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Hygienism, Disease Etiology, and the "Social Question:" Protecting Infant Health in the French Crèche, 1844-1898

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An abstract of

A thesis submitted to the Faculty of the

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Abstract

Hygienism, Disease Etiology, and the "Social Question:" Protecting Infant Health in the French Crèche, 1844-1898
By Rachel Shapiro

This thesis examines the rise of the crèche—a type of day nursery for infants—in France between 1846 and 1898. Through a study of the *Bulletin de la Société des Crèches*, the longstanding journal associated with the crèches, and an examination of medical reports, laws, and writing on regulation, it places the expansion of this institution within broader conversations on disease etiology, class, and public health.

This work contains two key chapters: "'Indispensable Conditions:' Ensuring Health in the Crèche" and "'The Crèche is Not a Hospital:' Poverty, Disease, and the Limits of Public Health."
It argues that mechanisms to limit disease and improve health within the crèche were shaped by contemporaries' understanding of disease, public health, and approaches to address France's "social question." While the rise of hygienism leant to the crèche movement an optimism about the ability of this new institution to reduce infant mortality and morbidity, a closer examination of reformers' attempts to promote health in the crèche demonstrate a simultaneous anxiety about its ability to fully control, contain, and neutralize disease, especially in a context of widespread urban poverty. This uncertainty reflects the wider limits of the nineteenth-century public health movement.

# Hygienism, Disease Etiology, and the "Social Question:" Protecting Infant Health in the French Crèche, 1844-1898

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## Introduction

In his 1846 medical report on the Crèche Saint-Philippe-Du-Roule, Dr. Siry, the doctor affiliated with the facility, described the role of this new childcare institution:

> Crèches are sanctuaries [*asiles*] open to infants from their first month of birth until the age of two. They are established, not to treat, but to prevent childhood illnesses; not to dispense medicines to weak bodies, but to put these bodies in a position to do without medicines, by giving them the vigor that they often lack, through a healthy and abundant diet, pure air, clothing to cover their nudity and replace their rags; so that, removed of the insects that devour them, they lose in the repeated lotions the dirt that defiles them. We wanted, in a word, to remove them from an environment fertile with misery and illness, to place them in conditions of strength and health.[1]

Dr. Siry's reflection reveals both the optimism and anxiety inherent in promoting hygiene within the crèche.[2] His confidence in the ability of the institution to prevent illness and improve health was grounded in the new scientific practices related to managing clinical and population health; as a "sanctuary," the crèche was supposed to fortify of infants' bodies with a careful balance of proper food, a clean setting, and adequate clothing. Yet in practice, maintaining and advancing wellness was more complicated than simply providing infants with better, more healthful conditions. While the crèche physically removed infants from their living conditions during work hours, the larger crèche movement often failed to engage with the root causes of poverty and its impact on infants' home environments. Even though reformers attempted to eliminate the "defiling" impact of dirt through hygienic practices and education, no amount of lotion could remove the close association between poverty, filth, and disease. Finally, the regulation of hygiene and disease in the crèche by personnel such as Dr. Siry raised troubling questions about

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[1] Fauconneau-DuFresne, Canuet, Siry, Izarié. *Rapports hygieniques et medicaux sur les Crèches du 1er arrondissements par les docteurs Fauconneau-Dufresne, Canuet, Siry et Izarié*, ed. Firmin Marbeau (Paris: Comptoir des Imprimeurs-Unis, 1846), 47-8.

[2] I have elected to keep the French word, crèche, when referring to such institutions instead of the English translation of "day nursery" or "day care center." This emphasizes the uniquely French iteration of this institution, which differed significantly in aim and character from similar establishments created in other countries.

the reach and limitations of attempts to regulate the physical bodies of infants in the name of health; while disease could be monitored and the polluting impact of dirtiness and poverty contained, infants could never be fully removed "from an environment fertile with misery and illness" since at night, they would go back to their families. Therefore, the crèche project's influence remained limited to the institution itself.

At the time of Dr. Siry's publication, the crèche was a new and innovative institution in nineteenth-century France established in response to the childcare needs arising from several factors, including women's participation in the formal labor market, concern over changing family and class dynamics, and a growing infant welfare movement. Industrialization and urbanization changed the composition of the family and ushered in new patterns of employment. Women moved to the city in search of jobs, either as single women in search of opportunity or to support their families.[3] They often found employment as servants, factory workers, laundresses, and day workers (*journalières*); those who had trouble finding work were often forced to sell sex in exchange for money.[4] As women began to work increasingly outside the home, the insufficiency of existing childcare options coupled with rising concern over infant mortality led to new discussions on ways to promote infant welfare. One potential solution was the crèche, a new type of establishment founded in 1844 by lawyer and philanthropist Jean-Baptiste-Firmin Marbeau. Created in the spirit of Social Catholicism and guided by a strong desire to increase maternal breastfeeding and encourage women to rear their own children, the crèche was a specialized institution meant to care for children during work hours. Unlike existing childcare

[3] Paris grew from approximately 548,000 people in 1804 to 2.5 million in 1900. Most of this growth was due to migration form the French provinces into the city. The population within Paris also expanded most quickly in the working-class neighborhoods (Rachel Fuchs, *Poor and Pregnant in Paris: Strategies for Survival in the Nineteenth Century* (New Brunswick: Rutgers University Press, 1992), 36.

[4] Rachel Fuchs examined records of women in La Maternité, a Parisian hospital catering extensively to the poor. She found that in the 1830s, the majority or women admitted for delivery were domestic servants, day laborers, or workers in sewing industries. She also notes that prostitutes commonly claimed many of the industries noted above, so it is also probable that many of the women listed were clandestine sex workers (26, 33).

options, such as wet nursing, *maisons de severages*, *garderies*, and care by relatives or neighbors, the crèche attempted to reduce infant mortality and morbidity through the use of hygienic childcare practices and close oversight by medical professionals. It set forth a new vision for infant health and wellbeing through the application of highly regulated scientific notions of childcare popularized by the *puériculture* movement. Constructed in the image of both philanthropy and science, it would allow indigent women to work outside the home while fulfilling their role as mothers.[5]

The nineteenth-century emergence of a public health movement concerned with physical wellbeing as a method for creating social change leant to the crèche an optimism about the ability of science to solve complex health and social challenges.[6] Hygienists generated evidence-based responses for preventing illness formulated upon anticontagionist views of disease etiology. Central to their approaches was the importance of changing the physical environment as a method to improve population health, a belief upon which the crèche movement built many of its practices.[7] Alongside institutions such as the *Salles d'Aisles* (preschools), maternal charities and health clinics, and a number of municipal and national offices meant to cater to the working class, such as the *Bureau de Bienfaisance*, the crèche attempted to enforce new standards of hygiene in order to provide infants with optimal care and educate poor mothers about medicalized childrearing practices meant to improve infant health. However, much like the

[5] Unpacking the ways that defenders of the crèches viewed women and work is more complicated than it may at first appear. Supporters of the crèche acknowledged that some women had to work outside the home to support their families and help pull themselves out of poverty. At the same time, authors viewed motherhood as a sacred duty of working women as well as women of leisure. These two beliefs were reconciled by the often-repeated refrain that women should only work outside the home when absolutely necessary. The crèche could then allow the woman to continue to perform her motherly obligations while working. What was most important was that the institution of the crèche not be "abused" by women simply seeking to avoid caring for their infants (see La Société des Crèches, "La Question des Crèches au Congrès de Bienfaisance de Weimar," *Bulletin des Crèches* no. 43 (1886): 350, for example).

[6] Fuchs, 154.

