

## **District nursing between the local and the international. Northern Norway 1890-1940.**

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The region of Northern Norway covers the country's three northernmost counties, for the greater part situated north of the Arctic Circle.<sup>1</sup> A regional research perspective showed an extensive local voluntary activity in the region, which included district nursing. The story of district nursing in Norway has not yet been written. I aim to show that while it began as part of a broad European movement, it developed in the North at the same time from explicit local traditions. District nursing became a field of tension between local agencies on one hand, and national and international agencies on the other, and is perhaps an example of how the ideal of implementing public health systems may become problematic.

Economic modernity came late to the region. In 1890, the majority of the population were fishing peasants. Among the Norwegians this was a gendered economy. The great export fisheries in the region were expanding; the men left home in January, and increasingly did not return until midsummer. In the meantime, the women with children and the elderly ran the smallholdings with some cows and sheep, potato patches, perhaps barley or oats in sheltered parts. In a typical household, most human and natural resources were utilized. While subsistence economy was the backbone of survival, it was supplemented by the more irregular money income from the fisheries.<sup>2</sup> The indigenous Sámi people were nomadic reindeer herders in mountain areas, and fishing peasants in fjord areas, and lived in a virtual subsistence economy throughout the period.

Local medical officers were partly state financed. Their districts were very large, with most transport by boat as road building was in an early phase. Many small hospitals had been built along the coast, financed by the regional fisheries to cater for fishermen and people with epidemic diseases.

In ethnographic sources, care for the sick in the region around the turn of the century was explained as a threefold responsibility, of the immediate family, the relatives, and the neighbours.<sup>3</sup> Family care was the foundation.<sup>4</sup> Both men and women nursed family members, but the extended absence of the menfolk must have supported a general tendency of the period to shift the main responsibility for sick care to the women. Relatives would help through a crisis: a young girl, a niece was usually sent to stay and give a hand. Men and women would do nursing and night-watching in turn at their neighbours'. The main concept in use was 'help'. Help in sickness and death was legitimated as neighbour duty and Christian duty, which it was a great shame to shirk. In addition to nursing, common forms of help were gifts of food and transport of the sick or of the doctor. People would join together in work-parties to make hay or harvest potatoes for sick neighbours. Neighbour help was possible through the exchange of information on health and sickness which was part of common courtesy; gossip about sickness was a form of local insurance. Central to this system was a woman, sometimes a man, with special knowledge of birth, death and illness, who 'was fetched' both to humans and animals in times of crisis. It was a service of mercy; she was not paid, but people gave what gifts they could afford. This was the system of 'the old society', which was more or less developed in different communities. In substance I suppose it is well known in many parts of the world.

Despite these networks, sick and infirm persons with no family ties were often destitute. Municipal poor relief was established relatively late in the region, at the end of the 19<sup>th</sup> century, and expanded fast. As elsewhere, the relief was portioned out as loans, on terms that people considered degrading. Sickness was the main cause that brought people under the Poor Law far into the 1920s.<sup>5</sup>

Migration to and from the region weakened the community care system. Expansion in trade and in mining and industry from the 1890s made for more integration of the money

economy into everyday life. Municipal taxation had been introduced in connection with poor relief, and increased the need for money income in the households. Even after national sickness insurance was introduced in 1911 for wage-earners, the Poor Law boards had to pay for the bulk of the hospital stays in the region.<sup>6</sup> The majority of the women, who were not fishermen or regular wage-earners, were excluded from this tentative modernization of social security in the early 20<sup>th</sup> century. Public sick care was largely an open and undecided field when the tuberculosis epidemic came to the North.

### **Sickness and nursing**

Tuberculosis struck the region late and hard from the mid 1880s. Mortality figures multiplied within two decades in the northernmost county, Finnmark.<sup>7</sup> On a national basis, tuberculosis culminated in 1900 with a mortality of 30 per 10,000 inhabitants, and then mortality was still mounting in the North. Finnmark reached a tuberculosis mortality peak of 50.9 per 10,000 inhabitants in 1906-1910. From the second half of the 1920s tuberculosis mortality declined steadily in the region.<sup>8</sup>

With the passing of the Norwegian Tuberculosis Act in 1900, registration of contagious cases became mandatory. If satisfactory sanitary measures could not be carried out in the home, isolation of the patient could be enforced, too. The medical officer as chairman of the local health board was responsible for registration, hygienic control of the homes, and the decision to move the patient if necessary. Most people with tuberculosis died at home during the entire tuberculosis period, though tuberculosis homes and sanatoria were gradually built on a large scale.

New fear of infection was fuelled by the many deaths and by information campaigns which introduced the concept of bacillae infection. Neighbour help was now conceived as much more dangerous, and the doctors complained that it was difficult to get help in homes

with tuberculosis. There are many stories of families in chaos and want when the mother lay ill.

