and averted an estimated 17,500 cases of measles.

Another central plank of Minister Wooldridge's seven-point plan was to create a greater role for GPs in Australian immunisation. The rationale was that, rather than having a range of providers deliver vaccinations, GPs were in a prime position to target children by virtue of the fact they saw 93 per cent of children an average seven times in their first year of life. The General Practice Immunisation Incentives (GPII) Scheme (Medicare Australia) was introduced on 1 July 1998 to provide financial incentives to GPs to monitor, promote and provide age-appropriate immunisation services to children.

By the late 1990s, 92 per cent of all one year olds were fully vaccinated in NSW.

### **NATIONAL SHIFT - IMPROVING HEALTH FOR ALL**

While the late 1980s saw efforts focus on SUDI and vaccination rates at a grass-roots level, work to improve child health was under way at a broader national strategic level.

In 1988, the Commonwealth produced the Health for All Australians report, which was promoted by the Health Targets and Implementation Committee as Australia's first national attempt to compile goals and targets for improving health and reducing inequalities in health status among population groups.

It proposed major national goals and set targets with the aim of reducing health inequalities and disadvantage, and improving health in the five priority areas of nutrition, prevention and control of high blood pressure, cancer, injury prevention, and health of older people.

As part of the process of developing these national goals, the Department of Health, Housing and Community Services funded a project to consider what was needed to highlight the health needs of children and youth from 0 to 24 years. The work was undertaken by a committee led by South Australia, with Dr Diana Jolly as the project manager. Members of the committee were: Professor Graham Vimpani, then Area Director, Child and Family Health Services, University of Newcastle, as Chair; Jewel

Buchanan, Nurse Unit Manager, Early Childhood and Child Health, NSW; Dr Margaret Dean, Medical Advisor, Department of Health, Housing and Community Services, Canberra; Dr Elisabeth Murphy, Medical Officer, Child and Family Health, NSW Department of Health; Dr Gay Ochiltree, Senior Research Fellow, Australian Institute of Family Studies, Melbourne; Professor Brent Waters, Professor of Child and Adolescent Psychiatry, University of NSW; Dr Neil Wigg, Director, Resource and Development Services, Child, Adolescent and Family Health Service, South Australia.

The result was the release of the 1992 Health Goals and Targets for Australian Children and Youth, which for more than 20 years has continued to guide work to improve the health of children and young people in Australia.

The goals represented a tangible shift in focus, from treating existing illness to prevention. They emphasised the importance of monitoring outcomes for children – including family and social functioning – and recommended a national action plan to address the health needs of young Australians.

The Health Goals and Targets for Australian Children and Youth established the framework for a more coordinated effort, reduced duplication, and enabled better sharing of expertise across State and Territory boundaries. They considered conditions that affected large numbers in the community or were particularly serious, or that had significant long-term consequences, and recommended broad strategies to implement them.

At a meeting in 1993, the Australian Health Ministers' Advisory Council (AHMAC) agreed to endorse the five health goals that subsequently became the foundation for the 1995 and 1996 Health of Young Australians and The National Health Plan for Young Australians:

1. Reduce preventable premature mortality
2. Reduce the impact of disability
3. Reduce the impact of vaccine-preventable disease
4. Reduce the impact of conditions occurring in adulthood that have their origin or early manifestations in childhood or adolescence
5. Enhance family and social functioning in order to promote the optimum development of the child and youth.

These goals still form the basis of many policy initiatives for young children and families today.

As a result of the goals, an increased focus was placed on health services promotion, prevention and early intervention strategies, adopting a whole-of-community approach but specifically targeting the needs of difficult-to-reach and disadvantaged groups. The NSW Government recognised that the provision of services to children required particular knowledge and skills by an experienced workforce, and that it should be boosted with regular monitoring and the establishment of partnerships between all levels of government, non-government organisations and the community.

## REMINISCENCES:

**Marg Greig**  
**Child and Family Health**  
**Nurse Tottenham**

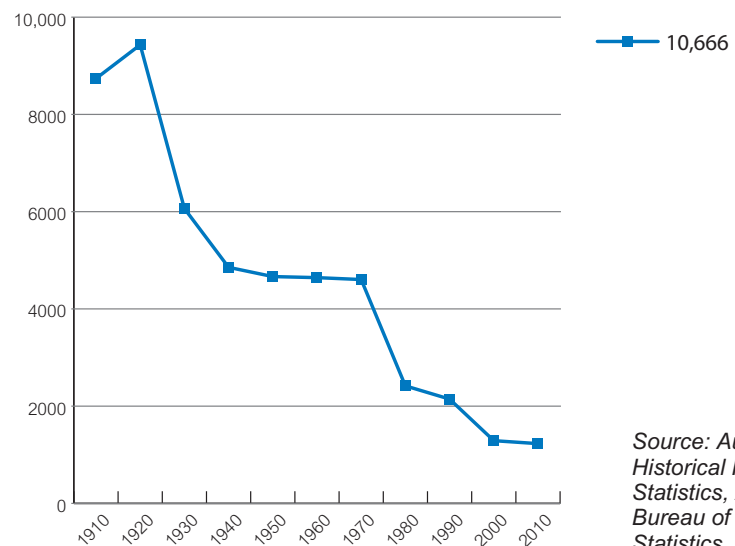
“When I started as the baby health nurse, I had an office in the ambulance garage – driving the ambulance out, rolling out the carpet and setting up the desk. After that I was moved with the community nurse to a room at the side of the hospital. I was working in a small community team with about 1000 people in the catchment area. I had to share the car with a community nurse to do home visits; it was a tiny little Ford car, not a four-wheel drive, and the roads were mostly gravel.

“I didn’t do a lot of home visits because the mums liked coming to town to do their shopping. I probably knew the background of all the mothers, which has totally changed. We have got a lot more influx of people coming from the coast for cheap housing. Many are lower socioeconomic families; I don’t know their backgrounds, and they are a lot more suspicious about services. I have to work a lot harder to get in there – but these people need a lot.

“These days everybody is advising everybody else via social media. But they are not asking the child and family health nurse, they’re Googling and asking friends, and they are not getting correct information all of the time. There’s nothing wrong with looking up information and reading, but I also think they need to have that home contact, that person they can trust who can sit and listen.”

A range of innovative health interventions began in NSW to address specific targets. For example, NSW Health funded the Kidsafe NSW Playground Safety Project in collaboration with area health services to ensure local councils and schools were able to comply with safety standards. The National Asthma Campaign aimed to increase the numbers of people with asthma who followed a recognised management plan. The NSW Department of Health supported initiatives to promote breastfeeding to the community, and began to implement action plans to ensure healthier food choices in child care centres and school canteens, as well as increasing levels of physical activity in children along with the Australian Sports Commission and NSW Departments of Education and Sport and Recreation.

Infant Deaths, Australia, 1901-2010



Twenty years on, in June 2014, a steering committee established to advise on a new National Child and Youth Strategic Framework for Health conducted a retrospective of the past 20 years. Its report highlighted how influential the 1992 Health Goals and Targets for Australian Children and Youth was in improving the health of children and young people in Australia.

The goals set in motion a nationwide mission over the next 20 years that resulted in a significant decline in preventable mortality, with infant mortality more than halving since 1992, and remarkable gains in reducing the incidence of SIDS and Aboriginal infant mortality. In the area of disability, a focus on pre-pregnancy and the antenatal health of mothers has seen a sharp decrease in the rate of neural defects, largely due to folate supplementation, and the age of diagnosis of sensorineural hearing loss has dramatically decreased due to the introduction of universal newborn screening programs.

Notification rates for a number of vaccine-preventable diseases have increased markedly, the report said, with vaccination rates for children improving. There have also been gains in reducing tobacco and alcohol use among young people, and a substantial amount of work in all States and jurisdictions to better identify children at risk of abuse or neglect.

## CHAPTER 13

### BABIES' BRAINS AND LIFELONG WELLBEING

The 1990s saw the release of a vast amount of compelling new knowledge about the impact of antenatal and early childhood experiences on lifetime health.

#### 1996–2000

By the mid-1990s, the success of early childhood health interventions were considerable. With infant mortality rates at an all-time low, communicable disease issues of the previous century a distant memory, and the ageing population, there could have been considerable pressure to direct health resources to the other end of life.

However, the 1990s saw the release of a vast amount of compelling new knowledge about the impact of antenatal and early childhood experiences on lifetime health that would affect the role of antenatal care and early childhood health services in particular – the knowledge that many of the chronic diseases developed later in life could be traced back to adverse, and potentially avoidable, experiences in childhood.

The initial focus of this research was to emphasise the importance of preventing child abuse and neglect – that stress and other toxic experiences reduced the likelihood of normal brain development and could lead to lifelong poor physical health, learning difficulties, behavioural disorders and mental illness. But during this decade, new research worldwide started to demonstrate that it was possible to go further than avoiding poor outcomes from childhood trauma. It became clear that it was possible to help all children to develop optimally, to be the best they could be, both in terms of their health and wellbeing, and their social and academic life and learning.

The new knowledge about modifiable risks to lifetime health and wellbeing – both physical disease and mental health issues that were being noticed – was to force a major change in policy and practice direction and radically change the way child and family health nurses worked.

#### RESEARCH INTO CHILDHOOD LINKS WITH LIFETIME HEALTH

In 1995, the British Medical Journal published the results of work by Dr David Barker which it dubbed “the Barker Hypothesis” – work that provided the link between a baby’s birth weight (and therefore the health and experience of the fetus in pregnancy) and the lifetime occurrence of cardiac disease. This work was later expanded to link pre-birth health and wellbeing to a range of lifetime health outcomes.

At the same time, Dr Vincent Felitti, Clinical Professor of Medicine at the University of California, San Diego and

Founder of the Department of Preventive Medicine for Kaiser Permanente, and his colleagues launched the Adverse Childhood Experiences (ACE) Study, which examined the link between adverse early childhood experiences and health problems later in the lives of 17,000 patients. It found that not only were adverse childhood experiences common – almost two-thirds of study participants reported having experienced at least one adverse childhood experience – but these childhood experiences led to a multitude of health and social problems.

The research team also found that the higher the number and the more intense the traumatic childhood experiences, the greater the number and the more severe the health issues in later life.



Also in the 1990s, international researchers began to study the health outcomes of orphans from Romania who had been kept in deprived conditions in State orphanages before the regime was overthrown in 1989. Using brain scans, they found that the brains of those orphans who had suffered neglect in their early years showed significant structural effects, and that these changes carried a range of health problems into later life, including delayed growth, average intelligence on the threshold of mental retardation, poor language development and a high prevalence of psychiatric problems and attachment disorders.

In April 1999, the results of the Canadian Early Years Study were published in *Reversing the Real Brain Drain: Early Years Study Final Report*, authored by the co-chairs of the study, Margaret McCain and Fraser Mustard. The authors, in their letter recommending the report to the Government of Ontario, summarised their findings as:

“We examined the evidence from the neurosciences, developmental psychology, social sciences, anthropology, epidemiology and other disciplines about the relationship among early brain and child development and learning, behaviour and health throughout all stages of life. We consider, in view of this evidence, that the period of early child development is equal to or, in some cases, greater in importance for the quality of the next generation than the periods children and youth spend in education or post-secondary education.”

The finding that brain development, and learning, was a process that was occurring at the fastest rate during life in pregnancy and the first three years, and that the outcomes of this sensitive period of development could have predictive lifelong impact, was groundbreaking. The publication of the Early Years Study was soon followed in 2000 by the publication of *From Neurons to Neighborhoods: The Science of Early Childhood Development*, edited by Jack Shonkoff and Deborah Phillips from the US-based Committee on Integrating the Science of Early Childhood Development, which started to explain in accessible terms the science of epigenetics and its relationship to early childhood.

Landmark publications such as these drew together what had been large and disparate bodies of research, joining the dots to show exactly the significance of the years from conception to three years old for setting the foundations for development, health and learning for the rest of life. They showed how addressing individual problems across the population could lead to public value, and led to a new government approach to build a public response to the new evidence.

**LANDMARK PUBLICATIONS WERE SHOWING THE SIGNIFICANCE OF THE YEARS FROM CONCEPTION TO THREE YEARS OLD FOR SETTLING THE FOUNDATIONS FOR DEVELOPMENT, HEALTH AND LEARNING FOR THE REST OF LIFE.**

In the late 1980s and early 1990s, research knowledge had already started to spread through services, including health services, on the impact of child abuse and neglect on children. This was now enhanced and extended by the new knowledge about child development, including brain development. For the first time, service providers were starting to get clear evidence about not only what not to do, but what they and parents could do to provide children with the best opportunities to succeed.