[7] Andrew Robert Aisenberg, *Contagion: Disease, Government, and the 'Social Question' in Nineteenth-Century France (*Stanford: Stanford University Press, 1999), 21.

wider public health movement in nineteenth-century France, interspersed with reformers' confident messages on the ability of the crèche to reduce infant morbidity and mortality lay a profound anxiety over the ability of public health and science to fully control and contain disease. The threat of epidemics, a common criticism raised by detractors of the crèche, was especially important in shaping its practices.[8] This fear raised larger challenges about the ability of this institution to overcome both the health and social threats of poverty, suggesting the limits of health alone as a means of transforming society. By examining an institution that focused its efforts almost exclusively on poor infants, it highlights contemporaries' struggle to determine the effects of nature versus nurture within the context of France's social question; while the science of childrearing laid the basis for creating health and social change through the crèche's practices, infants' broader familial context challenged reformers' belief in the power of health alone to transform society.

Historiography on the rise of the crèche has tended to examine institutionalization, philanthropy, or the relationship of this establishment to a new interest in childhood.[9] While acknowledging that founders created the crèche partially to fulfill a health imperative—

[8] La Société des Crèches, "La Protection des enfants du premier âge dans le Département de la Seine et les crèches," *Bulletin des Crèches* no. 46 (1887): 417.

[9] In the early 1990s, historians often referenced the history of crèches in their treatment of related subject-matter, such as the childhood welfare movement, gender and work, the rise of the welfare state, the development of public health institutions, and wet nursing. These works reflect a social history approach by prioritizing an analysis of social structures such as the economy, family, and health system. However, the majority of these works provide only cursory overviews of the crèches in their earliest iterations before World War I, typically focusing almost exclusively on Firmin Marbeau's seminal 1845 work "*Des Crèches; ou, moyen de diminuer la misère en augmentant la population*" and a few key pieces of legislation enacted to regulate these institutions (See Virginie De Luca Barrusse and Catherine Rollet-Echallier's *La Pouponnière de Porchefontaine: l'expérience d'une institution sanitaire et sociale*.; S. Reynolds' "Who wanted the Crèches? Working mothers and the birth-rate in France 1900–1950"; and Catherine Rollet-Echalier's *La politique à l'égard de la petite enfance sous la IIIe République*). Later works, such as those by Dorena Caroli and Catherine Bouve, also tend to focus more on the rise and spread of the crèche and the institutions supporting them, especially in the nineteenth century. Caroli employs a multi-country perspective to trace the ways that crèches spread across Europe and to explore how other countries borrowed and adapted systems, rules, and structures from crèches in France (Dorena Caroli. *Day Nurseries and Childcare in Europe, 1800-1939 (*Springer Nature: London, 2017). Bouve focuses her analysis exclusively on the rise of the crèche between 1844 and 1870. Her work examines the ways that the educational aim of the crèches was often at odds with the needs of its clientele (Bouve, Catherine. *L'Utopie des Crèches françaises au XIX siècle: un pari sur l'enfant pauvre* (Berne: Peter Lang SA, 2010)).

increasing maternal nursing—historians have narrowly focused discussions about health on the perceived failure of the crèche to impact breastfeeding rates.[10] This has precluded a more robust focus on the ways that its supporters and administrators tended to conceptualize and engage with health promotion and disease prevention. Finally, historians have not adequately placed the practices of this institution within a wider array of techniques and assumptions used by the emergent public health movement. Yet in reality, the crèche did not operate in isolation but was instead part of a larger constellation of social services that intervened under the auspices of health in order to transform the morals and habits of indigent families in the name of social stability.

The present work explores how efforts to improve health were deeply intertwined with changing epistemologies of disease, the infant welfare movement, medical professionalization, and the rise of public health as a more formalized, government-initiated movement. It focuses on the crèche as an important example of the successes, challenges, and limits of efforts to improve population health by asking "How did public health shape the crèche, and how can study of the crèche inform the way we understand the nineteenth-century public health movement?" This thesis begins with the opening of the first crèche in 1844 and ends with the passing of a revised set of national health regulations governing these institutions in 1898. It draws upon approaches to the history of medicine set forth by authors such as Charles Rosenberg. Following Rosenberg, this work treats disease as both biological and social—that is, influenced by the social processes involved in naming, treating, and experiencing illness. Thus, disease should be thought of as a "frame" within which patients, physicians, and society operate. This framework of disease as a

[10] These studies tend to focus on the inability of crèches to achieve their mandate of encouraging maternal breastfeeding and decreasing infant mortality. Many go as far as to claim that the early years of crèches should be considered a failed public health attempt to reduce infant morbidity and mortality. La Berge voices this most strongly in *Medicalization and Moralization (*Ann La Berge, *Medicalization and Moralization: The Crèches of Nineteenth-Century Paris*, *Journal of Social History* 25, no. 1 (1991): 65-87).

"social actor" is dynamic and historically contingent, yet importantly, it is limited by disease as a biological phenomenon.[11] Similar to Rosenberg, this work treats disease as both a "substantive problem and an analytic tool" by which to understand the social and biological context in which it arises.[12] Yet the focus in this work is not on disease itself but on the ways in which contemporaries perceived illness and understood issues of contagion and transmission. It argues that theories about disease etiology informed public health approaches, which in turn inspired the practices of the crèche. By examining key challenges that troubled the initial optimism of crèche reformers, such as the association of poverty with sickness and the nature of poverty as a broader phenomenon, it examines reformers' uneasy confrontation with the limits of both public health and science.

This thesis explores medical reports, the professional journal associated with the crèches (the *Bulletin des Crèches*), laws, and archival sources such as internal rules and regulations published by crèches, to examine the ways in which the crèche attempted to impact infant health well beyond efforts to increase nursing. Separated from the environmental constraints of the working-class household, the crèche was a space where new scientific and hygienic approaches to childrearing could be enacted under the auspices of health. In this new institution, disease and filth might be contained, even prevented, and the polluting impact of poverty itself sanitized. Yet while the crèche set forth a new vision for infant health, attempts to change both physical environment and behavior in the name of hygiene, as well as efforts to monitor contagion within

[11] Charles E. Rosenberg, "Introduction: Framing Disease: Illness, Society, and History," *in Framing Disease: Studies in Cultural History*. Charles E. Rosenberg and Janet Golden, eds. (New Brunswick: Rutgers University Press, 1991), xiii-xxvi: xx.
[12] Rosenberg, xxiii.

the crèche, reveal contemporaries' fear about the inability of scientific approaches to hygiene to fully contain and control poverty and disease.[13]

Chapter I of this work begins with a brief historical overview of the rise of the crèche, situating it within the emergence of the public health movement in the nineteenth century. It then moves to place the emergence of the crèche within a larger confidence in the ability of public health institutions to solve pressing health and social problems. By examining the ways disease etiology informed population welfare movements and their related institutions, it situates the practices of the crèche within a general optimism about the ability of public health and science to transform society. Through an analysis of the founding aims for this new institution, efforts to regulate the crèche environment, and the proliferation of rules and laws meant to control and contain disease, this chapter demonstrates that reformers believed in its ability to solve the pressing social and health problems of high infant mortality though the use of modern science. Specifically, this chapter shows that reformers were especially optimistic about their ability to control conditions within the crèche, including exposure to disease, about the crèche's capacity to change infants' behaviors through the institution, and about the establishment's use of public health to control disease.

The second chapter of this work shows that, although reformers situated the crèche within a wider network of public health strategies, France's "social question" forced them to consider the limits of its social and health project. Reformers' anxiety over the institution's ability to contain, control, and neutralize disease stemmed from a larger concern about the effectiveness of the establishment to transform the habits of the urban poor. Through an examination of the crèche's

[13] It is important to note that the crèche did not proffer a utopian ideal of eliminating poverty and disease. In fact, the institution worked to preserve social hierarchy while nevertheless taming and minimizing the threats associated with the working class (La Berge, *Medicalization and Moralization*, 67). Instead, it provided a "scientific" approach, through which the tenets of modern medicine could minimize disease and be leveraged as a mechanism for social control.

failed educational project, its difficulty operationalizing medical surveillance, and concerns over the statistical representation of morbidity and mortality data in the crèche, this chapter places the institution in the context of the larger limitations of social and health movements in nineteenth-century France.