To some of these homes came the early district nurses, from about 1880. They lived in the house – often sleeping on the floor – and took care of the sick, the children and the cows through the crisis. Sometimes the first thing they did was to sew clothes for the children. Making and mending clothes was one of the main tasks for women in the Arctic climate, and it was often neglected in illness. The system of living-in nurses, who were ready to take over necessary tasks in the household, was well suited to the needs of the sick women. The nurses were employed by local women's associations.

European voluntary nursing expanded in the 19<sup>th</sup> century through Christian communities of every denomination, from the Russian Orthodox Church to the Methodists.<sup>9</sup> The very first ambulant nurses in the region were Polish Catholic sisters of the congregation of St. Elizabeth, who established themselves in 1880 in the northernmost town, Hammerfest. Two years later they built a hospital.<sup>10</sup> Protestant deaconesses from the Mother House in the capital of Norway were contracted out to Christian poor relief and nursing societies established in the towns in the German deaconal tradition.<sup>11</sup> Originally, the parson was chairman and secretary, but at the turn of the century local women had taken charge of most of these societies.

Norwegian-speaking rural women were literate; they were inspired by pietistic revivals, and cultural and social popular associations flourished across the nation. The women of the North had a generation of experience from mission societies, and knew very well how to organize bazaars, raise money and mobilize people for an ideal cause. Torunn Hamran has shown that from the 1890s, independent small women's associations emerged in rural districts and towns in the North. They aimed to help the local sick, and combined different issues according to the prevalent needs of the community: supporting sick families with food,

clothes and labour-saving nursing equipment, distributing cod liver oil or soup to the schoolchildren, building a local hospital or a home, or keeping a nurse for the community.<sup>12</sup> A local girl, preferably, was trained in the capital or in a local hospital, at the expense of the association, which employed her afterwards.

### **National and international voluntary organizations**

At the national level, voluntary health care in Norway was first organized in The Norwegian Women's Sanitary Association (NKS), founded in 1896. This association was born of the nationalist, democratic and feminist climate of the time. It was a women's organization with no exact counterpart in the neighbouring countries. As NKS spread, the local and the national levels met; it was a principle of the NKS to give local member associations a free hand with their issues. NKS developed a crucial role in sustaining and expanding the local women's movement.<sup>13</sup>

The National Tuberculosis Association (NTA) was founded in 1910 and led by physicians in central public positions. The NTA was also organized at the local level in associations which, at least in the North, were mostly led and dominated by women. The NTA aimed to create a scientific tuberculosis policy for the nation, and ultimately bring this policy under state responsibility. The NTA was a member of the International Tuberculosis Union, and its leaders were inspired by the French dispensary system for prevention of tuberculosis. The tuberculosis dispensary aimed to trace the victims and their contacts, to register and instruct them. Trained social workers taught preventive measures to the sick and their families in their homes. The dispensary also distributed material help, though that was not the main intention.<sup>14</sup>

The NKS associations of the towns of Tromsø and Harstad set up dispensaries in 1911, run by the association's nurses, from which they distributed bed linen, cod liver oil,

milk and paper spittoons, and did sick visiting and night nursing in the homes. The public physicians of Harstad and Tromsø diagnosed patients in the dispensaries for free in their spare time. There was not much need for registration, since the towns were very small. In 1914 the nurse visited 45 sick people in Tromsø, and many of them must have been old acquaintances; 26 persons were examined at the station in Harstad, eight of whom had tuberculosis.<sup>15</sup>

A localized dispensary could only function in a town. The NTA agreed that in the countryside, the *principles* of the dispensary should be carried out in co-operation between the associations and the public physician, and by means of the nurses.<sup>16</sup> This was the core of NTA's dispensary plan, founded on the sanitary concept which dominated European and North American preventive medicine until the end of the First World War. From 1911 the NTA contributed to the acceleration of district nursing by giving support to associations who trained local girls. An association in Finnmark wrote: 'Everyone has been working with a rare commitment in the good hope to soon have a nurse in our midst.'<sup>17</sup>

In several countries *specialized* tuberculosis nurses were introduced to work in the dispensaries and visit the homes. In Sweden and Finland they were called dispensary nurses. In Denmark tuberculosis nurses were given courses by the Danish Tuberculosis Association.<sup>18</sup> Tuberculosis nurses in US cities visited sick poor and taught prevention of contagion, but the disease kept escalating, and the nurses took up the discussion of whether advanced cases should be permitted to stay at home at all. It was the dilemma of whether to take care of the individual or to protect society. Voluntary and official agencies eventually found specialized tuberculosis nursing less effective, and the system was not continued in the US after 1930.<sup>19</sup>

### **Nursing practice in the districts**

A nurse must be trained. She must be able to handle contagion, but the demands on her expertise went further than that: the community nurse was a professional care system in and

of herself. The voluntary movement furthered professional competence. An association in a small industrial centre wrote in 1919: 'Our nurse, whom we ourselves have had trained (...) began her work in mid August, she has been a wonderful help, as the village has had no physician in recent months.'<sup>20</sup> When the women built a voluntary health care system, they put their trust in the new female profession, girls with much the same cultural background and basic work knowledge as themselves. Voluntary district nursing became a motor in the development of the nursing profession, certainly in the north, but I think also on a national basis.