The value of this research to Government was further bolstered through the work of Nobel Laureate economist James Heckman, who analysed the relative investment of governments at various ages and stages, and demonstrated the phenomenal returns that could accrue from wise investment in the early years, with tapering investment continuing across the lifespan.

This new knowledge led to a change in NSW's approaches to early intervention and child protection. It illustrated and reinforced the importance of child and family health services in NSW in supporting all families early, and providing an early opportunity to intervene where families expecting or caring for young children were at risk of poor outcomes. The evidence indicated that services needed to be reoriented and extra funding allocated to the early years of life, to providing health and developmental screening and surveillance, and a gateway into the service system for families who needed extra support. As a result, Families First was born.

### CHILDHOOD TRAUMA AND EARLY BRAIN DEVELOPMENT

The research on early childhood, development and epigenetics dovetailed with other work happening in the child protection field. By the end of the 1990s, early results were coming out of The Dunedin Study, a detailed study of human health, development and behaviour that has followed the lives of 1037 babies born between 1 April 1972 and 31 March 1973 at Queen Mary Maternity Hospital, Dunedin in New Zealand. It was becoming clear from its findings that the stress of witnessing family violence as a young child led to a predisposition to violence in later life, and that the peak time of vulnerability was during the first year of life.

In September 1998, the world's leading experts in child abuse prevention gathered in Auckland for the annual conference of the International Society for the Prevention of Child Abuse and Neglect, which that year focused on innovation and inspiration. The keynote address was delivered by Dr Bruce Perry, an internationally recognised authority on children in crisis from the Child Trauma Academy in Houston, Texas.

Dr Perry showed the conference images of the brains of children who had been exposed to child abuse, clearly showing the impact of adversity on brain development, especially in the stress response system, which affected the capacity of the children to self-regulate feelings and behaviours.

Also presenting at the Auckland conference was David Olds, a Professor of Pediatrics, Psychiatry, Preventive Medicine and Nursing at the University of Colorado Health Sciences Center, whose work investigated ways of preventing health and developmental problems in children and parents from low-income families.

In 1977, Professor Olds had developed a nurse home- visitation program in the US designed to help young first- time mothers from low-income families to take better care of themselves and their babies. He had run several randomised controlled trials testing this intervention in Elmira in New York, Memphis and Denver, and showed that the program improved pregnancy outcomes, the health and development of children, and the life course of parents. It reduced child abuse, neglect, and/or injuries by 20–50 per cent and incurred a substantial cost benefit.

For the Australian delegates, the presentation was galvanising. Two weeks after the conference, the results were discussed at a meeting of the National Council of Community Child Health, a regular meeting of senior public servants from across Australia and New Zealand who were responsible for community child health. The



*Checking head circumference at the 6–8 week check – Doonside 2012.*

attendees agreed that the evidence was important and discussed how best to go about promoting it in Australia. The following March, 70 people from a range of different backgrounds met in Canberra to discuss spreading the word to all, including Health Ministers.

The result of these meetings was the establishment of the National Investment for the Early Years (NIFTeY), a non-government organisation that received Federal funding to promote early intervention strategies, advance community knowledge about the importance of the first three years to a child's later life, promote research into early intervention, and advocate for the importance of early positive relationships.

NIFTeY's supporters included clinicians, academics and researchers from the fields of early childhood education, community child health, infant mental health, juvenile justice, child advocacy, research, and adolescent physical and mental health. A large part of its work over the next 20 years was to run a series of high-level conferences featuring prominent international experts in the area of early intervention for children. Another key strategy was the development of a Listserve, which harnessed the increasing access of clinicians to information technology and sent out weekly research updates to thousands of subscribers, making cutting-edge research more accessible to healthcare workers than ever before.

Understanding that the complex issues affecting children needed a coordinated approach, NIFTeY was also instrumental in establishing in 2001 the Australian Research Alliance for Children & Youth (ARACY), a national non-profit organisation to translate best evidence on child and youth wellbeing into practical outcomes.

The result of this work is that in 2014-15, child and family health services in Australia may well be some of the best informed in the world, with clinicians aware of the evidence from the neurosciences and able to communicate it to families in meaningful ways.

### **CHILD PROTECTION, ABUSE AND NEGLECT - MAKING IT EVERYBODY'S BUSINESS**

In NSW in the mid- to late-1990s, a renewed public interest developed about child abuse following a Royal Commission into the NSW Police Service. Initially established in May 1994 to authorise Justice James Wood to investigate the existence and extent of corruption in the NSW Police Service, the scope of the enquiry had been expanded by the end of that year to include the protection of paedophiles by NSW police officers, and, consequently, the extent of child abuse and the implications for a response by the whole system.

The Wood Royal Commission caused long-term and systemic changes in the way responsibility for child protection is thought of and managed in NSW. As a consequence of its findings, which highlighted a failure of several government agencies to take action against child abuse – including exposure to domestic violence – protecting children began to be seen as a shared problem. In contrast to the prevailing perception by many that child protection was the job of statutory child protection services, Justice Wood stated that all frontline staff – whether from Health, Education or Social services – were responsible for identifying and responding to cases of child abuse and neglect.

The final report included a chapter on the NSW Health Department and made a range of recommendations that led to an enhanced role for Health and for health workers in recognising and responding to child abuse and neglect, starting with broader mandatory reporting responsibilities.

Other major changes in response to the Royal Commission recommendations included the establishment of expanded services to offer counselling and therapeutic intervention for children and their carers in cases of physical or emotional abuse or neglect. These complemented the existing network of sexual assault services. Comprehensive interagency guidelines for recognising and reporting abuse and neglect were developed, which included the impact of witnessing violence on children among the possible and reportable forms of child abuse and neglect.

The changes had a great impact on those services most involved with children and their families, and health workers like child and family health nurses and allied health staff working in child and family health.

Prior to the Royal Commission changes, only doctors were mandated by law to report child abuse and neglect. Following the Commission, a circular from the Director-General of Health directed other health professionals to report also.

The changes meant that there was a stronger mandate for health staff to report, but also that the scope of what was to be reported was broader and clearer. For many health professionals, the changes to their role were initially confusing. There was concern that child and family health staff were becoming quasi child protection staff, and that families would be alienated from the service due to the perception that nurses were conducting surveillance for child protection concerns. The NSW Department of Health made a decision to introduce training for staff, developed by the NSW Health Education Centre Against Violence, to provide them with the knowledge and skills to identify at-risk families, make a report to police or community services as needed, and provide the right services, alongside other agencies, to the child or children and family.

The statewide Play Your Part program promoted child protection as everyone's joint responsibility and gave health workers a clear understanding of their responsibilities under the law, and their role under the interagency guidelines. Thousands of nurses, doctors and allied health professionals were trained in how to identify and respond to suspected cases of child abuse – to “Recognise, Respond, Report”. The training helped child and family health professionals to see all of their other roles through the lens of child protection.

This lens also acknowledged exposure to domestic violence as a form of abuse. Video vignettes accompanied the training, focusing on the impact that different forms of abuse could have on people in their adult years, and the impact that intervention could have compared to the impact of other adults doing nothing to protect a child. For many health professionals, this training was an emotionally intense experience that brought home how crucial these changes would be for their clients or patients. It explained not only what health workers needed to do differently, but also why – to minimise or avoid the lifelong impact on the children who were experiencing abuse or neglect.

**JUSTICE WOOD'S REPORT  
LED TO THE DEVELOPMENT OF  
KEEP THEM SAFE, A FIVE-YEAR  
PLAN TO REFORM CHILD  
PROTECTION SERVICES TO  
MAKE CHILD PROTECTION  
A SHARED RESPONSIBILITY  
OF ALL FRONTLINE WORKERS  
WHO CAME INTO CONTACT  
WITH CHILDREN.**

The call to health workers to “play their part” went well beyond recognising and reporting suspected abuse and neglect to the (then) NSW Department of Community Services. The training was more intensive than previous training, and focused on the expectation that health workers would not just report and withdraw, but would maintain an appropriate role in supporting families where they had concerns about child abuse and neglect. Whereas child and family health services may have only reported to community services, this now meant they would often involve at-risk families in a comprehensive way in groups or other programs and parenting support, refer them to other services within Health, and take additional care to stay in contact with the family when their next scheduled health check was due.

If there were developmental vulnerabilities, or an infant was involved, the response might involve the provision of some more intensive support for a time to deal with those issues. In combination with the broadened focus driven by the Early Years Study, the effect of the enhanced child protection role for all health workers meant that child and family health began to have a more active role in identifying risks to positive and healthy early parent-infant attachment and child development (including risks from exposure to abuse or neglect) and in offering support and assistance.

One outcome of mandatory reporting by health staff was a massive increase in the number of reported cases. By 2008, the NSW Department of Community Services received 300,000 reports of child abuse and neglect – four times the number reported in 2000, representing one in six children in NSW. The child protection system was overwhelmed with cases, many of which were never dealt with.

In 2007, a Special Commission of Inquiry into Child Protection Services in NSW, headed by Justice Wood, was launched to work out what could be done to enable services in NSW to cope with the massive numbers of children deemed to be at risk. Its key recommendation was that mandatory reporting should be required only for children who were at “significant risk” of harm.

Justice Wood's report led to the development by the NSW Government of a comprehensive five-year plan (2009–14) to reform child protection services, known as Keep Them Safe (KTS): A shared approach to child wellbeing. Its central aim was to make child protection a shared responsibility of all frontline workers who came into contact with children. It also wanted to enhance the services provided across the spectrum, improve prevention and early intervention services, provide better protection for children at risk, support Aboriginal children and families, and strengthen partnerships with non-government organisations in the delivery of Community Services. As a result, child and family health professionals were trained to work with the new threshold in reporting and to refer to newly established Child Wellbeing Units to assist them in responding to child protection cases.

These changes have led to a more informed response, requiring child and family health nurses to stay engaged after a report rather than disengage, and to refer to a wider range of services outside Community Services if required. In essence, they were being asked to change their perception of their own practice to include staying connected with families with complex issues, and recognising the psychosocial aspects of their needs.

## FAMILIES FIRST

When Bob Carr became NSW Premier in 1995, he set up the Office for Children and Young People within the Cabinet Office, with Gillian Calvert as director. Its objective was to look at ways different stakeholders would work together, and in the next two years it pulled together the elements that would make up the Families First policy in NSW.

First announced by the Premier in 1998, the Families First strategy was a progressive initiative sponsored by the NSW Government “to reshape and develop the prevention and early intervention services that help parents and communities sustain the health and wellbeing of their children in the long term”. The strategy was explicitly nested within the research, which, as the early statements about the strategy promoted, “shows that significant improvement in a child’s health, education and welfare can be sustained when early intervention services are provided”.

Managed for the first five years by the Cabinet Office of NSW, the strategy depended on the collaboration of five key government departments – the (then) departments of Ageing and Disability, Community Services, Education and Training, Health and Housing – and non-government organisations funded by Government to provide services to families with children aged from birth to eight years. It focused on reorienting services in NSW to respond to the wave of new knowledge, and to provide services in a way that would address prevention and early intervention. It began a change management process aiming to coordinate existing support and expand services for families to provide the best support possible to children during their first three years.

The implementation of the Families First initiative started with the Mid North Coast, Far North Coast and South Western Sydney in 1999–2000. Families First was progressively implemented across NSW over the next four years, supported by existing resources, plus additional funding of \$54.2 million.

*Northern NSW LHD child and family staff who were able to attend an education day for child and family health nurses, 2014.*



## REMINISCENCES:

**Heather Mackinnon**

**Child and Family Health Nurse Forbes**

“During my time, I’ve organised cooking demonstrations, produced a cookbook and activity book for children, teaching parents to play with their kids. I’ve even organised a fashion parade and a play – as well as being a nurse, I was the co-director of a pantomime! I came here as a bride 34 years ago, and I’m proud to say I started as a clinician and I’ll finish as a clinician.

“When I first started in community health, the farmers would vaccinate their sheep with a ‘six-in-one’ vaccine and at that stage we were giving a ‘three in one’. I joked then that soon we would be doing the same, with safer combined vaccines for our babies, and that is the progress we have made. We started a community based immunisation clinic in Forbes with a mixed reaction of support from the local medical practice. Now practice nurses are employed and they vaccinate, so our numbers have declined slightly, but the overall coverage of babies being immunised is within the State average.

“I have seen big changes to the advice we give to mothers. One of the main changes is placing babies on their backs to settle and even now, despite all the promotion, we still have to encourage and remind mums and carers to do this. You can show the parents a graph with a dramatic reduction in the stats for SIDS but we still see stuffed toys in the babies’ cots on home visits. We have been involved in many promotional activities over the years involving SIDS education and general child safety issues.