Finally, this thesis concludes with a reflection on the crèche's twentieth-century transformation into an establishment more concerned with education and childminding than with health promotion. It argues that an examination of crèche reformers' understandings about the limits of both public health and the crèche might help explain the changing nature of this institution. It then finishes by examining how contemporaries' concurrent optimism and anxiety about the crèche's impact on infant wellness and the limits of public health offers important lessons for similar institutions in the present.

# Chapter I

## "Indispensable Conditions:" Ensuring Health in the Crèche through Science

In his founding 1845 oeuvre on the importance of the new institution of the crèche, Firmin Marbeau writes of the establishment's usefulness:

> "It [the crèche] says to hospices and to the *Bureaux de bienfaisance*: 'Help me, and I will help you. I will help you; so that working mothers will no longer ask you for bread; I will help you, so that the nursemaids will no longer ask you for bread nor for beds; I will help you, so that you will have less sick children to heal; I will help you, since I attack misery from three principal sources: unhealthfulness, immorality, and uncleanliness.
>
> …May the Crèches multiply! The poor infant will no longer be condemned to misery; charity…will reanimate him, will preserve him from cold and from hunger…the poor [child] will bless the hand of the rich benefactor; industry will grow to the wealth of the public; France, happier and richer, will have more workers, more numerous and strong soldiers; and man will have made one more step towards the promised land of charity!"[14]

Marbeau's explanation, situated within a growing body of work on the importance of the crèche, provides insight into the ways that reformers envisioned the social, health, and institutional utility of this new institution. Behind this statement is a confidence in the ability of this institution to solve a number of pressing issues afflicting nineteenth-century French society: growing urban poverty, poor health, immorality, and class estrangement. He points to the ability of the crèche to improve infant wellness by combatting the interrelated threats of poor morals, filthiness, and insalubriousness in producing ill health. Charity plays an essential role as a medium to solidify the relationship between the poor and the "rich benefactor," grow the economy, contribute to France's power through the production of soldiers, and decrease pauperism. Situated within a wider network of politics, practices, and organizations, he therefore advances the crèche as a solution in which health provides the basis for social and economic reform.

[14] Marbeau, 132, 134.

Marbeau's optimism in the ability of this institution to solve a number of pressing nineteenth-century concerns through health reflected the rise of new beliefs and practices on the best ways to manage populations' wellbeing. The emergence of public health in nineteenth-century France, and its assumptions about the relationship between disease etiology, illness, and social and economic reform, was especially central to the creation of this new establishment. As a new cadre of interdisciplinary experts worked together to advance large-scale health interventions, a growing faction of reformers similarly came together to document and discuss the problem of infant mortality.[15] These crusaders centered environmental reform as a strategy to control and limit disease.[16] Even though theories of disease causation varied widely throughout the century, most early hygienists embraced a "social theory of epidemiology" that postulated that social factors caused disease, centering poverty in efforts to transform population health.[17] In response, health and social reformers aimed to create new living and housing conditions, expanded private and public organizations offering services to vulnerable populations, and worked to improve institutions such as schools, hospitals, and prisons.

The crèche arose in this larger network of institutions meant to fill both a social and a health need. Importantly, the public health movement leant to the crèche a general optimism about the importance of health as a building block to a more peaceful, productive society. The rise of hygienism took place at a time when other reform efforts, such as those of the Saint-Simonians, created a climate of hope about the nature of health to "rehumanize an industrializing society."[18] Government personnel and social reformers alike moved from a moralizing response towards poverty in the 1830s and 1840s to "a complex sense of optimism and positivism of the

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[15] Ann La Berge, *Mission and Method: The Early-Nineteenth-Century French Public Health Movement* (Cambridge: Cambridge University Press, 1992), 15.
[16] Ibid, 38.
[17] Ibid, 96.
[18] Ann-Louise Shapiro, *Housing the Poor of Paris, 1850-1902* (Madison: University of Wisconsin Press, 1985), 5.

1880s."[19] Similarly, the emergence of both the crèche and public health took place during an expansion of charitable organizations and government initiatives catering to working-class families as a means to regulate the poor.[20] In spite of a lack agreed-upon disease etiology, hygienists nevertheless sought to establish evidence-based approaches to improving population wellness, which were adopted readily throughout France.

This chapter examines reformers' guiding principles, approaches, and confidence in establishing the crèche as a new method to reduce infant mortality and morbidity. It argues that the rise of the public health movement and changing ideas about disease causation led to optimism about the ability of the crèche to address infant health through scientific approaches to hygiene. Reformers were confident in the ability of the crèche movement to influence health and social wellbeing on three levels: in reformers' control of the health conditions within the crèche, including exposure to disease; in the crèche's capacity to change parents' and infants' behaviors through the institution, and in the establishment's use of public health to reduce infant mortality and morbidity. By borrowing techniques from wider efforts to improve population health, reformers could assert the ability of the crèche to reduce infant disease and deaths through science.

This section begins with an analysis of the relationship between public health, ideas on disease causation, and approaches to social reforms in nineteenth-century France in order to situate the emergence of the crèche within a larger effort to improve population wellbeing and social stability. It then moves to analyze the foundational aim of the crèche before turning to explore the ways that reformers harnessed the public health technique of managing the built environment in order to promote infant wellness through physical space. It then concludes with

[19] Fuchs, 154.
[20] Aisenberg, 4.

an analysis on the proliferation of surveillance as a means to prevent and control disease within the crèche by identifying non-compliance and establishing rigorous standards of care.

*Public Health, Disease Etiology, and Social Reform*

The rise of what would become the public health movement in nineteenth-century France stemmed from a confluence of changes related to medicine, science, politics, and demographics. Until the late eighteenth century, efforts to improve population health took place on a local level and were primarily limited to the passing of emergency procedures to address epidemics and strategic regulations to attempt to manage both nuisances and waste.[21] In the early nineteenth century, the rise of the "expert" through the professionalization of engineers, pharmacists, chemists, and physicians created a cadre of trained personnel who could collaborate to address challenging health issues, laying the basis for an interdisciplinary health response.[22] In important professional organizations and institutions, such as the Royal Society of Medicine and departmental and municipal health councils, these professionals generated observations and experiments meant to produce scientific information on the nature of disease transmission and offered proposed solutions to reducing illness.[23] The scientific method provided a new methodology for the testing of theories about disease, and the rise of statistics as a mechanism to understand health in the 1820s and 1830s justified public health approaches through the generation of new kinds of evidence.[24] Finally, the restructuring and emergence of a number of important administrative bodies, including the Paris Health Council and municipal and provincial

[21] La Berge, *Mission and Method*, 9-10.
[22] Ibid, 15-7.
[23] Ibid, 15.
[24] Ibid, 14, 17, 20.

health councils, led to an expanded role for administrators in managing issues related to population health.[25]

Perhaps most significantly, population changes over the long nineteenth century led to a number of urgent health problems requiring a population-level response, including epidemics, contaminated food and water, squalid urban spaces, and pollution. In the 1830s and 1840s, the population of Paris grew significantly through the migration of provincial laborers to the capital city searching for employment. By the middle of the nineteenth century, the Parisian working class had swelled to 400,000 people, out of a total population of one million inhabitants; 350,000 more workers were added to Paris's population following the annexing of a number of suburbs in 1860.[26] The influx of laborers exacerbated social and health problems, such as housing shortages, water quality problems, and disease transmission.[27] Industrialization and urbanization ushered in important changes in family structure and gendered relations within the family. Women in large urban centers began having fewer children and marrying later.[28] The rise of jobs in factories and the decline of traditional cottage industries created new opportunities for women's labor outside the home.