The nurses were extremely flexible and versatile. They nursed the critically ill and took care of their families; they transported sick people over sea and mountains to a doctor or hospital; they treated accidents and injuries, skied miles upon miles to visit old people, distributed food and medicine to the sick and sometimes fought cases with the Poor Law board. As the associations built and ran the majority of nursing homes and cottage hospitals of the region, several district nurses took charge, while they continued some ambulant nursing.<sup>21</sup>

Because the district nurses were voluntarily financed, they were easily accessible and independent of Poor Law bureaucracy. The people, on the other hand, were free to refuse their help. They *were fetched* by the families of the sick or by a neighbour, teacher, priest or doctor. They also tried to find out who might need their help, travelled about, visited and listened to gossip about sickness. In the first decades especially, they worked very autonomously. When telephone lines came to the area, frequent contact with the doctor was possible, and then he and the forewoman of the association usually directed the nurses' work between them. NKS nurse Solveig Lang wrote about her work as district nurse in the early 1930s:

'It might often be disheartening in the winter darkness to travel into the fjord in all kinds of weather, not knowing what conditions one would come to. But when one was indoors, one

met people who needed practical help – and often comfort. And then one was a nurse and discovered resources in oneself waiting to be used, translated into practice. When working in hospital, responsibility is shared by many. But district nursing in lonely places in the fjords – there one's abilities are put to the test.'<sup>22</sup>

The tradition of help was transformed. It retained its local basis, while employing paid professional nurses, and the range of services was expanded and adapted to the tuberculosis epidemic. The weaknesses of the new system were its demands on the strength and health of the nurses, and their heavy and often solitary responsibility. A nurse, who worked for a long time in a district, developed knowledge of the people second to none. But very many left district nursing after a short time; many were sick and invalid.

Around 1900 most nurses of the region had one year's training. This was gradually extended to three years in the 1920s, when nurses were trained at ten hospitals in the northern region, mainly for district work. At that time the market became saturated, and the local associations did not need to finance the training of their nurses. The local women's influence upon the development of the new profession diminished fast.

### **The local associations**

Research on voluntary district nursing in Northern Europe suggests some differences in aims, target groups and financing. Probably the oldest system was voluntary Christian relief and nursing societies for the urban poor. In Northern Norway these were financed partly by donations from the small middle and upper class, but mostly by bazaars. In many countries societies financed their work through contributions from regular subscribers, but we have not found this practice in Northern Norway. The central Church of Norway, unlike the Church of Finland, took little interest in district nursing, deaconal or secular. And unlike district nursing



in Denmark and Finland, district nursing in Norway had no regular state support. There were no public reports or statistics on nursing until 1927, and legislation was delayed until 1948. District nursing was growing wild.

Voluntary nursing in Denmark, for instance, was often organized according to the pattern of insurance societies: the paying members with their families had the nurse when sick, while membership was free for the badly off.<sup>23</sup> In Northern Norway, where most of the population did not earn regular wages, an insurance system would not work.

Instead, the women utilized the irregular money economy. In many photographs of associations, every woman is holding up her knitting or crochet work to show where their money came from. They worked, baked and practiced plays for bazaars and fêtes, and were supported by local choirs and musicians. The bazaars were held in fishing season, when the place swarmed with fishermen and money was loose, or when the fishermen returned home.

My mother put it like this: 'If you were a woman, you were in the association.' Around 1930, the registered members of the two organizations NKS and the Tuberculosis Association, equaled one in four women over 15 in the region.<sup>24</sup> To this must be added the many Red Cross associations, and local associations with no affiliations. It was a popular movement, and it kept growing. The associations aimed explicitly at the entire local community, not a special class of poor, and they sought the support of the local community, men and women, of all classes. Some of them formulated an objective of universal help in their statutes, for instance: 'The association seeks to support and help where help is needed'. Or: 'The task of the association is according to our ability to help and relieve sickness and want, where and whenever it is found.'<sup>25</sup>

So was this charity? Perhaps not, if charity is understood as assistance from the upper classes to the lower. Perhaps yes, if charity is conceived as potentially universal. Want was discussed as a result of sickness, which was well known as a universal potentiality. This

ethical universalism was translated into a working practice, long before the universalistic legislation of the welfare state.