“These days there are a lot more local organisations for support to mums and families. When I first started, we worked more closely with DOCS with welfare issues. Now there are more funded non-government organisations, like St Vincent de Paul, Centrecare, Family Support and disability services, schools as communities and our local council staff. With all these services, some doing the role we used to do supporting our families, I do wonder if we coordinate as well as we should.”

Families First asked all staff who supported families with young children to focus on the needs of very young children, provide universal as well as targeted services, develop prevention and early intervention services into local networks, expand home-based support for families by professionals and volunteers, and deliver services in a range of settings where families congregated. Its focus was to improve the environment for children from birth to three years, ensuring that families were fully supported during this time and could nurture their child as fully as possible.

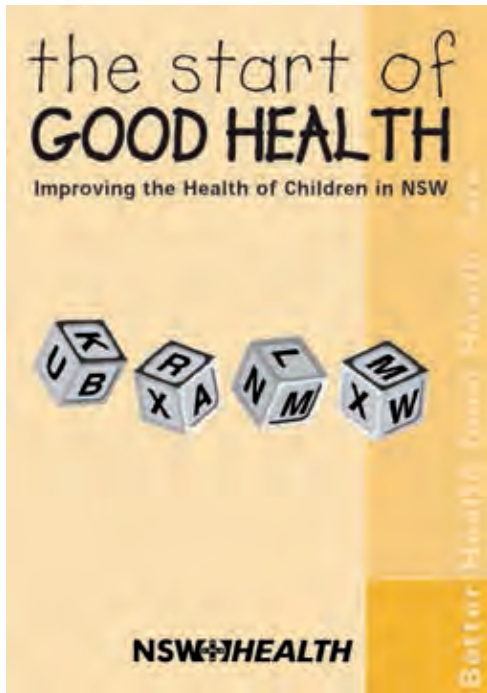
The program manager for Families First within the Cabinet Office was Dianne Hudson. From the beginning, the role of child and family health services was seen as one of the key platforms of the strategy. In an early article promoting the strategy written in 1999, Ms Hudson said: “Maternal and child health services have a particularly important role in supporting new parents. [Professor David] Olds found that prenatal and early childhood home visitation by nurses can reduce the number of subsequent pregnancies, the use of welfare, child abuse and neglect and criminal behaviour for low-income, unmarried mothers for up to 15 years after the birth of the first child. Existing services will be reshaped to broaden the range of settings in which they are provided to families; for example, at home and in centres. Current assessment practice will be developed to include social assessments of the family in addition to the baby’s health. This will allow family stresses to be identified early so that problems can be addressed.”

Families First also supported the development of new services, including enhanced antenatal support by a range of health professionals, more support for new parents in the form of parenting information, structured education programs, playgroups and parent support groups, and a range of interventions for families needing extra support, such as mental health services, drug and alcohol services, family support services, counselling and disability services.

The budget of \$54.2 million over the first four years of the strategy went predominantly to supporting non-government services through grants administered by Community Services. Education and Health each received smaller allocations to help with implementing the changes required to entrench the new philosophy into their systems. The main thrust of the strategy was to rethink how and why existing services were provided.

The implementation of Families First led to real changes at the service level, and to how individual health professionals supported families and made decisions about the services they required. It led to a reorientation of services to address early identification and early intervention, more early home-based support for new mothers, more referrals by child and family health nurses to other support services, finding new ways to access hard-to-reach families, and better joint planning in communities for families across the range of Government and non-government agencies.

By 2002-03, Families First was being implemented in all regions of NSW, and all the then area health services were involved. Coordination of the initiative shifted out of the Cabinet Office to the Department of Community Services. From this time, Families First became known as Families NSW.



## THE START OF GOOD HEALTH

NSW Health was a strong supporter of Families First from the beginning. In 1999, *The Start of Good Health: Improving the Health of Children in NSW* was released, entrenching the implementation of Families First in NSW Health's strategic policy. The Start of Good Health policy built on the *Caring For Health: Caring for Children* policy of the mid-1990s, and provided direction and guidance to the health system to ensure the provision of appropriate and effective services for children and families, based on the premise that early intervention could prevent a range of health issues in later life.

The Cabinet Office recognised the strong link between Families First and *The Start of Good Health*. In 2000, Dianne Hudson published a progress report in which she described the link. She said: "Maternal and child health services have an important role in supporting parents through pregnancy and following the birth of their children. Under Families First, and in line with *The Start of Good Health: Improving the Health of Children in NSW*, the focus is to provide accessible healthcare, support and information about parenting. We also want to link parents to other services as soon as possible if there are signs that they are in need of additional support."

*The Start of Good Health* drew together the 1992 Health Goals and Targets for Australian Children and Youth and the principles and aims of the Families First strategy into a document that described what the health system did, and how it would shift practice in the coming years to improve the health and wellbeing of children; improve the accessibility and appropriateness of health services; improve quality of services; and promote partnerships within health and with other agencies to increase the positive impact on the health of children. The policy included a strong focus on the social determinants of disease, stating clearly that the health system's role went beyond the provision of medical treatment to ensuring that a broad range of factors, including family, social, educational, environmental, economic and cultural, were taken into account when intervening to minimise risks to children and improve their resilience.

One of the specific actions under *The Start of Good Health* was the promotion of universal and targeted home visiting. Although home visiting had been a large proportion of the core work done by the first baby health clinic nurses since 1914, over time there had been a shift to child and family health nurses more usually supporting parents and their babies at child health clinics. *The Start of Good Health* and Families First aimed to increase home visiting by nurses, and the report on progress in 2000 sought to promote understanding of why as well as what had been achieved.

In the report, Ms Hudson said: "Families First is increasing home visiting by nurses because research tells us that better outcomes for children can be achieved, and home visiting by nurses is an effective way to reach those families that don't traditionally access clinic-based services. Mid North Coast,



*The Family Partnership Model shifted the role of parents from being passive to recognising them as having expert knowledge about their child.*



**THE FOCUS ON THE YEARS FROM CONCEPTION TO THREE HAD INTENSIFIED IN RESPONSE TO THE FINDINGS ON BRAIN DEVELOPMENT AND EPIGENETICS.**

Northern Rivers and South Western Sydney area health services are in the process of increasing the amount of home visiting that they provide. An additional \$1 million is being spent on employing extra early childhood health nurses on the North Coast, and more primary health nurses in South Western Sydney, to further expand home visiting services in 2000.”

These moves in the 1990s entrenched the idea that supporting families to provide better health and wellbeing outcomes for children was everybody’s responsibility. By reorienting governance arrangements, they led to a whole-of- government infrastructure that recognised the need to work together. As the new millennium dawned in 2000, agencies in NSW no longer provided services to families in isolation, and families throughout NSW continued to benefit as a consequence.

For child and family health services, the core business of the services had undergone a major shift. The focus on the years from conception to three had intensified in response to the findings on brain development and epigenetics; child protection had become a core part of business; and the assessment of family social wellbeing, parent and infant mental health, and the range of factors that could interfere with the development of strong and healthy parent-infant bonds, continued to increase as part of the service role.



*Mother and baby attend their scheduled health check 2012.*

## CHAPTER 14

### THE SHIFT TO A PARTNERSHIP MODEL

The universal introduction of a first home visit from a nurse for parents with newborns provided an unparalleled opportunity for child and family health nurses to work more closely with families in their own homes.

#### 2001–2007

The evidence about the importance of the early childhood years, the introduction of the Families First initiative, and the growing emphasis on psychosocial health as part of the work of child and family health services meant that there had to be a reorientation of how services were delivered. The universal introduction of a first home visit from a nurse for parents with newborns provided an unparalleled opportunity for child and family health nurses to work more closely with families in their own homes, and to see first-hand the experience of each family returning home with a baby.

The Family Partnership Model was introduced as a way of supporting nurses to better work in the contexts of home visiting and the greater focus on psychosocial health and wellbeing. The model emphasised the need to adopt a facilitative role to assist and enable parents to extend their problem-solving abilities, self-esteem, self-efficacy and interactions with their children.

For many child and family health nurses, who for so many decades had been considered by mothers to be the experts on babies and children, the shift to a partnership role with families could be challenging. Although the level of expertise required of child and family health nurses had not diminished, the role of parents shifted from one of passive recipients of expert knowledge from nurses to one where they were seen and respected as the expert on their own child. This change in the dynamic of the relationship between service providers and parents resulted in a radical change to the way the service was delivered.

Rather than a focus on weighing babies and conducting growth and development checks, child and family health nurses now also needed to consider the psychosocial wellbeing of all families, and in some depth. This led to additional training for the State's child and family health nurses and the increased professionalisation of their role.

#### UNIVERSAL HOME HEALTH VISITING

The majority of services provided by child and family health services were centre-based, with nurses focusing on well child healthcare. But there was a growing awareness among policymakers and healthcare providers that clinic-based services were probably failing to reach those who needed them most – the vulnerable families who rarely crossed the radar of government services, or families who were reluctant to access public health services for other reasons.

The universal health home visit became a cornerstone of prevention and early intervention as a way to ensure every family received a service, and also to identify families who required a greater level of care as early as possible. By reaching families early, it was hoped that problems could be dealt with sooner, before they became more serious. The change involved the delivery of at least one home visit, ideally within two weeks of birth, to every family in NSW by a child and family health nurse. The theory was that by conducting a home visit, the nurse was going into the family's space, rather than the family coming into an unfamiliar place where they did not feel at home. Conversations could be opened up by a nurse on a home visit in ways that would not be possible in a clinic environment. By offering a home visit to every family as a basic, essential and expected service, there was no stigma to using the service. The service would also reach those

who might not otherwise present to an early childhood health clinic but might really benefit from the service.

By offering a universal health home visit, service providers were also showing families that they recognised that often those families who most needed the assistance offered by the clinic were not able to leave the house to attend at the appointed time. These vulnerable families, including those where the mother was suffering postnatal depression or feeling anxious, were likely being missed by clinic-based services.

The key to the home visiting roll-out was its universality – that a visit should be offered to every family as an assumed basic service. By making it part of the services everyone was entitled to, like a doctor or hospital, the home visit became an expectation rather than an impost or embarrassment. There was a strong focus on psychosocial assessment to identify families who needed extra support. The way the service was provided in a Family Partnership Model recognised that any family with a new baby was going through a time of change and could become vulnerable and need extra support.

Many of the services already conducting home health visiting were finding it had benefits. Even without a formal assessment, experience and informed observation could highlight potential causes for concern that might otherwise have been missed, such as smoking in the house, parental isolation or stress between parents.

In 2003, based on the early indications of the benefits of the model, Premier Bob Carr made an election commitment that every family would receive a home health visit from a child and family health nurse within two weeks of the birth. The remaining timeframes for the staged implementation were brought forward. This implementation was a major undertaking: nurses had to be equipped with new skills and practical support, such as mobile scales and motor vehicles. However, redirecting resources to the universal health home visit was seen as a cost-effective strategy as it was now recognised that early intervention and prevention were critical to avoiding health issues in later life.

### A REORIENTATION AND SHIFT TO THE FAMILY PARTNERSHIP MODEL

The other key element of NSW Health/Families NSW Supporting Families Early and Maternal and Child Health Primary Health Care Policy was the move to a Family Partnership Model.

Existing models of care had been based on the 'medical model' that had so successfully been used to guide the care of physical complaints during the first three-quarters of the 20th century. But now the growing recognition of the importance of psychological and social determinants of child and family health led to a realisation that these models of care needed revision. What was required was a broader model of care that opened up conversations and allowed nurses to explore with parents the emotional, cognitive, socioeconomic, cultural and other aspects of their context that influenced child and family health.

The broader interpretation of health issues that contributed to each child and family's outcomes meant that parents would need to bring far more information to each health encounter to complement the information brought by the nurse. It was no longer appropriate for nurses to approach their relationships with their clients as expert clinicians offering advice to mothers seeking information.



*Mother, baby and child and family health nurse at the announcement of the 150,000th universal health home visit at the Community Health Centre in Missenden Rd, Camperdown, 23 February 2005.*

## REMINISCENCES:

**Cathy Smith**

**Child and Family Health Nurse Cowra**

“We used to primarily sit in a clinic and people would come in and have their baby weighed and off they'd go again. We are no longer that person in authority. We now work with the whole family. We are doing home visits and building a rapport. We need to build a relationship of trust so we can work with families to look at factors that may influence parenting outcomes such as psychosocial assessments and domestic violence screening.

“I had one mother who had just had her second child. During a home visit she informed me she felt so different towards this baby, that she felt she had never bonded with the first, who was now three, and was now blaming him for everything negative that happened in the home. She shared with me that her first had been unplanned, was a difficult delivery and that they moved to a new town where she knew no one when he was only one month old. She agreed to a referral to a social worker, and there was a positive outcome.”