As a result, philanthropists and government officials alike were faced with a number of urgent, highly visible health problems that required population-level reform. The resulting early public health movement was limited mainly to urban areas, due to the concentration of both health experts and administrations as well as pressing health issues in these locations.[29] Historians have traced the emergence of the public health movement in France to the 1829

[25] Ibid, 18-19.
[26] Ibid, 65.
[27] Ibid, 19-20.
[28] Smaller family size was more advantageous in large, industrial cities. Moreover, following the 1880s depression, many families experienced exacerbated financial difficulties that precluded their ability to care for more children (Rachel Fuchs and Victoria Thompson, *Women in Nineteenth-Century Europe* (Hampshire and New York: Palgrave Macmillon, 2005), 33).
[29] La Berge, *Mission and Method*, 20.

creation of the *Annales d'hygiène publique et de medicine legale*, which brought together hygienists, legal medicine specialists, and administrators from the Paris health council and provincial health councils.[30] While the early French public health movement was composed of administrators in local, departmental, and provincial governments, prior to the 1850s, the movement itself was only "quasi-official"; this meant that reformers worked through institutions that received government funding but that public health was neither fully institutionalized nor managed at a governmental level.[31] As the nineteenth century progressed, the French government played a larger role in funding, managing, and promoting health through national laws. French public health in the nineteenth century was marked by a number of features, including its moralizing tone, the importance of local health councils and journals, the emphasis on quantitative data analysis, and focus on filth and human waste. The advancement of hygiene founded on the principles of "bodily separation and aeration," a belief in "technocratic regulation" of health hazards, and finally, the "conviction that the improvement of health conditions depends on the civilization of certain subpopulations."[32]

The nature of public health interventions—especially the identification of effective measures by which to limit illness and death—arose in part / to a large extent out of contemporaries' understandings of disease etiology. The debate between contagionism and anticontagionism and the rise of bacteriology set in motion new interpretations of disease causation. Early hygienists were neither wholly contagionist nor anticontagionist, with many accepting that certain diseases, like smallpox, could be readily transmitted from person to person

[30] La Berge, *Medicalization and Moralization*, 19; Barnes, David S., *The Great Stink of Paris and the Nineteenth-Century Struggle Against Filth Germs* (Baltimore: Johns Hopkins University Press, 2006), 66.
[31] Ibid, 22, 320.
[32] Barnes, 67.

while professing that others resulted from the environment.[33] The cholera epidemics of 1832 and 1848 were especially detrimental to working-class neighborhoods, leading to a focus on housing, especially that of the poor.[34] These outbreaks solidified the prevailing anticontagionist theory, which contended that "local causes" such as filth, poor air quality, bad water and food, poor drainage and sewer systems, and overcrowding caused disease. Anticontagionist beliefs called attention to the "character of the urban environment" in order to "assess the importance of demographic rather than geographic factors."[35] These reformers believed in a miasmatic etiology of disease and focused on "conditions likely to vitiate the air" such as humidity, lack of light or ventilation, and drainage issues. This led to a "public health movement committed to removing surface filth" and informed by "the social etiology of disease."[36] Beginning with the sanitarians, efforts to change people's environment were central to approaches to improve population health. As many authors have pointed out, behind nineteenth-century efforts to improve sanitation lay a vision of improved morality, a sentiment that shaped the scope and content of early efforts to improve health. Shining the spotlight on "disgusting" substances or behaviors provided ammunition for reformers to intervene to prevent "health hazards."[37] As a result, hygienists looked to solutions beyond quarantines, instead seeking to modify the physical factors they believed caused disease.[38]

The subsequent rise of germ theory in the latter part of the nineteenth century changed contemporaries' understandings of disease causation and, to a more limited extent, the resulting public health approaches. For example, the discovery of the Tubercule Bacillus in 1882 by

[33] La Berge, *Mission and Method*, 96. Notably, there is a debate within the historical literature on whether early hygienists were proponents of contagionism, with authors such as Ann-Louise Shapiro claiming that they were (10).
[34] Richard S. Hopkins. *Planning the Greenspaces of Nineteenth-Century Paris* (Baton Rouge: Louisiana State University Press, 2015), 40.
[35] La Berge, *Medicalization and Moralization*, 14.
[36] Ibid, 13-14.
[37] Barnes, 67.
[38] Pinkney, 23.

Robert Koch and the subsequent popularity of "Koch's Postulates" in the 1890s established criteria for determining the causative interactions between bacteria and illness. In some ways, the rise of germ theory drastically transformed the purview and scope of public health. The claim that bacteria caused disease provided a new framework through which disease causation, as well as activities to prevent illness, could be assessed. It legitimized the work of medical professionals, such as doctors, and lessened the public health focus on the environment in favor of more concrete goals, such as vaccination and disinfection.[39] Yet as authors such as David Barnes and Ann La Berge have demonstrated, a significant amount of continuity existed between pre- and post- germ theory conceptions of disease. Barnes's description of the "sanitary-bacteriological synthesis" in which "commonsense cultural appeal and applicability of old knowledge…[was brought] into harmony with the specificity and scientific mastery inherent in the new knowledge of microbes" points to the coexistence of both microbial causes of disease and the continued reference to the link between poverty and disease.[40] Even after the rise of germ theory, the "social definition of the microbe" often dictated that markers of social status, such as food, housing, or actions, might lead to different "individual organic constitution[s]."[41] Ann La Berge has also referenced coexistence of germ theory and anticontagionism. She claims that the contention that germs caused disease actually supported the previous methods used by hygienists, leading to the resurgence of responses based on anticontagionism during the Third Republic in order to address idea that "society was fundamentally disease-ridden."[42]

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[39] Rachel Fuchs, *Gender and Poverty in Nineteenth-Century Europe (*Cambridge: Cambridge University Press, 2005).
*179;* La Berge, *Mission and Method*, 325.
[40] Barnes, *The Great Stink of Paris*, 3.
[41] Aisenberg, 81.
[42] La Berge, *Mission and Method*, 9.

Finally, the nature and activities of nineteenth-century public health efforts were closely linked to wider efforts to promote social reform, as through philanthropy?. While reformers centered *embourgeoisement* as a central social and health aim, measures to reduce poverty did not seek to change the existing social orders but instead, to promote a general advancement of civilization.[43] Especially during the Third Republic, republicans tended to view the answer to France's class problems "…in the self-made revitalization of the individual citizen" through education and improved work spaces and housing conditions.[44] Because of the value that the French people placed on individual liberty and autonomy, in the early part of the nineteenth century, the government rarely intervened directly in people's private affairs, even to promote health. However, the rising movement to limit the transmission of illnesses, coupled with new scientific understandings about disease causation through the use of statistics, provided support for government intervention in the affairs of individual citizens under the auspices of protecting population hygiene.[45] The growing recognition that shared public works—such as clean water management or waste disposal—depended on the collective habits of the population, and later, the notion that germs transcended each person's body, justified health interventions within the previously sequestered domain of the individual.