In one respect, practice fell short of the ideal, as most of the associations took a small fee for the nursing, if the family could afford it. For some families this meant that they did not call for the nurse. And universalism itself had its limits. From the mid-19<sup>th</sup> century onwards, Norwegian state policy was to suppress Sámi language and culture in the hope that it would die. Missionary organisations who had supplied Sámi language texts and preachers, took up deaconal work among the Sámi. From 1911 on, for several decades, they employed a number of district nurses to work among the Sámi people. The mission nurses were supposed to learn the language and to give priority to the Sámi before the Finnish-speaking Kvens and the Norwegians.<sup>26</sup> These nurses were alone in Norwegian health service to attach an explicit importance to Sámi language and culture. Ethnicity meant that was not possible to treat all alike after all. At the same time the nurses introduced Norwegian ideas and ways into Sámi sick care.

### **The international public health movement**

General public health nursing developed in Europe and America as one aspect of what today is called 'the hygienic movement'. International politics shifted after the First World War to a positive concept of science-based public health, which led to a broad promotion of health rather than the limited sanitary battle against infectious disease.<sup>27</sup> The efforts to establish the causes and prevention of disease and poverty scientifically meant a strong move away from charitable relief and, as we shall see, from sick care.<sup>28</sup>

Educating and standardizing personal hygiene, child-raising and housework culture was only possible through personal contact. It was generally recognized that the ambulant nurses might hold the keys to the homes and the minds of the mothers. The central and county

levels of the NTA, the NKS and the Red Cross employed itinerant teaching nurses to lecture and to visit homes with sick people and instruct them in sanitary measures. Several of these nurses travelled in Northern Norway. As the historian Teemu Ryymin has shown, the central tuberculosis establishment generally came to view the region as less than civilized. This had to do with its multi-ethnicity on the one hand, and its tuberculosis situation on the other. Instruction was considered as much needed.<sup>29</sup>

Several international agencies were more or less directly involved in effecting a shift from district nursing to public health nursing in Scandinavia. After 1912 the professional nurses' organization, the International Council of Nurses, promoted preventive health care as a new field for nursing.<sup>30</sup> So did the Norwegian Nurses' Association, which, however, had few members in Northern Norway before the Second World War.<sup>31</sup> District nursing was clearly a problem for nursing professionalism. In the 1920s, Norwegian nursing leaders argued that district nurses were mostly cheap servants for the ladies of the associations. The future lay in public health visiting, not in almsgiving, housework, religious mission or in live-in nursing.

The Rockefeller Foundation (RF) had been involved in the French dispensaries, where they introduced nurses who were specially trained in public health work. The RF's goal to establish science-based public health systems required public health nurses on a higher level, in terms of education and certainly in terms of social class. University courses, independent of the hospitals, were designed to educate leaders of public health nursing.<sup>32</sup> The RF analyzed public health nursing in the influential Goldmark report from 1922-1925, and became directly involved in nursing education in 44 countries, including Finland and Denmark, over a 34-year period.<sup>33</sup> Norway was excluded from the RF effort because its training of nurses was considered below standard.<sup>34</sup> The historian Bridget Towers states that the RF expanded the principles of industrial management into international health and welfare planning through an

intimate partnership of private sector, state and voluntary agencies.<sup>35</sup> Public health nursing was an aspect of this management which created a new professional role of nurses in advising, controlling and monitoring: nurse as functionary. In her study of the establishment of public health nursing in Denmark, the ethnologist Henriette Buus shows that RF and Danish authorities agreed to hand-pick future public health nurses from among those with the best professional education and the 'highest cultural rank'. Buus points out that public health nurses could not be recruited from midwives, district nurses or deaconesses, because they were to visit even the homes of the better off, and must not be associated with philanthropy or poor relief, or with the supposed degradation of giving birth.<sup>36</sup> Health and sickness, and even health and birth, were to be separated.

### **The systematic tuberculosis work**

The management outlook was strong in Norway. The NTA leaders argued repeatedly that the local associations' work was scattered, casual and near-sighted, that the local women did not know how to manage the money they raised, and, in particular, that their cooperation with the local medical officer was at fault.<sup>37</sup> It was not easy to make the doctors, who worked alone in their districts, prioritize preventive work.<sup>38</sup> On the other hand, 'the thousand associations' with their money and nurses were a great asset. As the International Tuberculosis Union declined at the end of the First World War, the national tuberculosis associations in the Nordic countries exchanged plans and ideas. Sweden had a well-organized dispensary system run by the counties, partly voluntary, partly publicly founded, with a focus on the tracing of tuberculous cases. The NTA planned a new organization based on the Swedish pattern, on the side of the local associations, but at the same time through them.<sup>39</sup> It was called '*the dispensary organization*' or '*the systematic tuberculosis work*', and aimed at a central,

medicalized management of all voluntary tuberculosis activity. It retained the sanitary model for preventive work.