Each parent was now considered to be bringing his or her own expertise to the relationship with the health professional – specific expertise on her or his own child, family and situation in life.

The role of the nurse had shifted from being a dispenser of expert knowledge to supporting parents to make the best decisions for their baby, based on their family's unique circumstances, knowledge and health history. For many child and family health nurses, their training had not prepared them for this shift to what had been called a biopsychosocial model of care. It was difficult to let go of the role of expert, which had been part of the identity of many nurses for decades, and move to a new identity as a partner, collaborating with parents to produce improvements in health.

The Maternity and Child Health Policy Unit within the NSW Department of Health was conscious that a change of significant magnitude needed to be supported, and worked with clinicians to find a way to make the change easier. It identified a model developed in Britain, which had been the basis of many successful early intervention programs worldwide. Professor Hilton Davis, a clinical child psychologist from Guy's Hospital in London, and his colleague Crispin Day were approached to help train the workforce in their Family Partnership Model.

From 2002, the UK-based team visited and provided training for staff, eventually developing a local network of trainers. Supervision was initially provided by teleconference and videoconference from Britain until the local networks were developed enough to provide support from within NSW.

Nurses were trained in a completely new way of approaching their work with families. Along with their allied health colleagues, they were also provided with training to help them elicit and discuss the psychological and social problems that many families experience. The training and supervision bolstered their ability to be effective in helping families through a supportive partnership with parents.

As the training and practice within the Family Partnership Model became more embedded within the system, it became clear that while some people found the transition intuitive and easy, others struggled with the change. The training helped to make the change, but to establish a successful partnership between parent and professional required a set of traits that enabled the health worker to meet the parent as an equal, without devaluing their own expertise. Family partnerships became embedded in the university curriculum for child and family health nurses, and the role of the workforce was reshaped as a result.

### THE SUPPORTING FAMILIES EARLY: SAFE START POLICY

In 1989, the Maternity Services in New South Wales review (Shearman Report) had identified postnatal depression as a significant cause of maternal morbidity, affecting 10-15 per cent of all new mothers. This had started a body of work within NSW Health that examined the evidence about postnatal depression and the possible indicators and causes of maternal morbidity, and led in 1993 to the announcement of a statewide review of postnatal depression services by the then Minister for Health, The Hon. Ron Phillips.

**NURSES WERE TRAINED IN A COMPLETELY NEW WAY OF APPROACHING THEIR WORK WITH FAMILIES AND WERE ALSO PROVIDED WITH TRAINING TO HELP THEM ELICIT AND DISCUSS PSYCHOLOGICAL AND SOCIAL PROBLEMS.**

The report of that review was published in 1994, and recommendations included widespread changes such as implementing training for health workers, developing guidelines for management of postnatal depression services, the establishment of specialised psychiatric mother/baby postnatal inpatient services, the institution of antenatal parenting education on normal adjustment to parenting and postnatal depression, and the introduction of screening for postnatal depression using the Edinburgh Postnatal Depression Scale.

Tresillian had released a postnatal depression training package in 1993, which served as a starting point, and the recommendations started to be implemented across the State. By 2001, a series of training packages had been developed, and training in postnatal depression screening, identification and management had become mandatory for the child and family health workforce. Where possible, staff attended training sessions. For more isolated child and family health workers, there was a self-paced distance education package with cassettes. The Edinburgh Postnatal Depression Scale had become part of routine practice.

Even while screening for postnatal depression was becoming established, there was recognition that the evidence was pointing to a need for a more comprehensive approach to psychosocial assessment in pregnancy and the early years. There was mounting evidence of the breadth of psychosocial issues that affected parent and infant outcomes, and that many of the issues could be identified and addressed antenatally. This evidence was being picked up by clinicians and discussed in a series of forums that were the precursor to the NSW Integrated Perinatal and Infant Care (IPC) program, which attracted leadership and funding from the NSW Centre for Mental Health. Aimed at improving the mental and physical health of mothers and their infants, the IPC program was promoted as being based on a population model for universal biopsychosocial assessment of all women during the antenatal and perinatal period. The assessment was intended to identify needs, followed by the provision of appropriate care and support to mothers and their infants at risk for adverse physical and mental health outcomes. This model of prevention and early intervention, including mental health problems and disorders, had not been done anywhere else in the world.

While in the early 1990s both mental health and maternal, child and family health could be seen to be responding to the emerging evidence in parallel, by 2001 mental health, maternity services and child and family health were engaged in a firm partnership to address the issue of perinatal mental health. The work had also reached the national stage, and through the hard work and advocacy of leaders in the field, such as Emeritus Professor Beverley Raphael, then Director of the Centre for Mental Health in NSW, the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000 included a specific strategy area for perinatal mental health.

The Centre for Mental Health allocated national mental health reform and incentive funding to the value of \$3.5 million over a five-year period to support the implementation of IPC. This included training for primary care workers (including midwives and early childhood nurses) in the identification and response to mental health issues for mothers and their infants, and ensured that specialist mental health services supported the network of care provided to mothers



## REMINISCENCES:

Deborah Beasley  
Child and Family Health  
Nurse Blue Mountains

"I really enjoyed the experience of family partnership. It was an opportunity to be able to sit with parents and help them think through ways of using the skills they had to change their lives, and not get stuck in and replicate what had happened to them.

"Home visiting is very important. You see families in their own environment and it tells you a lot about what is happening. The whole house might be full of beautiful furniture and décor, and yet there would be no space for the children and no pictures of baby – that made me think immediately something was wrong, that this family wasn't relating to this child.

"Sometimes you would come in as a stranger and the child wanted to be cuddled by you and they are avoiding their parents. That would tell you everything was not okay. Sometimes there would be no food in the cupboard, the house was dirty, you could just tell the mother had postnatal depression.

"In my experience, there are very few parents who genuinely don't want the best for their children. They just don't know how to do it. We help them think that through and make a difference."

**THE AVERAGE AGE AT WHICH DEAFNESS WAS DIAGNOSED FELL FROM BETWEEN TWO TO THREE YEARS OF AGE TO DIAGNOSIS IN THE FIRST WEEKS OF LIFE.**



SWIS-H neonatal hearing screening in progress.

and infants. Collaboration with the Families First initiative was an integral component of the program. By 2002, five area health services had received funding to develop and trial assessment models. These models provided clinical and procedural experience that was to inform the development of a statewide IPC program.

In 2010, the eventual result of the trials was released. The NSW Health/Families NSW Supporting Families Early package was launched to bring together initiatives from NSW Health's Primary Health and Community Partnerships Branch and Mental Health and Drug & Alcohol Office. It promoted an integrated approach to the care of women, their infants and families in the perinatal period.

The Maternal and Child Health Primary Health Care Policy formed the overarching policy aspect of the NSW Health/Families NSW Supporting Families Early package. With the release of the package, psychosocial assessment both antenatally and postnatally became a core part of the health system for families expecting or caring for a new baby to identify vulnerable families from a universal platform of primary healthcare services, including universal health home visits.

From 2009 to 2010, new positions were funded to support families identified as needing coordinated case management and support for multiple and complex issues. An online education platform, SAFE START Assessment and Screening Training, was developed and rolled out for more than 2000 NSW primary health staff, predominantly from child and family health services.

### CHANGES TO DEVELOPMENTAL SURVEILLANCE

The changes to child and family health practice driven by the evidence and growing capabilities offered by new technologies were not limited to antenatal and early postnatal care. Another significant development flowing from increased understanding of brain development in early life was changes to developmental surveillance.

If hearing loss in infancy is not identified during the critical early years – especially the first year – children's brains will have difficulty forming the neural connections they need to be able to interpret sound meaningfully for the rest of their lives, leading to the possibility of ongoing communication problems. Conversely, if hearing loss is picked up in the first few months of a baby's life and hearing amplification is introduced early, there is a good chance of normal speech development. In fact, the key predictor of the development of communication in children with hearing loss is the age at which their problem was diagnosed.

Early hearing tests were based on whether a child responded to sounds, such as a ticking watch or corn in a bottle. But with the advent of new technology, it became possible to screen babies for hearing loss from birth.

In 2002, the Statewide Infant Screening – Hearing (SWIS-H) program commenced in NSW to offer a hearing screen as soon as possible after birth to all babies. Babies were offered a second test if they received a 'refer' result on the first, and then if necessary were referred to a SWIS-H paediatric diagnostic audiology service.

As a consequence, the average age at which deafness was diagnosed fell from between two to three years of age, with the first hearing aid fitted at four years, to diagnosis in the first weeks of life and fitting of amplification by three to six months of age.



A nurse plots a child's growth in the Personal Health Record, 2012.

Vision screening was once conducted after children had started school, at the age of five or six. Growing understanding of the critical developmental periods for vision meant that this was now seen as possibly too late for effective treatment, prompting a re-evaluation of the timing of vision screening.

With vision screening dependent on children being able to respond to questions about what they could see, population-based screening was brought back to the age of four in NSW with the introduction in 2008 of the universal Statewide Eyesight Preschooler Screening (StEPS) program.

As a result, many children have since been diagnosed with and received treatment for serious vision disorders that may not have previously been picked up in time for effective intervention.



A nurse fills in the Personal Health Record during a health check at Doon-side Community Health in 2012.

In addition to hearing and vision tests, from 2007 greater emphasis was placed on parents having expertise in their own children and therefore being best placed to identify possible developmental problems, as part of the parent-led model. In line with growing parental health literacy, in 2007 major changes were made to the personal health record (PHR, or the Blue Book), and health checks from six months were enhanced with the addition of the Parents' Evaluation of Developmental Status (PEDS). The PEDS is an evidence-based screening tool filled out by parents to help harness their knowledge of their child to help with early detection of developmental delays.

In practice, it meant that before they saw the nurse, parents had already answered a set of questions in the personal health record that focused their own concerns, if any, about their child's learning, development and behaviour. Answering the 10 questions, parents could respond 'yes', 'a little', or 'no', and add a comment to prompt their conversation with the nurse if they wished. The child and family health nurses also used their knowledge and experience to explore parents' concerns, or raise anything the nurses observed that may not have been noticed by parents. Based on the outcome of this process, a secondary screen, the Ages and Stages Questionnaire (ASQ) and/or the ASQ: Social and Emotional (ASQ:SE) could be given to parents to take home, providing a more detailed tool designed to pick up more specific issues. The introduction of these two tools has offered tangible ways to draw out parents' observations and worries about their children, no matter how small, to inform assessment of children's needs and help with accurate referrals to other services as needed.

"Building on the philosophy of parent as expert, PEDS meant we moved from screening to surveillance. It meant we were getting more accurate information and much earlier identification as to when a child might have developmental problems," says Associate Professor Elisabeth Murphy, now Senior Clinical Advisor for Child and Family Health in NSW Kids and Families.

The introduction of PEDS not only drew out parents' knowledge, it could bring them to appointments prepared and it actively involved them with the nurse in the assessment, putting them in a better position to make informed decisions.



The Personal Health Record (Blue Book) 2013.

## REMINISCENCES:

**Robyn Johnston**  
**Child and family health nurse**  
**Sydney's Northern Beaches**

"When I started in child and family health in 1999, I was very excited when one of the families I was seeing had enrolled in a breastfeeding research project and I needed to complete a questionnaire with her and forward it to the research contact person. The research was longitudinal in design and examining the length of breastfeeding in Northern Sydney and why mothers were deciding to wean. I'm not sure if this spurred my interest in research but soon after that I began my Masters of Public Health, and in 2010 I was accepted as a Doctor of Philosophy student at the University of Technology, Sydney.

"Evidence-based practice is the foundation of child and family health nursing, and in my time as a child and family health nurse I have witnessed the implementation of programs that are evidence-based. For instance, the use of the psychosocial assessment, including the Edinburgh Postnatal Depression Scale, which are underpinned by research demonstrating the effect of family violence on children, both antenatally and postnatally, the effect of depression on attachment. Early identification of developmental issues through the use of parent-led development questionnaires, such as PEDS, allow for early intervention. Other screening tools currently used in child and family health that are based on previous research include StEPS and SWIS-H.

"The child within the family has always been the focus of child and family health and our clinical practice ensures that this will continue into the future."

In 2013, the Personal Health Record was updated again. For the first time, the review of the resource was informed by an online survey that attracted over 4000 responses. In line with feedback from parents, the new Personal Health Record included information about developmental milestones at the beginning of each scheduled health check, providing parents with an easy checkpoint to refer to when they were answering questions before each health check. The growth references were also updated in line with new international standards, and a greater emphasis was placed on web links and online services, because parents wanted information to be up to date and easily accessible.