*The Rise of the Crèche*

The increase in women working outside of the home and the resulting changes to family composition and to infant health led to a public health focus on France's infant mortality problem. The rise of women's participation in the formal workforce created new social and

[43] Ibid, 42.
[44] Barnes, 63.
[45] Joshua Cole, *The Power of Large Numbers: Population, Politics, and Gender in Nineteenth-Century France* (Ithaca: Cornell University Press, 2000), 9-10.

health challenges, especially around questions of childrearing and maternal and infant wellness. The rapid acceleration of urbanization changed the composition of France's cities and the dynamics within the family. Family size in urban centers declined as couples began having fewer children, and childhood took on a new meaning.[46] Poverty, unplanned pregnancy, and unemployment posed special problems to women working to support themselves or their families. In 1864, approximately 75,000 Parisian women worked outside the home, and by 1886, 1,073,142 women held jobs throughout Paris; of this nearly one million women, 11 percent had a least one child.[47] Women typically earned only half the wages of their male counterparts, and were often the first to be laid off in times of hardship.[48] Unplanned pregnancies complicated women's ability to support themselves and led to a record number of infant abandonments throughout the century.[49] For women keeping their infants, wet nursing was a widespread phenomenon that allowed poor mothers to continue to work shortly after giving birth; however, infant mortality was especially high for infants sent out to nurse, leading to a widespread condemnation of this practice by the mid nineteenth century.[50]

Over the course of the nineteenth century, high infant death rates became a source of national anxiety and led to the emergence of a robust child welfare movement urging action at the societal, national, organizational, and personal levels. Better surveillance techniques revealed the magnitude of France's mortality problem, which reformers attempted to address through legislation, education, and health reform. Approximately 34,000 children were abandoned every

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[46] Fuchs and Thompson, 33.
[47] Bouve, 39.
[48] La Berge, *Medicalization and Moralization*, 65.
[49] Infant abandonment was especially high in the department of the Seine. Rural women often came into the city and gave birth to children that they then abandoned. Infant abandonment rates varied between 3.7-16.1% of all births in the early nineteenth century (Bouve, 6).
[50] George Sussman, *Selling Mother's Milk: The Wet-Nursing Business in France, 1715- 1914* (Urbana: University of Illinois Press, 1982), 122.

year by the mid nineteenth century, 64 percent of whom died by age one.[51] While infant mortality statistics vary significantly depending on the source, Marie-France Morel estimates that death rates in the early nineteenth century were between 100 and 350 per 1,000 infants overall.[52] Doctors, legislators, and public health reformers mobilized to question the health-toll of the wet-nursing industry and infrastructure meant to protect foundlings' wellbeing.[53] Because childhood acquired a new meaning throughout the century as the alleged depopulation of France made visible questions of national vitality and military strength, the government intervened to pass a number of important laws meant to protect children, such as the 1874 Roussel Law regulating wet nursing and the 1881 Jules Ferry Law establishing free and mandatory education as well as a number of pronatalist policies, especially during the Third Republic.[54]

Charity organizations were central to efforts to improve children's wellbeing. The infant protection movement matured during the "golden age" for philanthropy, during which time religion provided a central motivation for many private charitable efforts to cater to the poor in the early part of the nineteenth century. Religious activism was especially important to initiatives related to maternal and infant health, as reformers tended to venerate the family as the cornerstone upon which the social order rested. As a result, especially in the first half of the nineteenth century, a number of religious institutions offered charity to mothers and infants, although many required that the woman meet certain moral requirements to receive aid.[55] Social Catholics, in particular, played a large role in private initiatives to help the working class-family. Its proponents tended to adopt more practical and progressive views towards charity for working

[51] Caroli, 14; Bouve 14.
[52] Morel, 197.
[53] See George Sussman's *Selling Mothers' Milk: The Wet-Nursing Business in France 1715-1914* and Fanny Faÿ-Sallois' *Nourrices à Paris au XIXe siecle* for a robust discussion on the wet nursing industry in nineteenth-century France.
[54] Cole, 4.
[55] Fuchs, 199.

women compared with other Catholic ideology.[56] They tended to favor the use of "personal interventions" to address the problems afflicting the working-class family instead of government action. They sought to strengthen the relationship between the bourgeoisie and the working-class since they believed a multitude of working-class problems stemmed from the "mutual estrangement between classes."[57] Moreover, they believed in the importance of changing both working-class morals and the physical and material conditions surrounding the poor in an effort to strengthen and spiritualize bonds within the working-class family.[58] During this period, reformers created important charity foundations, such as the *Société Protectrice de l'Enfance* and the *Société de la Charité Maternelle*, and called for legislative measures to curb infant mortality and address the negative effects of poverty on infant health.[59] In spite of the proliferation of charities, however, very few catered specifically towards new mothers prior to the 1870s, and many only offered services to married women.[60]

In spite of momentum to reduce infant mortality, childcare options for working-class women remained limited. While there were some private efforts by charities and other organizations to provide resources and limited leave for new mothers, this was sometimes too expensive for poor women and unevenly distributed.[61] Moreover, France did not guarantee mandatory maternity leave until 1913. Infants could be placed with a wet nurse, although this could be expensive and was often deadly. Neighbors or family members might care for children, and it was not uncommon to see girls as young as six years old pulled from school in order to

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[56] Caroli, 15.
[57] Mary Lynn Stewart, *Women, Work, and the French State: Labour Protection and Social Patriarchy, 1879-1919* (Kingston, Montreal, London: McGill Queens University Press, 1989), 20.
[58] Ibid, 47.
[59] Ibid, 50.
[60] Fuchs, 127-8.
[61] Stewart, 173.

take care of siblings.[62] *Maisons de severages* and *garderies* offered childcare options to those who could afford to pay.[63] *Maisons de severages* provided childcare on weekly or monthly basis, while *garderies* were located in the homes of older, primarily lower-class, women who cared for a few infants during the day.[64] In both cases, surveillance was often inconsistent, and the quality of care and hygienic conditions varied greatly by location.[65]

Amid this climate of concern over infant mortality and morbidity and the need for expanded childcare options, the new institution of the crèche emerged. Jean-Baptiste-Firmin Marbeau, a lawyer and philanthropist, became convinced of the need to provide care for children under two years of age while completing a report on the *salles d'asiles* in Paris. The pre-cursor to the preschool, *salles d'aisles* only accepted children aged three and above, forcing working mothers to place young infants with a wet or dry nurse, *severeuse,* family member, or neighbor.[66] Marbeau envisioned an institution that could reduce infant morbidity and mortality and decrease infant abandonment. While the crèches became secular starting in the 1870s, Marbeau founded this institution in the spirit of Social Catholicism. Behind his philanthropic goal to "eliminate pauperism without disturbing the social, political and economic order" was a desire to instill religious and class-based values.[67] These included strengthening "maternal feelings" by allowing women to keep their infants instead of sending them to wet nurses and creating solidarity between social classes.[68] Like other Social Catholics, Marbeau linked this new institution to the

[62] Fuchs, *Gender and Poverty in Nineteenth-Century Europe*, 159.
[63] Rollet-Echalier, 94.
[64] La Berge, *Medicalization and Moralization*, 67.
[65] Ibid, 75.
[66] Infants could also be placed in in a *garderie*, a private nursery run out of the household of working-class women or *maison de sévrage*, a private nursery where infants could receive care on a weekly or monthly basis (Ibid, *67)*; Larry Prochner, "The American Crèche: 'Let's do what the French do, but do it our way,'" *Contemporary Issues in Early Childhood* 4, no. 3 (2003): 269; Rollet-Echalier, 94.
[67] Bouve, 75.
[68] Caroli, 15.

larger goal of improving relations between classes by strengthening the working-class family.[69] While the organization emanated from a fundamentally religious context, the crèche was open to young infants of all religions as long as the mothers "…were poor, conducted themselves appropriately, and worked outside of the home."[70] Religious women were especially involved in the operation of the crèches, although between 1870 and 1890, increasingly, management became secular.[71]

Alongside its religious goal, the institution arose from a larger public health imperative to protect infants and improve mothers' childrearing practices. The combination of discourses on health and religion bolstered reformers' optimism in the crèche project by legitimizing their focus on infant wellbeing as the basis for social wellbeing. In his foundational text, *Des Crèches, ou moyen de diminuer la misère en augmentant la population*, Marbeau described its goal as "…procuring for the child pure air, healthy, sufficient and age-appropriate food, a suitable temperature, cleanliness, and uninterrupted care; to give to the mother the liberty of her time, of her arms, and to permit her to carry out her work without worry."[72] As suggested in its title, the crèche worked to increase the population by decreasing mortality through healthy care and by supporting the mother's ability to work without abandoning her child or sending it to a wet nurse. In the 1870s and 1880s, the goal of this institution was reformulated by the *Société des Crèches*. The *Société* described the crèche's aim as:

> …aiding workers to feed and raise their infants themselves. It [the crèche] cares for, during work hours, without distinction of religion, the child between fifteen days and three years of age whose mother works out of the home and who conducts herself well. It is closed on Sundays and holidays. No child spends the night there; none is admitted

[69] Ibid, 15.
[70] Marbeau, 66.
[71] Caroli, 21.
[72] Ibid, 71.