In this scheme, the nurses were to hygienize the homes of the tubercular systematically, according to a set standard, 'and to give detailed prescriptions for everything, with practical demonstrations.' Material help was claimed to rank under poor relief and was to be abandoned. The secretary-general of the NTA warned the associations that when their help kept a sick person alive, they prolonged the time in which he possibly might infect others.<sup>40</sup>

The NKS and the NTA agreed, and a Central Board was established in 1923 with the state Chief Medical Officer for Tuberculosis as chairman.<sup>41</sup> He was also a prominent and active member of the NTA. Boards on municipal and county levels were planned, led by medical officers, with representation from local authorities, and restricted representation from the local associations. There were several such associations in each municipality in Northern Norway, so a great proportion of them, perhaps half, were left out. This corporative system was called 'the Tuberculosis Committees'.<sup>42</sup>

The Central Board adopted new instructions for the associations' nurses in 1926. According to these instructions, the nurses were to become functionaries under the municipal health board and follow up sanitary legislation, including tracing of cases and home visits under the tuberculosis law, which was the duty of the medical officer. She was also to function as school nurse. Previously, when a district nurse met someone she suspected to have tuberculosis, she advised him or her to visit the doctor. Thus she traced new cases. But this had normally been a part of the overall work in the community, in which the nurse prioritized according to the situation.

Now the nurses needed a new name. In 1926 the Central Board decided to give the nurses the title of 'health sisters' or public health nurses.<sup>43</sup> They were to be specially educated. Short courses were set up in Oslo by the Norwegian Nurses' Association, the NTA

and the Central Board. Travel was expensive, and not many 'health sisters' from the North were able to join a public health course before the Second World War.<sup>44</sup>

In 1911, the instructions for the nurses of the National Tuberculosis Association stated: 'The nurses' duty is to visit and nurse those of the sick, weak and old in the community who need help.'<sup>45</sup> The new instructions stated that 'A public health nurse shall be the assistant of the Medical Officer and assist in the work to prevent illness, improve hygiene and ensure that the Health Board instructions are met.'<sup>46</sup> (If the doctor did not live in the community, the nurse might answer to the chairwoman of the association that employed her.) Official tasks were transferred to voluntary women's associations, and voluntary nurses were to perform doctors' duties. It was cheap; public money was extremely tight between the wars, and the nurses were mostly paid with bazaar money. According to the new instructions, the nurse might be charged with nursing in the homes, primarily tuberculosis or other contagious cases, when the Health Board work was done. The sick had to wait until everything else was done, and the doctor was the one to give the orders. Everyone agreed that the doctors had much to do. The Central Board did not discuss whether the nurses might also have much to do, or whether they were justified in giving sick nursing second priority. This was an international issue: should public health nurses also do 'bedside nursing', in fact combine the two jobs? The Goldmark report concluded yes, the professional nurses no. Practice was different across Europe, and the physicians were divided.

### **How the plan was implemented**

The aim of the 'dispensary organization' was to separate tuberculosis prevention as much as possible from sick nursing and from the distribution of material help, and to merge voluntary and public activity under a centrally managed state system. Between 1927 and 1933, a grant was given from state profits of liquor sales. From these funds, 'the wine monopoly money' ,

the local tuberculosis committees could apply for a substantial contribution, from one-fourth to one-half, of the wages of the health sister, if she worked under the Medical Officer and subject to the Central Board instructions.<sup>47</sup> The associations re-named their nurses and applied for the money. One association that had employed a nurse for ten years wrote in 1929:

‘Our nurse has done live-in nursing for 138 ½ days and nights, carried out 45 sick visits, weighed and measured school children in four schools and done two disinfections. (...) We had the luck to receive 500 kr. of the profits of the Wine Monopoly for wages for the health sister. Our medical officer, in recommending our application, stated that our NKS nurse did not have too much to do as a sick nurse, so her post as a public nurse might well combine with the rest of her work, which was done.’<sup>48</sup>

This was the typical way of meeting the demands. The nurse stayed in the homes nursing the sick and did health board work in her spare time. The local doctor, of course, recognized the need for sick nursing of his patients and supported the association. Each year the Central Board detailed their control further, to make sure that the municipal tuberculosis committee that applied for money was not a fictional name for some women’s association.<sup>49</sup> This meant that some nurses became employed by the municipality, with financial support from local associations. A small association with 16 members wrote:

‘We have joined Tjøtta and Vevelstad tuberculosis committee to share in the public health nurse. It is a good initiative, and we have become fond of our nurse Marie, who has been doing live-in nursing of old bedridden people the whole time.’<sup>50</sup>