### ABORIGINAL MATERNAL AND INFANT HEALTH STRATEGY

Despite the substantial gains being experienced by mothers and babies across the general population, the health outcomes of young children in one section of society remained a matter of extreme concern: Aboriginal families.

The Aboriginal Perinatal Mortality Project reviewed Aboriginal perinatal deaths and reported some shocking statistics: in 2000, the NSW Aboriginal perinatal mortality rate was 17.9 per 1000 births, compared to the non-Aboriginal rate of 9.7 per 1000 births. This was largely attributed to prematurity and low birth weight – 11.9 per cent of Aboriginal babies were classified as low birth weight, almost twice as many as non-Aboriginal babies (6.4 per cent).

The report estimated that more than half of Aboriginal mothers did not receive antenatal care, resulting in increased perinatal mortality and morbidity because pregnancy complications were not being addressed.

Under the leadership of the NSW ministerially appointed Maternal and Perinatal Committee (with the support from the then NSW Minister for Health, Andrew Refshauge), action was taken to address Aboriginal outcomes. It was clear that, to achieve success, creative public health strategies would be needed to increase the self-esteem of Aboriginal women, raise standards of living and create strong, cohesive Aboriginal communities. To increase access by Aboriginal women to maternity services, these services would need to be culturally appropriate and accessible.

The NSW Aboriginal Maternal and Infant Health Strategy (AMIHS) was funded by NSW Health in December 2000 and rolled out to seven sites in 2001. It aimed to improve the health of Aboriginal women during pregnancy and decrease mortality and morbidity in their children by introducing targeted antenatal/postnatal programs and offering statewide training and support for midwives and Aboriginal health workers who provided these services.

AMIHS took a holistic view of health, acknowledging the importance of issues such as transport, housing and safety. It identified and sought to address the barriers preventing Aboriginal women from accessing services, which ranged from the practical (lack of transport or child care) to cultural (a suspicion about mainstream government services, or a lack of recognition of the need for antenatal support).



**THE SERVICE DEVELOPED A PARTNERSHIP MODEL BETWEEN ABORIGINAL HEALTH WORKERS AND MIDWIVES, ACKNOWLEDGING THAT ABORIGINAL COMMUNITIES WERE NOT A HOMOGENEOUS GROUP.**

The strategy extended the postnatal period from six to eight weeks and ensured a continuum of support by linking maternity services to child and family health or community services. Crucially, the service developed a partnership model between Aboriginal health workers and midwives, acknowledging that Aboriginal communities were not a homogeneous group but that services needed to be culturally appropriate for each community.

“It was about having flexibility within the service, having a women’s reference group as part of the model, and developing a trusted service. I think being located in the community and having an Aboriginal health worker as part of the service was key,” says Elizabeth Best, Manager, Priority Populations Unit, NSW Kids and Families.

The AMIHS also saw the introduction of a range of innovative community developments designed to engage Aboriginal communities. One of these, the Birra-Li Aboriginal Birthing Service in Newcastle, set up an Aboriginal women’s wisdom group to support women in parenting and family issues, and conducted wide community consultation and development as well as providing primary healthcare. It partnered with several external agencies to address the other needs of Aboriginal mothers, for example by setting up the Karuah Safe Drive Program to help Aboriginal women obtain their driver’s licence and address other road safety issues highlighted by the community.

An evaluation of the AMIHS found that the service had demonstrated clear improvements in perinatal morbidity and mortality: the rate of low birth weight babies in the services decreased from 15 per cent in 2003 to 12 per cent in 2004, and the number of perinatal deaths fell from 18.6 per 1000 births in 2003 to 5.4 per 1000 births the following year. The low numbers involved meant these findings were not statistically significant, but they were nevertheless encouraging. Premature births also dropped significantly – from 20 per cent in 1996–2000 to just 11 per cent after the establishment of the AMIHS.

The evaluation found significantly more women in the AMIHS were accessing services, with 78 per cent attending their first antenatal visit before 20 weeks of pregnancy. The women were very satisfied with the programs, especially the home visits and the help with transport to appointments.

They were particularly positive about the level of continuity provided by a culturally appropriate caregiver working with a midwife. The close connection that these teams established with the communities meant they could provide home visits and follow up women, especially those who were hard to find.

It also provided more holistic care by linking with the Brighter Futures program, a prevention and early intervention program run by the NSW Department of Community Services designed to build parents’ capacity to care for and nurture their children. While there was initially some concern among AMIHS workers that linking to Brighter Futures would reduce the level of trust they had built in the communities, after lengthy discussions the advantages of the link started to become apparent, as it was able to provide additional support to families.

With a high level of skill and commitment, the teams built trust with the Aboriginal mothers, finding that they could elicit more clinically relevant information from them than

had previously been forthcoming; for example, about their smoking, marijuana or alcohol use during pregnancy.

Another important strength of the program was that it provided training and support to the midwives and Aboriginal health workers; for example, via a maternal and infant health course, an annual conference and through telehealth sessions.

Initially funded to set up new services in five local health areas that served large Aboriginal populations, the AMIHS was extended to seven services. After the evaluation showed it was making a difference, funding was provided by NSW Health and matched funding was provided by the NSW Department of Family and Community Services for five years under a memorandum of understanding. The service has now expanded to 45 sites and over 80 locations in NSW.

The evaluation of AMIHS highlighted that there needed to be a strategy to provide a seamless transition to early childhood health services – the gains achieved for mothers and babies were not being carried through the next few years to allow Aboriginal children to start school at the same level of advantage as non-Aboriginal children. As a result, a child health extension of the AMIHS program in selected sites has been funded by NSW Health.

Building on the success of the AMIHS model, Building Strong Foundations (BSF) for Aboriginal Children, Families and Communities services provide culturally safe and secure early childhood health services that work with parents, carers and the local community to support the health, growth and development of Aboriginal children from birth to five years, so they are healthy and ready to learn when they start school. There are currently 15 programs across NSW.

Key to achieving this outcome is an acknowledgement of the importance of a holistic and whole-of-life view, referring to the social, emotional and cultural wellbeing of the whole community. BSF program planning and service provision is informed by service reference groups, which includes representation from local elders as well as other key stakeholders and service providers. This also ensures that strong linkages are kept with Aboriginal mothers and babies programs, including the AMIHS, as well as mainstream maternity and child and family health services.

The BSF staffing model is underpinned by a team approach, with care provided by a child and family health nurse and an Aboriginal health worker. In some locations, the core team is supported by other disciplines, including social workers and allied health therapists such as dietitians, speech pathologists and occupational therapists.

As well as providing health checks and referrals to specialised healthcare, an important part of BSF services is their close work with communities on innovative ways to improve Aboriginal children's health. Examples include the establishment of a community garden, which not only generates a supply of healthy food but also provides a safe, positive community space for Aboriginal children, mothers, fathers and carers; and the digital diary project, a partnership project with the local TAFE, which involved mothers using multimedia tools to document the progress of their children, and which subsequently led to some mothers starting other study at the local TAFE.

## CHAPTER 15

### CHILDREN'S WELLBEING: A SHARED RESPONSIBILITY

The science led to renewed interest in identifying risk as early as possible to avoid child abuse occurring.



Justice James Wood with NSW MP Linda Burney at a Keep Them Safe event – the launch of Alternative Dispute Resolution, 18 June 2010.

Source: Keep Them Safe Newsletter, Issue 8

### 2008–2012

By 2008, the evidence on the impact of child abuse and neglect on the brains of developing children was firmly established. Research such as the Adverse Childhood Experiences (ACE) Study had demonstrated the lifelong impact of abuse and neglect and the cumulative effect of multiple adverse events. The ability of the study to link poorer health outcomes at 40 and 50 years of age to early childhood experiences was key evidence of both the potential and actual huge cost of these preventable determinants of health to the health and human services systems as well as to individuals over time.

Evaluation of early childhood interventions were also starting to demonstrate ways to offset such costs with analyses by credible groups such as the RAND Corporation demonstrating that specific intervention programs overseas could accrue a \$17 return for every \$1 spent in early life, by the time the child reached middle age.

There was also mounting international research that tertiary-level child protection services, while necessary, were not a sufficient answer to the problem of child abuse and neglect. There was a much greater chance of success in achieving improved outcomes with earlier intervention, before abusive parenting practices became entrenched.

The science was also showing that the best outcomes would be achieved from intervening to prevent exposure to adverse experience at all, and this led to renewed interest in strengthening the support and intervention available to families early, and identifying risk as early as possible to avoid child abuse occurring.

The 2008 Wood Special Commission of Inquiry into Child Protection Services in NSW recognised this, with early changes to the scope of the inquiry to include prevention and early intervention within the terms of reference. The investigations of the Commission defined the child protection system as all services involved with, caring for and protecting children, not only those involved in intervening once risk of harm was suspected. The NSW Government response to the recommendations of this inquiry, Keep Them Safe, altered the landscape around child protection with its comprehensive suite of changes to prevent child abuse and better respond to the abuse and neglect that had occurred.

The changes to the system altered the way all agencies, including Health, were expected to work. At the same time as the threshold for statutory intervention was raised, the responsibilities of other parts of the system increased to find, monitor and assist those families below the threshold. The changes made it clear that a report to any part of the system about child abuse or neglect was the start of involvement in changing the situation, not the end of that agency's responsibility, as it had often been seen in the past.

In addition, the funding for new services included specific evidence-based programs for children who had not yet been abused or neglected, but whose families were experiencing a number of risk factors associated with a higher potential for later entry into the statutory child protection system. Leading the list of programs with a robust basis in the evidence was sustained nurse-led health home visiting.

## REMINISCENCES:

**Glenda Wilson**  
**Child and Family Health Nurse Narellan**

“What makes a good child and family health nurse? I think it’s someone who can listen, who can be empathetic to the mother and her needs. I have been working on a sustained home visiting program. It can take 12 to 17 months before some of them are comfortable to tell you they are living with domestic violence. You can imagine how hard it is to establish a relationship if you only have one visit. You hope you get her involved in the service and eventually they trust you enough.

“We don’t offer a service that just a nurse at the doctor’s surgery can offer. We have best practice, we have to follow policies, we have to keep up professional development to keep our registration. People don’t realise how much work we put into what seems like a simple baby check.

“A sense of humour is important, and you have to value motherhood. I think we have lost the value of the mother in society. Child care is important and going back to work is important, but being a mother is important too.”

## SUSTAINED HOME VISITING

Strong evidence had emerged that vulnerable families would benefit from supportive interventions at a grass-roots level led by child health nurses – such as sustained health home visiting.

Professor David Olds’ work, whose intervention involved sustained home visitation in the US, and two other trials in Australia had provided strong evidence that this kind of intervention would work for vulnerable families and was cost effective.

The first Australian randomised controlled trial of sustained home visiting commencing antenatally and continuing until the child turned two for at-risk mothers in a disadvantaged community (the Miller Early Childhood Sustained Home-visiting trial, MECSH) recruited at-risk mothers around Liverpool in Sydney’s west before birth and provided them with up to 25 visits in the first two years of their child’s life.

The follow-up of the three-year pilot established that sustained nurse home visiting programs enhanced outcomes, resulting in better breastfeeding duration and, for some subgroups of mothers, better experience of motherhood and children’s mental development. Based on these findings, recurrent funding for a program site of sustained health home visiting was provided in NSW.

The NSW Government, based on the recommendations of the Wood Commission into Child Protection Services in NSW, had also recognised sustained home health visiting-type strategies as an effective prevention and early intervention approach to improving outcomes for children living in at-risk families, and funding for a further two sites was provided.

In 2010, two further program sites were initiated. All five programs were funded to further refine the program and define the target group that would benefit most from this intervention.

Sustaining NSW Families, as the program is now known, is a child and family health nurse-led intervention with families receiving a minimum of 26 home visits. The program uses the SAFE START assessment and pathway to identify families that may benefit. Families enter the program ideally in early pregnancy, but can enter up to four weeks after the baby’s birth. A complex intervention, its aim is to improve the health, development and wellbeing outcomes of children and to support and strengthen the capacity of parents to provide a safe and nurturing environment. That means working with the parents to create healthy relationships with their children that do not replicate the negative experiences they may have had in their own childhoods and relationships.

“It’s about creating an environment to plan the things children need to be healthy socially, emotionally, cognitively and physically, and work through a structured program,” says Deborah Beasley, Manager, Child and Family Health Unit.

“It contains a lot of preventive health promotion, around, for example, breastfeeding, immunisation, nutrition, exercise and safe sleeping, but it also looks at what the parents want to change in their lives as parents. It assists them to keep the baby in mind, which is about meeting the emotional, social, cognitive and physical needs of their child in the critical period of brain development, and helps them work together with professionals to achieve the best outcomes. It’s really using the skills of child and family health nurses.”