> when sick. The crèche is inspected daily by a doctor. The public is always admitted to visit.[73]

In this reformulation, feeding (generally exclusively framed as breastfeeding) and allowing workers to keep their children emerged as the central aim of the crèche. It established itself as a nonreligious institution, which responded to the wider secularization of France's public institutions; however, it still only provided services for mothers conducting themselves appropriately. [74] Finally, preventing ill health emerged as a central concern of this new establishment, as the crèche needed to be monitored by a doctor and no sick infants were to be admitted.

The crèche's key activities related to existing public health priorities at the time of the establishment's emergence. Because these practices were backed by evidence and justified by science, integrating them into the creche's founding mission allowed reformers to claim confidently that the crèche could reduce infant morbidity and mortality. Through education on *puériculture*, or the science behind childrearing, the crèche attempted to permanently transform the behaviors of working-class women. Sometimes called paedology, *puericulture* was a scientific approach to the care for children that was frequently integrated into education, medicine, and childcare throughout the nineteenth century.[75] Popularized by Dr. Adolphe Pinard, it led to the creation of specialized schools to train staff of crèches and *gardéries* as well as nurses.[76] According to Bouve, the crèche was itself "a *puériculture* school" meant to instruct mothers on the latest hygienic approaches to childrearing.[77] Most central to ideas on the science behind childrearing was breastfeeding, coupled with personal hygiene and sanitation. Because nursing was a key practice to which medical reformers attributed better infant health outcomes,

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[73] La Société des Crèches, *Bulletin des Crèches* no. 25 (1882): 1.
[74] Caroli, 21.
[75] Ibid, 5.
[76] Ibid, 57.
[77] Bouve, 182.

the foundational aim of the crèche to increase maternal nursing reflected prevailing public health assumptions that maternal breastfeeding was one of the most important strategies to improve infant wellbeing.[78]

Lastly, the rise of the crèche responded to a central fear of contemporaries, who believed that industrialism and the rise of the urban working-class had destroyed family bonds.[79] Behind the rise of the crèche lay a fundamentally conservative aim to bolster mother and child relationships by allowing the woman to raise her infant herself instead of abandoning it, aborting it, or sending it to a wet nurse. While the institution supported working mothers, it only advocated for women's work out of poverty and necessity; reformers specified repeatedly that the crèche was not meant to release women of their maternal duties but instead, to facilitate her role as a mother by allowing her to raise her child. As Marbeau explained, "the Crèche effectively comes to the aid of the child, its mother, and its family, without harming the sacred role of maternity, and without encouraging either laziness or vice."[80]

The first crèche opened in Paris in 1844. Like most early crèches, it was only available to legitimate infants possessing both a birth certificate and a certificate attesting that they had been vaccinated.[81] During the day, children would be provided with food, care, and time for play and enrichment; moreover, they would receive medical visits from a doctor and would be breastfed

[78] The explicit focus on breastfeeding stemmed from the lack of safe artificial feeding methods prior to germ theory. In response, charitable institutions recommended breastfeeding, and the government as well as private businesses even tried initiatives to incentivize mothers to nurse their own children instead of sending them to wet nurses (Sussman, 164, 30; Rollet-Echalier, 96). The focus on breastfeeding further arose out of a wider public health backlash against the wet nursing industry, which reformers credited for France's high infant mortality rates (La Berge, *Mission and Method*, 269-270). The application of statistics to health questions in the nineteenth century shed light on the relationship between wet nursing and high mortality. Contemporaries attributed this trend to wet nurses' reliance on artificial feeding and the lack of surveillance to ensure minimum standards of infant care (Rollet-Echallier, 94). By allowing the woman to place her infant in the crèche, the institution worked to prevent the use of wet nurses in order to lower infant mortality, since women were supposed to come to the crèche at least twice a day in order to breastfeed their infant, which took place in designated, hygienic spaces (Fauconneau-DuFresne, Canuet, Siry, Izarié, 113).

[79] Bouve, 198.

[80]Fauconneau-DuFresne, Canuet, Siry, Izarié, 63.

[81] The insistence on accepting only legitimate infants was relaxed in the 1870s. Prochner, 272-3; Caroli, 18;

twice a day by their mother.[82] A *cause célèbre* of the upper class, this new institution spread rapidly, and by 1850, there were twenty-three in Paris. In 1846, Marbeau founded the *Oeuvre de la Société des Crèches* (often referred to as the *Société des Crèches*), a professional organization meant to increase both the funding and the influence of this establishment. In the last quarter of the nineteenth century, the *Société* described its purpose as: "First, to help found and support crèches; Second, to perfect and propagate the institution [of crèches]. It [the *Société*] accords grants to crèches to which the statutes and rules have been communicated."[83] This central body raised funds to support the expansion and development of crèches and created rules, regulations, and mechanisms for communication and decision-making between crèches. While it played an important advisory role, it had no direct power to manage individual establishments, which were responsible for making and enforcing their own rules.[84] As the official publication of the *Société des Crèches*, the *Bulletin des Crèches* promoted the institution of the crèche and publicized its utility to donors, the government, and the wider public.[85]

The rise of the crèche was therefore a response to the growing interest in protecting children and addressing the health and social challenges accelerated by urbanization. This would be done by increasing maternal breastfeeding and instructing working mothers in proper infant

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[82] La Berge, *Medicalization and Moralization*, 69; Rollet-Echalier, 92.

[83] La Société des Crèches, *Bulletin des Crèches* no. 25 (1882): 1. It is important to note that grants from the Société did not make up a significant portion of the revenue raised by most crèches. For example, in 1882, the Société gave grants to 12 crèches, while there were over 30 in the department de la Seine alone (La Société des Crèches, "Compte financier de la Société des Crèches pour l'année 1881," *Bulletin des Crèches* no. 25 (1882): 480-481).

[84] La Société des Crèches, *Bulletin des Crèches* no. 72 (1893): 1.

[85] After the *Bulletin* was relaunched in 1876, its goal was to "cease the isolation of the crèches and their publications, in other terms, federate the crèches."[85] This stemmed from the desire to have more cohesive rules and practices between institutions and to define standards of care between crèches. In order to do so, not only did the *Bulletin* disseminate key regulations from the *Manuel* and other publications, but it also sought to shape individual establishments' procedures by fueling public pressure. The intended audience of the *Bulletin* primarily included government officials, individual benefactors and philanthropists, and crèche officials. Each crèche was supposed to subscribe to the publication, which was meant to promote cohesiveness and outline emergent practices and policies. Most of the articles in this publication took the form of exposés about individual establishments. The *Bulletin* lauded institutions that embodied aspects of the "ideal" crèche and lampooned those whose policies or practices threatened the values behind the regulations the *Société* set forth. In this way, it established informal standards for what an ideal crèche needed to embody.

care techniques. Crèches would be placed in working-class neighborhoods close to both the *salle d'aisle* and the *Bureau de Bienfaisance*. Not only would they provide infant care, but they would also function as de facto pediatric medical clinics where volunteer doctors would ensure infant health and development.[86] As a "social stability" mechanism, it worked to pacify the working-class family by improving bonding and socialization between the mother and her child.[87] While its project was one of *embourgoisement* and "solidarity between social classes," ultimately, it was designed more to spread bourgeois morality, values, and habits than to provide working-class women and their families with opportunities for social mobility.[88]

*Science, Space, and Health Promotion in the Crèche*

In 1844, the Crèche de Chaillot opened in the downtrodden *Bouquet-des-Champs* neighborhood of Paris. For 20 centimes a day, women could place their infant in this three-room, twelve-cot institution between sunrise and eight in the evening on workdays. An all-female staff of *berceuses* (caregivers to newborn infants) and *sevreuses* or *gardiennes* (caregivers to weaned infants) oversaw the operation of the crèche based on periodic supervision and advice from *les dames charitables*, a group of female philanthropists. An all-male council oversaw the general administration of the crèche. Mothers were supposed to return twice during the work day to breastfeed unweaned infants, although, in practice, these infants were more commonly artificially fed. A medical doctor volunteer would inspect infants daily or weekly to ensure health and development, carefully writing notes on each infant in the crèche register.[89]

[86] Prochner, 271.
[87] La Berge, *Medicalization and Moralization*, 83.
[88] Caroli, 15.
[89] La Berge, *Medicalization and Moralization*, 69; Rollet-Echalier, 92.