Both the Central Board and the associations used the concepts of public health in a strategic game. When an association applied for money for ‘dispensary work’, it was more often than

not spent on sick relief, in the form of food and clothes, in addition to nursing equipment and cod liver oil. One association wrote virtuously in their report in 1931 that they were engaged in information work to improve public health. Actually, they distributed money relief to sick families, and lent them bed linen and air-cushions.<sup>51</sup> So much of the state funding went to live-in nursing of the sick and material relief. And in the 1932, ten Sámi missionary nurses also were recruited as ‘public health nurses’.<sup>52</sup>

The decline of tuberculosis and the many new institutions made it possible to give higher priority to prevention, and the associations were generally positive to health work, especially for the school children. But they did not conceive of it as something separate from sick nursing and help. Examination of school children with home visits from the nurse led straight to material help to families, as the interwar crisis hit the fishing communities, and municipal poor relief broke down in many areas. The associations extended their responsibility for the children and the sick. They distributed means of living on a greater scale, financed necessary hospital stays, and gave support to their families.<sup>53</sup> The ideal of universal help was cemented.

It was the same voluntary or mission nurse who continued to interweave health promotion, sick nursing and material help in her work. The ‘wine monopoly money’ probably kept up the number of nurses, which peaked in the crisis year of 1933, when there were 115 voluntary nurses in the region. In the two northernmost counties there were as many voluntary district nurses as medical officers.<sup>54</sup> In the 1930s, NKS became involved in broader health issues such as building of local public baths and control stations for babies, while in Northern Norway tuberculosis was still the dominant issue.

In Norway, the health boards of the largest towns (including Bergen) employed nurses.<sup>55</sup> In rural Norway as a whole, the main system in the late 1930s seems to have been ‘combined’. Nurses were employed by their associations to nurse the sick, and did part-time



public health work for the municipality. The ideal of total co-ordination was abandoned, the Central Board declined, and the ‘systematic tuberculosis work’ was never really carried through.<sup>56</sup> In the 1930s, the Norwegian Red Cross established a nursing school in the Eastern region of the country, where public health was part of the curriculum, but it closed after a few years. After the Second World War, a state school in public health nursing was established, and public health nursing became a separate profession within the field of nursing.

With the introduction of the eight-hour working day in institutions from 1939, nurses began to leave rural districts for hospital work and the prospect of some off-duty hours. The women’s associations kept growing, and were confronted with overwhelming tasks in the region during and after the war.<sup>57</sup> In the 1950s there was great shortage of nurses everywhere, and voluntary district nursing in the region came to an end. Many nurses were married and had left paid work, and of those, many ‘were fetched’ to help their neighbours in sickness. In a way district nursing returned to its origins.

A great thought of the 20<sup>th</sup> century was that managed science eventually should free society from sickness. The shift of focus from sickness to health was evident in district nursing. In Northern Norway the reverse process also was evident: the local agents, the women, transformed a health ideal into the imperative of sick care. One question is whether this implicit paradox continued into the post-war welfare state.

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<sup>1</sup> This paper is a result of a book project carried out with Professor Torunn Hamran, University of Tromsø: Elstad, Ingunn and Torunn Hamran. *Sykdom. Nord-Norge før 1940*. Fagbokforlaget, Bergen 2006. Part of the paper was presented at the conference ‘Nursing History: Profession and Practice’, University of Manchester/Royal College of Nursing, Manchester 18 November 2005.

<sup>2</sup> Elstad, Åsa. *Arbeidsliv i fiskarbondeshushald. Kulturelle perspektiv på sosialisering og kjønnsidentitet, Bø og Hadsel i Vesterålen 1870-1970*. Unpublished PhD. thesis, University of Tromsø 2002. Ch. 2 and 3.

<sup>3</sup> National Archive, Oslo: Gards- og grannesamfunnsundersøkinga, Nordland og Troms I: 71-79; II: 6, 52, 61, 69-71. No districts in Finnmark were studied. Institute for Cultural Studies, University of Oslo: 340 life stories from the region, beginning in the 1880’s, the great majority from Nordland and Troms.

<sup>4</sup> See Blom, Ida. *Feberens ville rose. Tre omsorgssystemer i tuberkulosearbeidet 1900-1960*. Fagbokforlaget, Bergen 1998: 17-22.

<sup>5</sup> National statistics on municipal relief, NOS Fattigstatistikk 1900- 1927.

<sup>6</sup> Annual county board reports (Amtstingsforhandlingane), Nordland, Troms, Finnmark.

<sup>7</sup> Blom 1998: 10-12; Brochmann, S.W. *Bidrag til epidemiens historie i Norge i eldre tider*. Homepage of Foreningen Norges døvblinde. <http://home.online.no/~fndbred/sykd2.htm>. 2005: 153-155 (Originally published in *Tidsskrift for Den Norske lægeforening* nr.7-24 1936); Medical statistics: *NOS Sundhetstilstanden*, tuberculosis statistics for the years 1880-1882; 1885, 1897, 1899.