## ESTABLISHMENT OF NSW KIDS AND FAMILIES

The Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals was launched in 2008 following public interest in a series of adverse events that had occurred in NSW hospitals. The Commission was conducted by Peter Garling, SC, and among the 139 recommendations in his final report were sweeping changes to the NSW health system that aimed to modernise work practices, administration and equipment.



*Narellan Community Centre.*

He devoted a section of the report to babies, children and young people, recommending that NSW Health should establish a Children and Young Peoples' Health Authority "to provide all healthcare for children and young people, throughout NSW, whether in the community, or in a public hospital, commencing with neonates who require tertiary or higher level services and concluding with young people at the end of their 16th year of life".

"The guiding principle of NSW Kids is that the paramount consideration in the provision of healthcare is the promotion of the health and wellbeing of the population and the prevention, diagnosis, treatment and cure of the illnesses of the population in a manner which best promotes the wellbeing of children and young people," the report said.

NSW Kids was to maintain a proper funding balance between community-based services and acute care in hospitals, ensure that all healthcare for children was consistent, and ensure that there were adequate services and facilities for the provision of mental health services to children and young people. It was also to provide education and training to all clinicians about the health and wellbeing of children and young people, provide public education, and commission and conduct research.

The Minister announced in August 2011 the formation of an expert group, chaired by the Hon. Ron Phillips, which consisted of a number of professionals who brought a variety of skills and experience to consider how such a body could lead to improved health outcomes for children and young people in NSW.

NSW Kids and Families, a title chosen to reflect that its services were broader than just those for children, formally came into being on 1 July 2012. Its board was chaired by the Hon. Phillips and members included Clinical Professor David Bennett, AO; Ann Brassil; Christine Corby, OAM;



*Ms Joanna Holt, Chief Executive NSW Kids and Families, and the Hon. Ron Phillips, Chair of NSW Kids and Families Board, launch Healthy, Safe and Well: A Strategic Health Plan for Children, Young People and Families 2014–24 on 5 December 2014.*

## REMINISCENCES:

**Wendy Urquhardt**  
**Child and Family Health**  
**Nurse Wagga Wagga**

“Back in the 1980s, we were doing lots of sleeping and settling with mothers. I almost can’t recall ever seeing a father come in at that stage.

“A lot of the clients were out-of-towners from smaller towns. We certainly knew some of them had postnatal depression, but we didn’t have the formal Edinburgh score.

“One of my clients had been with us all day. She was a well-educated woman with her first baby. She ticked all the boxes and then she said: ‘I feel so much better now. I don’t feel like I want to throw him on the fire.’ We asked her to come back in again and then reassessed that she was safe and contacted her husband. She did end up with fairly mild psychosis. I guess I realised someone may tick all the boxes and may look good and be highly educated but may still suffer depression. From then on we went a little bit more in depth with the mothers.

“Today you’d pick it up more easily. We are now more confident talking about it and engaging family members. Also the general population is now more aware of depression – they go to see their GP; we’re not always the first one to pick it up.”

Dr Susie Piper; Professor Graham Vimpani, AM; and Emeritus Professor William Walters AM.

Its mission was to champion the health interests of children and young people at home, in the community or in hospital, including health services for babies, children, adolescents, mothers, parents and families.

Its strategic health plan for children, young people and families provides direction and a system-wide approach to promoting good health and improving health services specifically for mothers, babies, children and young people.

As a result, there will be improved health, early intervention and the delivery of integrated, best-practice care in five strategic areas: during pregnancy and birth, promoting good health for children and young people, addressing risk and harm, intervening early for at-risk children, and delivering best-practice, age-appropriate and culturally responsive care as close to home as possible across the State.

NSW Kids and Families recognises that health is best served by taking a ‘life-course’ approach, addressing health needs from before birth through to young adulthood. This approach recognises that healthcare is dynamic and that life experiences and social, biological and behavioural issues can all impact health and development over time. It also recognises that caring for children, young people and families in NSW is a joint effort and that partnership between government, community and private health sectors is crucial.

The establishment of NSW Kids and Families ensures that the health workforce will be further developed and supported, including all levels of clinical staff, promoting coordinated healthcare for young people, and implementing eHealth tools to support staff. The plan provides a blueprint that will focus attention where it is needed to create a healthier future for children in NSW, no matter where they live.

## CHAPTER 16

### ADAPTING TO MODERN TIMES

Child and family health nurses have evolved so that the service they provide is responsive to local community needs.



*Community Health Centre at Royal North Shore Hospital, home of the Northern Sydney Local Health District Child and Family Health Directorate.*

### 2012–2015

The proliferation of technology, women returning to work earlier, the greater role of fathers and grandparents, and changing immigration patterns have all prompted child health services to adapt – in terms of both delivery and educational messages that need to be locally responsive.

Child and family health nurses working with parents have evolved and no longer only follow a prescriptive curriculum in services offered to mothers. Now, they also incorporate other social determinants of health in the issues they address, and the service they provide is responsive to local community needs. Mothers' groups have evolved into parents' groups, while shifting immigration patterns and the changing ethnicity of neighbourhoods have led to services being adapted with the delivery of culturally targeted programs.

Early childhood health nurses have become increasingly professionalised over the past 25 years, and today the current accepted qualification for a child and family health nurse in NSW is the completion of a recognised postgraduate education program.

### EARLY CHILDHOOD HEALTH SERVICES TODAY

Primary child and family health services are currently available from about 500 sites across NSW. For well families, recommended contact with primary health services at a minimum consists of an initial home visit soon after the birth followed by a series of developmental checks outlined in the NSW Personal Health Record (PHR, or the Blue Book) and the provision of parenting support and advice.

The service sees almost all of the 100,000 babies born each year in NSW for their first health check, with about half of families continuing to use the service throughout the first year. Child and family health nurses regularly see about one-third of children aged between one and four.

Child and family health nurses today focus on a significant range of parenting and child health topics that include the benefits of breastfeeding, parent/infant attachment, parenting skills, sleep and settling issues, maintaining support networks, and the achievement of developmental milestones. There continues to be a strong focus on early intervention, and services are delivered under a strengths-based partnership model with parents.

However, the main function of these primary services today is to identify families for whom more support is required and to provide that support, or link families into support, where possible. Babies and children with significant issues may be referred to the secondary tier of services involving nursing, allied health and other support services, while tertiary services for those with complex problems are offered in the form of residential and day stay programs through family care centres or Tresillian and Karitane.

### THE IMPACT OF THE HEALTH REFORM AGENDA

In the lead-up to the Federal election in 2007, the then leader of the Opposition, Kevin Rudd, promised to review the national health system.



NSW map of Local Health Districts established 1 January 2011.

The National Health and Hospitals Reform Commission, chaired by Professor Christine Bennett, was established in February 2008, and its report, released the following year, recommended substantial reform, including a boost for primary health and preventive health measures.

In 2011, the NSW Government implemented changes to the governance of NSW Health, which aimed to allow each individual part of the health system to focus on its core strengths. Regional health services were given far more autonomy and responsibility while the role of the Ministry and other NSW level parts of the health system were changed accordingly.

As part of the new governance arrangements, Local Health Districts (LHDs) were given clear responsibility and accountability for governing hospital and health service delivery for their local district under Service Agreements with the Ministry of Health. It means that the LHDs are responsible for prioritising and shaping the services they offer, but this can be challenging for local child and family health services, which seek to influence longer-term health outcomes, to compete for scarce resources against more acute services with more immediate measurable outcomes.

Despite the changes to accountability as a result of the reforms, the Maternal and Child Health Primary Health Care Policy (2010) continued to provide the policies and guidelines for the way child and family health services were to be provided. The need to include psychosocial screening and assessment in the service provided to every family through the comprehensive primary care assessment model, SAFE START, and the provision of maternal and child primary healthcare services including universal health home visiting, remains current.

### THE PROFESSIONALISATION OF CHILD AND FAMILY HEALTH NURSING

Child and family health nursing is a highly specialised profession: nurses are required to work in partnership with clients, undertake home visiting, offer a range of clinic-based services and engage with local services.

Based on their education, experience and skill, they must work with parents and carers to rapidly understand the family context, the physical, social and emotional health of each member, and the impact that may have on the child. They need to use this information to differentiate the low risk from high risk, to understand what additional advice and support parents may need and refer appropriately.

Child and family health nurses must understand normal child development from infancy to school age, what constitutes an acceptable variation for achievement of each developmental milestone or area, and what constitutes a delay. They need to be able to educate and support parents on infant sleep and settling, feeding and nutrition, play and stimulation. They need to be able to help parents provide safe and healthy environments for their children, recognise risks and address them.

They need to be able to recognise the early signs of illness, and to provide the appropriate advice and support on child health issues from immunisation to obesity to injury. They need to have high-level communication skills, an understanding of perinatal mental health,



## REMINISCENCES:

**Cathy Bye**

**Child and Family Health Nurse Narellan**

“When I first started in the 1970s, it was very much that the mums were in and out – you were just seeing numbers. You didn’t ask how they were feeling if you thought there were another 20 people waiting. We now focus on mothers and babies and you take the time and do more checks.

“Mothers used to come in and it was, ‘Hello Mrs B, your baby is six months old, this is what you do’, and they were out the door. Now we will ask what he’s doing, listen to what they want and actually give them some power, the information they want, rather than just telling them.

“Parents are still very much wanting this service. In the Macarthur area, we used to have 12 as our maximum in mothers’ groups, and now it’s up to 16 to 18 just to get the mothers into groups. But mothers’ expectations have changed. They will say ‘he’s not sleeping through the night’ and that might be a two- or three-week-old baby. It’s such a shock for them. They are seeing on the media celebrities looking really glamorous after they have had a baby, but they have got all the supports. The mothers have unrealistic expectations.

“I think our role is going to be increasing and our responsibilities will increase. Certainly with hospital admissions being reduced, the sooner women go into the community the greater the responsibility on the community to pick up the pieces. For example, breastfeeding rates have gone down with mothers being discharged early, so we can try to keep breastfeeding up at home by supporting them.”

and knowledge of what constitutes postnatal distress, anxiety and depression. They need the knowledge to detect child protection risk, potential domestic violence and other interpersonal issues, and the skills to respond appropriately and refer as needed.

They need to be able to deliver their services in homes, clinics, preschools, schools, community halls and shopping centres, and to groups or individuals. There are few branches of nursing that require this breadth of skills.

However, 25 years ago the picture of child and family health nurses was different. Many were qualified as midwives and had also achieved registration status as mothercraft nurses, but some registered nurses were employed as generalist nurses to work in child and family health. These nurses in many instances had not completed an accepted child and family health nursing qualification. Those who understood the specialist nature of child and family health nursing were concerned that, from a professional and employment perspective, their skills were not being recognised.

In the early 1990s, a small group of nursing unit managers and a nurse academic recognised the need to give child and family health nurses in NSW a more united professional voice. The Child and Family Health Nurses Association (CAFHNA) was established in 1990 with the aim of promoting the role of child and family health nursing as a specialty field, providing professional development opportunities for nurses, and providing input into policy development and healthcare decision-making at all levels of governance and government.

With no existing standards or competencies for professional practice in child and family health nursing, at the time CAFHNA was established there was great variability of practice. The Association has taken a leading role in overseeing professional standards, education and information sharing during the sweeping changes brought about by the move to a Family Partnership Model. It has also had an important influence on government policy, providing a perspective that can only be given by child and family health nurses, as opposed to midwives, paediatric nurses or registered nurses.

At the same time, child and family health nurses started to come together to share information. Before the 1990s there were few opportunities for nurses to attend conferences – the available conferences were either too expensive, too focused on medicine, or covered aspects of nursing that were not relevant to child and family health.

In January 1993, the first child and family health conference was held at Macquarie University in Sydney. Run by Northern Sydney Health, it brought together a group of people who shared a common interest in child and family health to discuss the way forward for the profession and to offer clinical staff the opportunity to learn from one another in a professional environment.

CAFHNA now holds study days and local conferences and is a member of the national Maternal, Child and Family Health Nurses Australia Inc. (formerly the Australian Association of Maternal, Child and Family Health Nurses), which holds a biannual conference and publishes a journal, The Australian Journal of Child and Family Health Nursing.

One of the biggest issues tackled by CAFHNA was to establish standards and competencies for child and family health nurses that could be recognised by individual employers and by NSW Health. As a consequence, most child and family health nurses now have postgraduate qualifications and are required to achieve and maintain a minimum competency standard.

Training evolved from hospital-based training, which involved a basic qualification usually coupled with midwifery and then child and family health, to the university sector. The graduate certificate in child and family health nursing is now offered by the University of Western Sydney, the University of Technology, Sydney (UTS) and the College of Nursing.