Importantly, the emergence of the first crèche was an exercise to establish the functionality and rationalize the utility of a new type of institution. As a result, Marbeau and others quickly moved to establish a *crèche-modèle* based on their experiences with the Crèche de Chaillot. The creation of a model institution "…had as its goal proving that the Crèches are possible; that a Crèche costs little to establish and to maintain, and that it produces the happiest of effects without inconvenience to anyone."[90] It reflected the larger trend in public health towards experimentation and the testing of models and theories; it was also meant to generate evidence that could be used to prove the health impact of this new establishment.[91] Marbeau provided a number of rules to which this ideal crèche needed to conform. Most central to this project was the selection of a "very healthy, well aerated, exposed, location large enough for the number of infants that it needs to contain."[92] It specified the need for pure air, large windows, multiple rooms, and heating.[93] This work was the first time the crèche reformers attempted to specify the physical and material conditions necessary to support infant health; subsequent publications by the *Société* and government regulations would focus extensively on the most hygienic and scientific ? to promote the health environment of the institution.

Modifying the environment in which people lived was an essential public health approach bolstered by the prevailing scientific assertion that dirt and filth caused disease.[94] Managing population wellbeing was therefore a key factor that influenced early efforts to transform urban areas.[95] In the early nineteenth century, reformers worked to build sewage systems, guarantee access to clean water, and improve trash management. Haussmannization in the 1850s through

[90] Marbeau, 5.
[91] La Berge, *Mission and Method*, 15.
[92] Marbeau, 72.
[93] Ibid, 72-75.
[94] Ibid, 3.
[95] Ibid, 50.

1870s ushered in important public works projects, such as street expansion and parks, and created a new order to urban life through the reorganization of public spaces.[96] Authors such as David Pinkney and Richard Hopkins have suggested how efforts to redefine urban spaces in the nineteenth century were closely linked to prevailing assumptions about the relationship between poverty and disease and closely tied to social disciplinary mechanisms.[97] Alongside transforming the urban environment, a renewed interest in private spaces, including individual dwellings, played an important role in conversations about health. In the latter part of the nineteenth century, efforts to manage wellbeing shifted to examine private dwelling places and institutions, such as pools, theaters, and schools.[98] Whereas in previous centuries, reformers tended to view efforts to monitor and manage the environment of the home (as well as the behaviors of its individuals) as a violation of individual liberty, as the nineteenth century progressed, they began to see the regulation of private dwellings as essential in efforts to promote the population's health.[99]

The public health focus on regulating the environment in order to promote health led to an emphasis on the importance of the physical structure of the crèche. Because the anticontagionist disease framework remained popular up until the 1880s and 1890s, early efforts to articulate the ideal crèche prioritized the management of the physical factors they associated with ill health, such as the shape of the building, its ventilation and heating systems, and the materials used in caring for infants. This appeal to popular practices to prevent disease and their link to behavioral change helped to strengthen the argument that this new institution could limit

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[96] Barnes, 51.

[97] For Hopkins, positivism plays an essential role in justifying the reorganization of greenspaces under the auspices of public health; for Pinkney, Napoleon's concern with both social unrest and his desire to make the city more "livable" and stable as well as the rise of anti-contagionism bolstered efforts to transform the city's spaces. Pinkney, 23-4; Hopkins, 38.

[98] La Berge, *Mission and Method*, 322.

[99] In fact, Aisenberg identified the 1850 law on insalubrious dwellings as the first major piece of social legislation in the nineteenth century. This law allowed for regulations of conditions within individual homes (45).

disease and improve health. Most articles announcing the opening of a crèche included a full description of the layout of the building and the materials and features of the space. By creating dedicated spaces where infants could be washed and dressed in new clothes, fed clean food, provided with fresh linens, and given fresh air, reformers believed they could protect infant health by managing their care environment.

Many sources recommended an isolation room for sick infants, a laundry room, kitchen, space for breastfeeding women, *vestiaire*, a room with a sink and/or bathroom, and a garden or general space for infants to go outside.[100] By the end of the nineteenth century, the ideal crèche needed to have at least two separate rooms: one for weaned infants and one for infants still nursing or being "artificially fed" through cow's milk or other substances. The separation of weaned and unweaned infants reflected contemporaries' acknowledgement of the need to provide specialized, age-appropriate care to infants of different ages.[101] Such efforts to separate infants into developmental groups did not only stem from a recognition of the need for tailored approaches to children of different ages; but they also arose from a belief that having more rooms and fewer common spaces would limit disease transmission between children.[102] Dividing infants into multiple areas might hamper contagion by decreasing the probability that infants would come into contact with disease-causing agents; further subdividing infants based on their age reflects contemporaries' belief that diseases affected children of different ages distinctly, with younger infants being more susceptible to severe impairment or death following illness.[103]

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[100] It is doubtful that most crèches would have had the ability to have such a significant structure unless they were built specifically for the purpose of minding children. In the early period, it was more frequent that crèches used existing buildings, which came with predetermined layouts (Bouve, 187).
[101] This is best reflected in the different regulations for supervision and care for infants below the age of eight months and those between eight months and 3 years. Fewer caregivers (1:12 instead of 1:6) were required for older infants, who also experienced a different routine within the crèche due to their increased mobility (Caroli, 34).
[102] La Société des Crèches, "Les Crèches de Gentilly," *Le Bulletin des Crèches* no. 75 (1894): 344.
[103] Importantly, in nineteenth-century France, childhood was divided into two key stages: *la premiere enfance* (approximately birth to seven), and *la seconde enfance* (between seven and fourteen years old) (Colin Heywood,

While using separate rooms for infants of different ages played an important disease prevention role for infants who were supposedly healthy, these spaces were insufficient if an infant became ill during the day. Crèches needed to follow strict protocols for dealing with sick infants, who could not be kept in the same space as healthy infants out of fear of spreading disease. The goal was to find the mother and immediately send the infant home to prevent the spread of illness within the establishment. The mandate of the *Société des Crèches* that "None [no children] are admitted when they are sick" led to the need to establish protocols for infants who became ill after being admitted for the day.[104] While waiting for the mother to be located, the infant was to be immediately separated from others in an isolation room. As one author writing on the daily activities of the crèche explained, "With almost all childhood illnesses [*maladies du jeune age*] being very contagious, the preservation of all by the distancing of one [infant] is a rigorous imperative."[105] Although each crèche was supposed to have a dedicated room to quarantine any child that became ill, the *Bulletin* provided very few details on what an isolation room would contain. For crèches that did not have a dedicated room, the infant might be taken to the *directrice*'s office or an unused room to separate him from the other children. In discussions of the ideal layout, reformers tended to stress quarantine rooms as one of the most important disease prevention measures administrators could enforce. Both before and after the rise of germ theory, isolation remained an important method to limit disease transmission.[106] The emphasis on having an isolated room in which to put sick children had its roots in the common criticism of detractors, who believed the crèche would create epidemics by assembling many poor, sick infants in a single location. While the crèche had a rule explicitly refusing the

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*Growing Up in France: From the Ancien Régime to the Third Republic* (Cambridge: Cambridge University Press, 2007), 73).