<sup>8</sup> Medical statistics, *NOS Sundhetstilstanden*. 1934: 16.

<sup>9</sup> See: Nelson, Sioban. *Say little, do much. Nurses, Nuns and Hospitals in the Nineteenth Century*. Penn, Philadelphia 2001. Murray, Elizabeth. Russian nurses: from the Tsarist Sister of Mercy to the Soviet comrade nurse: a case study of absence of migration of nursing knowledge and skills. *Nursing Inquiry* 11 (3): 130-137 (2004).. The Danish nursing historian Susanne Malchau concludes that modern nursing was inspired by the Sisters of Charity, founded in France in the 1630s (Malchau, Susanne. *Women religious and Protestant Welfare: The Sisters of Saint Joseph's Empire of Catholic Hospitals in Denmark*. In: Werner, Yvonne Maria (ed.) *Nuns and Sisters in the Nordic Countries after the Reformation*. Studia Missionalia Svecana, Uppsala 2004, p.112. See also: Stocks, Mary. *A Hundred Years of District Nursing*. George Allen & Unwin Ltd., London 1960; Tallberg, Marianne. Den ambulerande sjuksköterskan på landsbygden i början av 1900-talet – en pionjär inom hälsovården. *Hippokrates, Årsskrift för Finlands medicinhistoriska Sällskap*, 1.årg.: 126-137; Summers, Ann. The costs and benefits of caring: Nursing charities, c.1830-1860. In Barry, Jonathan and Colin Jones (eds) *Medicine and charity before the welfare state*. Routledge, London and New York 1991.

<sup>10</sup> Nilsen, Else-Britt. *Nonner i storm og stille*. Solum forlag, Oslo 2001: 80.

<sup>11</sup> Martinsen, Kari. *Freidige og uforsagte diakonisser. Et omsorgsyrke vokser fram 1860-1905*.

Aschehoug/Tanum –Norli, Oslo 1984, ch. 1-2, 9; Archive of “Tromsø frivillige syke- og fattigpleie.”

<sup>12</sup> Hamran, in Elstad og Hamran 2006: ch.6.

<sup>13</sup> See Blom, Ida: ‘Don’t spit on the floor.’ In Sandvik, Hilde, Kari Telste and Gunnar Thorvaldsen (eds) *Pathways of the Past. Essays in honour of Sølvi Sogner*, Novus, Oslo 2002: 238-239.

<sup>14</sup> Barnes, David S. *The making of a social disease. Tuberculosis in Nineteenth-Century France*. University of California Press, Berkeley 1995: 15, 17-18; Farley, John. *To Cast Out Disease. A history of the International Health Division of the Rockefeller Foundation (1913- 1951)*. Oxford University Press, Oxford 2004: 51-55. I would like to thank Erik Ingebrigtsen for the reference to Farley.

<sup>15</sup> NKS, annual reports from the associations.

<sup>16</sup> *Nasjonalforeningen 1910-1935*. 25-years publication of the NTA, Oslo 1935: 59-60.

<sup>17</sup> NKS annual reports: Talvik sanitetsforening 1917.

<sup>18</sup> Hilden, Adda. *Tuberkulosesygeplejersken*. Nationalforeningen til bekæmpelse af lungesygdomme, Vanløse 1987: 31, 83.

<sup>19</sup> Robbins, Jessica M. “Barren of Results?” The Tuberculosis Nurses’ Debate, 1908- 1914. *Nursing History Review* 9 (2001) 35-50.

<sup>20</sup> NKS annual reports. Melbu sanitetsforening 1919.

<sup>21</sup> These cottage hospitals (sjukestuer) were tiny hospitals with no resident physician, for all kinds of diseases and injuries, and often a couple of beds for patients with tuberculosis as well.

<sup>22</sup> Lang, Solveig. *Minner fra 30-årene*. Rolløya Pensjonistforening, Ibestad 1993: 3.

She worked in Ibestad, Troms.

<sup>23</sup> Clausen, Inger, Vibeke Larsen, Erik Lund-Jensen, Karin Müller. *Landsygeplejens historie 1863-1910*. Dansk Sygeplejeråd, København 1999: 57-72.

<sup>24</sup> Census data from 1930, association data from 1928: NKS annual report 1928; Fortegnelser over foreninger tilsluttet Nationalforeningen mot tuberkulosen pr. 1. juli 1928, Meddelelser fra Den norske Nationalforeningen mot tuberkulose (hereafter Meddelelser) aug. 1928: 97- 109. Double memberships are subtracted, and associations in other fields which joined the NTA collectively are not included (e.g. abstinence associations or youth associations (ungdomslag)).