These courses are all based on a professional framework and cover core information about child health, health promotion, primary healthcare and running groups, with a much greater emphasis today on infant and perinatal mental health.

With education and research becoming increasingly important in the daily work of child and family health nurses, in 2006 Professor Cathrine Fowler, the former Head of Education and Research at Tresillian, became the first Chair of Child and Family Health Nursing in NSW, a position at UTS sponsored by Tresillian.

A key role of this clinical chair has been assisting in developing the professional capacity of child and family health nurses as well as undertaking research into child and family health. Much of this work has been promoting the need for child and family health nurses to use a range of assessment tools and nursing strategies that will support parents in the care of their children and in maintaining the health of their family. Tools and strategies such as the Edinburgh Postnatal Depression Scale and the NCAST Parent Child Interaction Assessment Scale, strengths- and relationship-based approaches that are evidence-based and validated for nurses means their practice is well informed by evidence of what actually works.

*The Child and Family Health Centre in Alexandria celebrated 100 years on 5 August 2014.*



The way nurses are educated has shifted over the years. There is increasing emphasis on perinatal mental health – not just postnatal depression and anxiety – and nurses also learn about infant mental health, parent infant/child interactions, perinatal mental health and working in partnership as part of their everyday thinking. Today, child and family health nurses are more likely to obtain higher-level qualifications that equip them to search and critically appraise the academic literature and continually update their skills as new evidence emerges. Many child and family health nurses now hold a Master's degree and an increasing number are involved in PhD studies.

At the same time as child and family health nurses were becoming more professionalised, there was recognition by paediatricians that similar issues – behaviour management, child protection, child development and population health issues – were becoming increasingly important and impacting on their daily work, rather than acute sickness in the hospital setting.

There was a decision to establish the Faculty of Community Child Health within the Australian College of Paediatrics, which began to work on the role of community child health, professional development, curriculum, workforce issues, policy and advocacy. With the amalgamation of the Australian College of Paediatrics within the Royal Australasian College of Physicians, there was a change of name to the Division of Paediatrics and Child Health, and the Faculty became the Chapter of Community Child Health within the Division.

Over time, nurses have taken more responsibility in the area of child and family health as they have become more professionalised in partnership with community paediatrics.

### THE CHANGING DEMOGRAPHIC PROFILE OF FAMILIES AND MULTICULTURALISM

Recent years have seen child and family health services evolve in line with the changing demographic profile of families.

There is a trend towards women having babies later in life and returning to work earlier due to financial or professional imperatives. Young children are more likely now to spend time in child care, meaning it is becoming increasingly important to educate child care workers in the importance of early development, prevention and early intervention, and how to impart these messages to parents.

Unlike 25 years ago, it is not always the mother that has sole responsibility for young children, with fathers and grandparents playing an increasing role. Child and family health nurses are also increasingly recognising the specific experience and needs of blended and same-sex families.

Mothers' groups have now become parents' groups and may include any combination of caregivers. The groups have largely moved away from the curriculum model – a structured course over several weeks – to groups where parents can drop in and share their experiences. Parents' groups have evolved to suit the demographics in their local area. They are often parent-led and locally responsive, placing a greater emphasis on local social and individual needs. The skills in facilitation required by child and family health nurses are now very different from the didactic style of group leadership once often used for parent education sessions.



Parents at the Carlingford Early Childhood Health Centre in 2014.

Photo used with permission courtesy of Northern Sydney Local Health District.



Images of the trial app for the e-Blue Book project 2012–14.

## REMINISCENCES:

**Lorraine Thomas**  
**Child and Family Health Nurse Narellan**

“I think mothers often don’t know how to mother any more. For some women it’s instinctive, but for others you have to teach them basic things – how to read and how to make eye contact with their babies – they are not doing that like they used to 10 years ago.

“Social media has been amazing in terms of information, but human connections have taken a slide. We have to teach mothers to connect with their children again, to not be so fixated on social media or big screen televisions. Television isn’t enough – mothers have lost the art of being able to play and engage with their babies.

“We are looking at attachment theory and seeing how important it is to establish that secure attachment from the start. With all the modern information about brain development and early childhood stimulation, our role is more important than ever.”

A much greater recognition of the cultural needs of Aboriginal families has raised awareness of the need to provide culturally appropriate services. Changing immigration patterns have also necessitated changes to local services, such as specialised care for refugee families in both rural and metropolitan areas of NSW. Statewide policies on cultural competency and the use of interpreters have set the framework for local service providers to develop programs suited to these local needs.

Universal child and family health service provision means all families are entitled to a child and family health service as a minimum – but what the Family Partnership Model means is that nurses are now better able to deliver these in a more contextualised manner.

The Family Partnership Model enables parents and families to work with the nurse to overcome their difficulties, build strength and resilience, and fulfill their goals more effectively.

### THE IMPACT OF TECHNOLOGY

Like all areas of healthcare, child and family health nursing is having to evolve fast to meet the new pressures associated with emerging technology.

The technological revolution has impacted services in two ways. Two decades ago, professional advice was offered by child and family health nurses face to face in the clinic environment, while social support for the daily business of bringing up a child came from social mothers’ groups.

Today, electronic medical records and the introduction of eHealth mean child and family health nurses are coming to terms with changes in the way they record their interactions with families and how those records can be used. The advent of electronic records can bring a computer or a tablet into the interaction with parents, with possible changes to the interaction as a result. Ensuring that the engagement with the client is not affected by the presence of the screen is a challenge for the modern health professional.

But perhaps more significant is the effect technology has had on parents and children. The easy and immediate availability of information on the internet means that, to some extent, parents no longer feel the need to turn to experienced child and family health nurses for assistance.

While some websites do provide excellent information for parents, it is of constant concern to health professionals that other information is available that has no basis in evidence, no relationship to established clinical standards and no quality controls. It can be very difficult for a parent to discern the real source of information on the internet, and there is a risk that parents may be misinformed or unduly worried by what they find there, or may be reassured when in fact they should be trusting their instincts and seeking professional help. In addition, obtaining information from the internet rather than from a child and family health nurse means parents may lose the benefit of the relationship with a trusted health professional, and the advantage of having a nurse’s knowledge and experience applied to their personal situation.

In the last few years, digital devices have replaced face-to-face social interaction for some parents and young children. For many parents, mothers' groups have given way to Facebook groups, story books to iPad games, conventional settling methods to a screen. It is possible that instead of gazing into her baby's eyes as she breastfeeds, today's mother is just as likely to be scrolling through her phone.

The accessibility, flexibility and speed of new technology open up many opportunities and advantages for children and parents. As with all things, however, it appears that balance in the use of technology is important for health and development. While it is too early to fully understand the implications of this for early brain development, there are serious concerns that the widespread overuse of technology such as smartphones, tablets and computers may be posing risks to children's health and development. Concerns are emerging about the effect of these devices on developing vision, on sleep, and on learning social skills and engaging with parents and others, as screen time reduces the opportunities for children to learn social skills, language and other key life skills.

Technology and mass marketing are also increasing pressure on families. Social media means that many parents are bringing up their children in public view, creating anxiety due to constant comparison to others. At the same time, older children are being continuously targeted by marketing messages, causing increasing pressure on their parents to keep up. The open communication encouraged by Facebook, Instagram and the instant Twitterfeed is creating new privacy issues and new parenting challenges.

There is urgency for child and family health services to adapt rapidly in light of these changes. The emphasis is now on teaching parents to engage directly with their children – that what a baby has always needed most is a parent or carer who is engaged with and engages them. Ten years ago, Families NSW badged resources for parents to provide practical guidance on the social and emotional development of their child, but the resource Love, Talk, Sing, Read, Play remains as applicable today as when it was written. This information has been translated into four major community languages and adapted for Aboriginal families, and has been an effective guide for nurses and parents to work together, translating the findings of the research into practice.



The early social, emotional and intellectual development of children.

Recognising that most parents now turn to websites rather than books, the Personal Health Record now contains links to reputable websites, such as the Raising Children Network, so parents have access to a dependable resource. Still, a lot of nurses' time is currently spent countering misleading messages derived by parents from the internet.

Despite the fears associated with technology, it also holds considerable potential to enhance child and family health services.

An immunisation app for parents has been developed, with a very positive response, as part of the Save the Date to Vaccinate campaign. There is a NSW Health Facebook page to engage Aboriginal mothers and promote health messages, which has proved so successful that it is still being used several years after it was set up. Parents can also use Tresillian and Karitane parenting telephone advice services or the Tresillian Live Advice, an interactive online service accessed via Facebook.

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"For me, the most satisfying things have been when mothers have reported back elsewhere that it's wonderful that the nurse came around and worked with them to think differently and help solve their particular problem. It's often simple little things that have helped them, like together putting the baby to sleep in a quiet darkened room rather than the bright stimulating family area, or going outside to sit with the mother, while the baby goes to sleep, and talking together.

"This job is a privilege. If it means that family gets off to a slightly better start and the parents are less fraught, that the baby may be more settled and there may be more confidence in their parenting, then it's all worthwhile."

Contacting parents via SMS message to remind them about appointments, engaging them through social media, providing timely responses to questions online and developing apps to support breastfeeding and settling are all services currently being trialled with some success in NSW.

### CONCLUSION

The past 25 years have seen unprecedented improvements in the delivery of child and family health services, which have been swift to react to emerging new evidence.

As a result, babies and young children in NSW are now experiencing significantly better health outcomes than they did in 1989.

The number of deaths from SIDS has plummeted, from more than 200 in 1986 to around 50 per year today. The introduction of statewide hearing screening for newborns means the approximately 80 babies who are born with a hearing impairment in NSW every year are now fitted with hearing aids in their first month of life, enabling the brain development that is crucial to their long-term ability to communicate. Similarly, the universal

Statewide Eyesight Preschooler Screening (StEPS) program is identifying around 7500 children a year and referring them for further assessment, many of whom are found to have vision problems that would not otherwise have been identified until much later, or at all.

The past 20 years have seen the greatest ever expansion of Australia's national immunisation program, which is now one of the most comprehensive in the world in terms of the number of vaccines delivered and the immunisation coverage that is achieved.

Our knowledge about the origins of adult disease has dramatically improved over the past 25 years. Today, we understand that a person's experiences in the first years are the most important of their lives, laying the foundations for their future health trajectory, and we have a far better understanding of the vital role parents play in providing children with the conditions to be the best they can be.

As a result of this new understanding, prevention and early intervention for child abuse and neglect are now firmly on the government's agenda. There has been significant investment in preventive health services, and the universal home health visit ensures that more vulnerable families are being identified and referred to the support services that will make a permanent difference for their children.

One of the greatest success stories is the targeted Aboriginal Maternal and Infant Health Service, which is helping to make a real difference to health outcomes for Aboriginal babies and their families. Through this service, and others like it, for the first time in 200 years we appear to be moving in the right direction to close the gap between Aboriginal and non-Aboriginal infant mortality rates.

NSW now has a cohort of highly educated, extremely competent child and family health nurses, supported by an appropriately trained community paediatric and allied health workforce. We know the outcomes they are seeking and have developed the evidence-based tools to help them achieve these.

There are now better services and structures in place that will continue to see these outcomes achieved into the future. Standards and competencies have been developed for child and family health nurses that have cemented their role, increased their recognition within the health services, and given them better standing within Local Health Districts. Importantly, there are also better links between Maternity and child and family health services, and better interagency collaboration on child health in general.

However, there are many challenges ahead. The interface of child and family health nurses with general practice, particularly since the rise of the practice nurse, and the relationship with non-government organisations which provide services that have traditionally been the domain of child and family health nurses, have all impacted child and family health nursing in modern times. This is an opportunity for child and family health to work within these changing structures and maximise the possibilities they afford.

It is also timely to ensure child and family health is providing services the families of today need and want, to embrace the opportunities afforded by new technology and tailor services in such a way that its dangers are addressed. Into the future, the partnership between nurses and families is likely to become even more important as anxiety increases due to technology and the pressures of an increasingly globalised society threatens to interfere with the vital relationship between parents and their babies.

In the 100 years since child and family health services were born in Australia, the basics have not changed. Babies still need love and care, parents still need advice on feeding, sleeping and settling. Through the years, one constant has remained: the special quality that makes child and family health professionals so effective. It is their ability to be empathetic, their application of knowledge, their keen intuition when something is just not quite right, their sensitivity and their ability to support parents at this crucial stage that will ensure their continued value to the families of NSW into the future.

*Waiting for the child and family health nurse,  
Doonside Community Health, 2012.*



## APPENDIX

### ESTABLISHMENT OF BABY HEALTH CENTRES

The first Baby Health Services which commenced in the city metropolitan areas and country regions are listed below.

The information was retrieved from histories sent to the New South Wales Department of Health or on the basis of verbal advice.

The list is incomplete and some dates may not be accurate due to records being destroyed or lost in floods or fire.

### NORTHERN SYDNEY AND CENTRAL COAST

	Commenced		Commenced		Commenced
Artarmon	-	Avalon Beach	1962	Balgowlah	1962
Berkeley Vale	-	Berowra	1973	Brooklyn	1979
Carlingford	1973	Chatswood	1924	Collaroy Plateau	1962
Cremorne	1956	Crows Nest	1987	Dee Why	1936
Eastwood	1936	Elanora Heights	1965	Forestville	1960
Frenchs Forest	1967	Galston	1979	Gladesville	1931
Gosford	1936	Harbord	1949	Hornsby	1926
Hunters Hill	1952	Kanwal	1984	Kincumber	1986
Lane Cove	1928	Lindfield	1936	Manly	1923
Mangrove Mountain	1960s	Marsfield	1986	McMahons Point	1966
Mona Vale	1964	Mosman	1926	Narrabeen	1952
Newport	1953	Northbridge	1936	North Epping	1915
North Ryde	1960	North Sydney	1915	Pennant Hills	1952
Point Wollstonecraft	-	Roseville Chase	1961	Ryde	1927
St Ives	1960	Scotland Island	1989	Seaforth	1953
South Maroota	-	Terrey Hills	1981	The Entrance	1965
Toukley	1979	West Pennant Hills	1965	West Pymble	1967
West Ryde	1927	Willoughby	1938	Woy Woy	1932
Wyoming	1980	Wyong Mobile Van	1932		

### SOUTHERN SYDNEY

Alexandria	1914	Annandale	1921	Arncliffe	1949
Ashfield	1926	Bangor	1984	Balmain	1915
Beverly Hills	1948	Bexley	1935	Bondi Beach	1948
Botany	1946	Brighton Le Sands	1956	Bundeena	1945
Burwood	1924	Caringbah	1930s	Chippendale	1916
Clovelly	-	Concord	1944	Cronulla	1939
Daceyville	1918	Double Bay	1956	Drummoyne	1968
Dulwich Hill	1956	Engadine	1957	Ersleville	1952
Five Dock	1933	Glebe	1915	Gymea	1961
Hillsdale	1980s	Hurlstone Park	1940	Hurstville	1929
Jannali	1950s	Kings Cross	1961	Kingsgrove	1948
Kogarah	1928	Kurnell	1960	Leichhardt	1919
Malabar	1960	Maroubra	1942	Marrickville	1923
Mascot	1916	Menai	1981	Millers Point	1916
Miranda	1957	Mortdale	1926	Newtown	1914
Oatley	1969	Oyster Bay	1965	Paddington	1917



Pagewood	1952	Petersham	1926	Ramsgate	1952
Randwick	1925	Randwick (Karitane)	1923	Redfern	1920s
Riverwood	1948	Rockdale	1920	Roselands (Karitane)	1966
South Hurstville	1969	St Peters	1916	Strathfield	1944
Surry Hills	1921	Sutherland	1934	Sylvania (Karitane)	1958
Summer Hill	1954	Ultimo	-	Waverley	1923
Woolloomooloo	1915				

## WESTERN SYDNEY

Anzac Village	1966	Auburn	1944	Bankstown	1924
Baulkham Hills	1957	Belmore	1951	Blackheath	1935
Blacktown	1947	Cabramatta	1947	Camden	1938
Campbelltown	1939	Campsie	-	Canley Heights	1961
Carlingford	1969	Castle Hill	1950s	Chester Hill	1955
Condell Park	1964	Doonside	1969	Dundas	1976
Earlwood	1932	Ermington	1960	Fairfield	1946
Fairfield Heights	1963	Glenbrook	1960	Granville	1919
Greenacre	1961	Greystanes	1973	Holsworthy Village	1966
Ingleburn	1951	Katoomba	1935	Lakemba	-
Lalor Park	1961	Lawson	1936	Lidcombe	1929
Liverpool	1934	Macquarie Fields	1963	Marayong	1964
Merrylands	1947	Miller	1967	Milperra	1980s
Mount Druitt	1963	Mount Pritchard	1967	Old Toongabbie	1965
Padstow	1959	Panania	1961	Parramatta	1926
Pendle Hill	1958	Penrith	-	Picton	1940s
Prairiewood	1989	Punchbowl	1948	Regents Park	-
Revesby	1950	Richmond	1934	Riverstone	1952
Rydalmere	-	St Marys	-	Seven Hills	1961
Springwood	1943	Toongabbie	1962	Wentworthville	1944
Westbridge Hostel	1950-closed 1988	Wetherill Park	1983	Windsor	1934
Yagoona	1957				

## HUNTER

Aberdeen	1943	Abermain	1922	Adamstown	1926
Beresfield	1962	Boolaroo	1918	Cardiff	1939
Carrington	1923	Caves Beach	1978	Cessnock	1917
Charlestown	1952	Clarence Town	-	Denman	1938
Dora Creek	1936	Dungog	1940	Edgeworth	1965
Gresford	1939	Greta	1956	Hamilton	1925
Hawks Nest/Tea Gardens	-	Karuah	1975	Kotara	1960
Kurri Kurri	1921	Lambton	1947	Lemon Tree Passage	1975
Mayfield	1923	Mayfield West	1944	Maryland	1988
Medowie	1978	Merewether	1953	Merriwa	1938
Minni	1918	Morisset	1961	Morpeth	1954
Murrurundi	1938	Muswellbrook	1930	Nabiac	1985
Nelson Bay	1953	New Lambton	1919	Newcastle (Parry St)	1915
Newcastle (King St)	1920/25	Pacific Palms	1984	Purfleet Station	-
Raymond Terrace	1940	Rutherford	1965	Scone	1938
Shortland	1966	Singleton	1928	South Singleton	1934

Stockton	1924	Stroud	1940	Swansea	1936
Tanilba Bay	1979	Toronto	1944	Truby King Centre	1932
Wallsend	1917	Wangi Wangi	1963	Waratah	1924
Weston	1922	West Wallsend	1918	Wickham	1926
Windale	1967				

## ILLAWARRA

Albion Park	-	Berkeley	1964	Berry	-
Bowral	1932	Coledale	-	Corrimal	1969
Cringila	1976	Culburra	-	Dapto	-
Fairy Meadow	1952	Figtree	-	Gerringong	1948
Helensburgh	-	Huskisson	-	Kiama	1937
Lake Illawarra South	-	Milton	-	Mittagong	1933
Moss Vale	1933	Nowra	1934	Oak Flats	-
Port Kembla	-	Shell Harbour	-	Stanwell Park	-
Thirroul	1960	Unanderra	-	Warrawong	-
Wollongong	1927	Woonona	1956		

## CENTRAL WESTERN

Bathurst	1926	Blayney	1939	Canowindra	1938
Condobolin	1959	Cowra	1930	Cudal	1940s
Eugowra	1954	Forbes	1929	Grenfell	1930s
Hillston	1963	Holbrook	1947	Kandos	1939
Lake Cargelligo	1959	Lithgow	1927	Mandurama	1947
Millthorpe	1934	Molong	1937	Murrin Bridge	1959
Oberon	1937	Orange	1928	Parkes	1935
Peak Hill	1954	Portland	1942	Quandialla	1930s
Rylstone	1936	Tottenham	1934	Trundle	1955
Tullamore	1962	Tullibigeal	1930s	Wallerawang	1964
Weethalle	1930s	West Wyalong	1959	Yeoval	1950

## NEW ENGLAND

Armidale	1934	Barraba	-	Bellata	1979
Bingara	-	Boggabri	-	Bulahdelah	1964
Bundarra	-	Caroona Reserve	1955	Curlewis	-
Deepwater	-	Delungra	-	Drake	1981
Emmaville	1971	Forster	1929	Glen Innes	1933
Gloucester	1940	Gunnedah	1939	Guyra	1941
Gwabegar	1967	Inverell	1929	Manilla	-
Mingoola	1980	Mungindi	-	Narrabri	1926
Nundle	1960s	Pilliga	1967	Premer	-
Quirindi	1940	Spring Ridge	-	Tambar Springs	-
Tamworth	1940s	Tamworth South	1965	Taree	1929
Tenterfield	1940	Tingha	-	Uralla	1933
Walcha	1930	Walla	1934	Warialda	-
Wee Waa	1967	Werris Creek	1955	Wingham	1929

**NORTH COAST**

Alstonville	1975	Ballina	1938	Bangalow	-
Bellingen	1945	Bonalbo	1943	Bowraville	1949
Brunswick Heads	-	Byron Bay	1943	Casino	1932
Coffs Harbour	1940	Coraki	1948	Crescent Head	-
Dorrigo	1940	Goonellabah	-	Grafton	1932
Illuka	-	Kempsey	-	Kendall	-
Kingscliff	1985	Kyogle	1935	Laurieton	-
Lismore	1932	Macksville	1935	Maclean	1937
Mallanganee	1952	Mullumbimby	1943	Murwillumbah	1938
Nambucca Heads	1957	Port Macquarie	-	Sawtell	1955
Smithtown	1962	South Grafton	1946	South Lismore	1964
South West Rocks	1962	Tabulam	-	Tweed Heads	1968
Urbenville	-	Urunga	-	Wauchope	-
Wingham	-	Woodburn	1947	Woolgoolga	1933
Yamba	1954				

**ORANA AND FAR WEST**

Baradine	-	Binnaway	-	Bourke	-
Brewarrina	-	Broken Hill	1921	Carinda	1929
Cobar	-	Collarenebri	-	Coolabah	-
Coolah	-	Coonabarabran	-	Coonamble	1958
Dubbo	1929	West Dubbo	-	Dunedoo	-
Geurie	1936	Gilgandra	1933	Girilambone	-
Gulgong	1936	Gulgargambone	1963	Hermidale	-
Ivanhoe	-	Lightning Ridge	-	Mudgee	1936
Mendooran	-	Munbil	1939	Nanima Reserve	1956
Narromine	1934	Nymagee	-	Nyngan	1968
Quambone	1928	Stuart Town	1936	Tooraweenah	-
Trangie	1934	Walgett	1968	Warren	1938
Wellington	1930	Wilcannia	-		

**SOUTH EASTERN**

Adaminaby	1952	Batemans Bay	1929	Bega	1941
Bemboka	1987	Bermagui	1941	Berridale	1936
Bigga	1941	Binalong	1938	Bombala	1937
Boorowa	1936	Bowral	1932	Braidwood	1949
Bundanoon	1982	Bungendore	1932	Cabramurra	1968
Candelo	1987	Captain's Flat	-	Cobargo	1946
Crookwell	1928	Delegate	1960s	Eden	1950
Eucumbene	1955 - closed 1960	Goulburn	1926	Gunning	1923
Harden	1937	Hilltop	1985	Jindabyne	1940
Marulan	1983	Mittagong	1933	Mogo	1979
Moruya	1955	Moss Vale	1933	Murrumbateman	1985
Narooma	1963	Nimmitabel	1930s	Pambula	1950
Queanbeyan	1932	Robertson	1984	Rocky Hall	1972
Tarago	1985	Taralga	1949	Tathra	1982
Towamba	1980	Tura Beach	1980s	Yass	1928
Young	1927				

**SOUTH WEST**

Adelong	1936	Albury	1928	Ardlethan	1935
Ariah Park	1935	Balranald	1961	Barellan	1934
Barham	1955	Batlow	1930	Berrigan	1939
Buronga	1961	Carrathool	1963	Coleambally	1966
Coolamon	1936	Cootamundra	1923/24	Corowa	1932
Culcairn	1924	Dareton	1961	Darlington Point	1960
Deniliquin	1940s	Euston	1961	Finley	1939
Ganmain	1947	Goolgowi	1963	Griffith	1934
Gundagai	1923/24	Hay	1940s	Henty	1928
Hillston/Roto	1940s	Howlong	1978	Jerilderie	1936
Jindera	1978	Junee	1930	Kyalite	1961
Leeton	1930	Lockhart	1937	Mathoura	1937
Matong	1954	Merriwagga	1963	Moulamein	1921
Narrandera	1930	Oaklands	1932	Rand	1977
Ross Circuit	1976	Springdale Heights	1979	Stockinbingal	1938
Talbingo	1962	Temora	1930	The Rock	1937
Thurgoona	1979	Tocumwal	1937	Tumbarumba	1957
Tumut	1928	Urana	1941	Urinquinty	1984
Wagga Wagga	1928	Walla Walla	1977	Wentworth	1961
<i>(Records destroyed by floods - probable date)</i>					
Yenda	1937				

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