<sup>25</sup> NKS annual reports, Harstad og Trondenes sanitetsforening 1919 and Nordreisa sanitetsforening 1929.

<sup>26</sup> State Archive of Tromsø: Private archive 69, Norsk samemisjonsselskap.

<sup>27</sup> Dubin, Martin David. The League of Nations Health Organisation. In: Weindling, Paul (ed.) *International health organisations and movements, 1918-1939*. Cambridge University Press, Cambridge 1995: 67. Towers, Bridget. Red Cross organisational politics, 1918-1922: Relations of dominance and the influence of the United States. In Weindling 1995: 37.

<sup>28</sup> Weindling, Paul. Introduction: constructing international health between the wars. In Weindling 1995: 4.

<sup>29</sup> Ryymin, Teemu. Formaningens former i et flerspråklig område. Opplysningsarbeid mot tuberkulose i Finnmark. In Malterud, Elvbakken, Solvang (eds): *Sunnhet og sykdom i kulturelt perspektiv*. Rokkansenteret, rapport 12, Bergen 2005: 94-101. He shows the potential for conflict in that the itinerant teaching nurses of the NTA were instructed to tactfully inspect and correct the hygienic standard of the homes, and report to the Health

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Board chairman if necessary. See also Lähteenmäki, Maria. En tuberkulosdrabbat familj i norr. Hur förebyggandet av tuberkulos påverkade allmogens levnadsvanor. *Historisk Tidsskrift för Finland* 3 årg. 89, 2004: 193-209.

<sup>30</sup> Hvalvik, Sigrun. *Bergljot Larsson og den moderne sykepleien*. Akribe, Oslo 2005: 79-80.

<sup>31</sup> Melby, Kari: *Kall og kamp. Norsk sykepleierforbunds historie*. NSF/Cappelen, Oslo 1990: 62.

<sup>32</sup> Farley 2004: ch. 13 and 14.

<sup>33</sup> Rafferty, Anne Marie. Internationalising nursing education during the interwar period. In Weindling 1995: 267.

<sup>34</sup> Hvalvik 2005: 213.

<sup>35</sup> Towers 1995: 38.

<sup>36</sup> Buus, Henriette. *Sundhedsplejerskeinstitutionens dannelse. En kulturteoretisk og kulturhistorisk analyse af velfærdsstatens embedsværk*. Museum Tusulanums Forlag, København 2001: Ch. 4 and 5.

<sup>37</sup> Meddelelser, Nov. 1919: 106-109.

<sup>38</sup> Schjøtz, Aina. *Folkets helse – landets styrke. 1850-2003*. Universitetsforlaget, Oslo 2003: 282-289.

<sup>39</sup> Albert Tillisch, in Meddelelser May 1919.

<sup>40</sup> Birger Øverland, in NKS publ. Folkehelsen 1919: 113 ff.

<sup>41</sup> Meddelelser June 1920: 49-53.

<sup>42</sup> Tuberkulosenemdene. Meddelelser Feb. 1923: 6-7; Meddelelser April 1927: 37-40; Nils Heitmann, Meddelelser Oct. 1929.

<sup>43</sup> Meddelelser April 1927.

<sup>44</sup> Jfr. Finnmark County board reports (fylkestingsforhandlingar) 1933-1934.

<sup>45</sup> Meddelelser Nov. 1915.

<sup>46</sup> NKS Folkehelsen 1930: 32.

<sup>47</sup> Heitmann in Meddelelser Oct. 1929; Meddelelser Feb. 1931: 7-8.

<sup>48</sup> NKS annual report 1929: 217 (Dyrøy).

<sup>49</sup> State Archive of Tromsø. SATø 69:37 1933 82-92. Finnmark County Sak 67 1935: 271.

<sup>50</sup> NKS annual report 1931: 412.

<sup>51</sup> NKS annual report 1931: 420. Grønning sanitetsforening.

<sup>52</sup> Finnmark county 1931 sak 93: 378; 1933 sak 70: 306. State Archive of Tromsø SATø 69 boks 34 1932: 90.

<sup>53</sup> E.g. NKS annual report 1929: 491, Hammerfest sanitetsforening. NKS annual report 1929: 489, Vadsø og Nordvaranger sanitetsforening; Finnmark county 1930 sak 71: 328.

<sup>54</sup> Medical statistics NOS Sunnhetstilstanden 1933.

<sup>55</sup> Blom 1998: 54-57.

<sup>56</sup> Andersen, E. Helsesøstrenes arbeide og utdanning. *Tidsskrift for Den norske lægeforening* vol. 58 ,1, 1938: 25-40.

<sup>57</sup> Bjarnar, Ove. *Veiviser til velferdssamfunnet. Norske Kvinners Sanitetsforening 1946-1996*. NKS, Oslo 1995: 51-60.