[104] La Société des Crèches, *Bulletin des Crèches* no. 25 (1882): 1.

[105] La Société des Crèches, "Une journée à la crèche, " *Bulletin des Crèches* no. 30 (1883): 663.

[106] Barnes 163.

admission of ill infants, quarantine rooms were a mechanism through which the institution could placate the concerns of critics and assert their confidence in the ability of the institution's safeguards to prevent illness.

Alongside the use of specialized rooms, aeration and proper heating were essential techniques upon which the crèche relied to promote health. Throughout the nineteenth century, air was seen as an important medium influencing health, especially for children. A number of influential treatises and curriculums educated doctors and children alike on the importance of air, especially in the context of exercise and outdoor spaces.[107] Air became especially central to public health following the Paris cholera epidemics in 1832 and 1848, during which time "the two became virtually synonymous."[108] This interest in air stemmed from the prevailing anti-contagionist view of the cholera epidemics, in which hygienists believed that disease arose from localized conditions, such as the "lack of air and light."[109] Regulating heating and air quality in the crèche reflected prevailing ideas of disease causation. This interest in temperature and air circulation initially had its roots in miasma theory, which was the still the operational paradigm for disease etiology when the first crèche, the Crèche de Chaillot, was created. According to this belief, "bad air" caused disease. Noxious smells and stale air indicate the possible presence of illness, which could be transmitted through inhalation. Ventilation and aeration were considered key tools to prevent illness and were harnessed by the wider public health movement; they were seen as key, frontline strategies for preventing ill health and provided assurance that the crèche had integrated the most scientific and up-to-date medical knowledge on disease prevention.[110] Even after the acceptance of germ theory, aeration and ventilation continued to play a central

[107] Hopkins, 54-47.
[108] Ibid, 43.
[109] David H. Pinkney, *Napoleon III and the Rebuilding of Paris* (London: Princeton University Press, 1958), 23.
[110] Barnes, 67.

role in regulations addressing health within the crèche. Contemporaries could now use germ theory as justification for the practice of airing the building out at night, ensuring minimum volumes of air for each infant, and providing children with access to fresh air during the day. As Catherine Bouve has stated, having "good air" played both a physical and psychological role. Not only was the renewal of air thought to prevent disease transmission, the air within the crèche could be contrasted with the foul air in the surrounding city.[111] Controlling the environment of the crèche by controlling air and heat circulation allowed reformers to demarcate the crèche as a separate environment from that of the neighborhood; while it was physically located in the *quartier*, its hygienic conditions distinguished it from other structures in the community.

The crèche harnessed existing views on aeration as a key mechanism to control air quality for indoor spaces. Air played a central role in conversation in the *Bulletin* on important techniques to manage health. As one writer put it, well ventilated rooms in the crèche were "a veritable bath of air and light."[112] The comparison of clean air and lighting to a "bath" is of particular relevance, as bathing and notions of cleanliness took on an important health significance as the century progressed.[113] Ensuring the circulation of air within the crèche took a number of forms. When personnel built crèches instead of renting or buying already-constructed buildings, reformers provided careful specifications on the placement of windows and doors in order to ensure optimal air circulation.[114] In order to make sure that each infant had access to adequate, fresh air, the 1869 regulations governing the crèches set a minimum air requirement of 8 cubic meters for each infant.[115] As a result, crèches frequently reported the total air volume within the institution as well as the maximum number of infants accepted. Setting a minimum

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[111] Bouve, 125-6.
[112] La Société des Crèches, "La Crèche Hippolyte Noiret," *Bulletin des Crèches* no. 70 (1893): 173.
[113] Sussman, 128.
[114] See, for example, La Société des Crèches, "La Crèche Picpus," *Bulletin des Crèches* no. 43 (1886): 327.
[115] Rollet-Echallier, 92.

standard for air distribution was not enough on its own. Writers debated the best ways to circulate air within the crèche. During the night, when all of the infants were at home, the doors and windows were supposed to be open, only closing before the infants arrived in the morning to heat the crèche if necessary.[116]

Closely tied to ventilation was the temperature of the crèche. Hygienists and doctors believed that avoiding drafts of cold air and maintaining a consistent temperature were essential elements to protecting health. Depending on the crèche, air was generally heated to between 12 and 17 degrees Celsius in the winter, and efforts were made to ensure that temperature during the summer did not exceed 33 degrees.[117] A number of different heating systems existed, varying from fires to stoves and heated pipes. Hygienists concerned with crèches and similar institutions such as *maternités* struggled to find the best mode for heating these buildings. Perceived drawbacks of fires and certain stove systems included irritation of the throat and lungs, susceptibility to respiratory diseases, and dangerous fumes. While hot water furnaces were preferred, the cost of fuel led some institutions, such as the Crèche Hippolyte Noiret, to instead modify their existing furnace system. [118]

The last major aspect of the infants' environment that reformers sought to manage was the use of technology—specifically equipment—within the crèche. Technology played an important role in supporting efforts to control the built environment and as well as facilitating the enactment of new health behaviors. Reformers were especially likely to mention new apparatuses after the rise of germ theory when crèches began to use new advancements, including sterilization apparatuses, water filters, and specialized construction materials. These

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[116] Bouve, 128.
[117] La Société des Crèches, "Crèche Madeleine Brés," *Bulletin des Crèches* no. 71 (1893): 225 ; La Société des Crèches, "Crèche de Seraing," *Bulletin des Crèches* no. 47 (1887): 400 ; La Société des Crèches, "Crèche Fourcade, compte moral et financier pour l'année 1906," *Bulletin des Crèches* no. 125-6 (1907): 429.
[118] La Société des Crèches, "La Crèche Hippolyte Noiret," *Bulletin des Crèches* no. 70 (1893): 179.

practices were meant to reinforce their status as a hygienic institution employing the best care practices related to infant health. Crèches boasted of the use of equipment such as Chamberland Filters to improve water quality and sinks equipped with Harvard water systems.[119] Following the integration of germ theory into approaches to health, an emphasis on controlling microbes led to a renewed prioritization of technology limiting the spread and growth of germs. After contemporaries began to accept pasteurization and sterilization as important methods to kill bacteria, especially in milk, articles discussing the features of the crèche began to focus on the need for sterilization equipment. Both pasteurization and sterilization were especially important in crèches because many artificially fed infants received cow or goat's milk from bottles. In 1892, the *Conseil Municipal de Paris* mandated that crèches receiving government funding distribute only sterilized milk.[120] Crèches with more resources opted to buy specialized equipment to sterilize bottles, including a bain-marie or sterilizers reliant on the Egli-Sainclair System; some chose to pasteurize milk at the crèche using equipment for the Soxlhet Method and similar pasteurization techniques.[121] The use of disinfection methods meant to kill germs further led to the use of new materials for cribs, chairs, and flooring, such as the change from wooden cradles to iron cradles and the use of washable flooring materials.[122]

Health equipment represented a significant portion of operating expenses but was justified by its ability to limit the spread of disease. In 1892, the General Inspector of Childhood Services created an itemized list of the necessary equipment and associated costs for opening a typical crèche accepting eight unweaned and twelve weaned infants. Republished in the *Bulletin*,

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[119] La Société des Crèches, "Devis d'Installation d'Une Crèche," *Bulletin des Crèches* no. 70 (1893): 172; La Société des Crèches, "Crèche Picpus," *Bulletin des Crèches* no. 43 (1886): 328.
[120] Rollet-Echallier, 174.
[121] La Société des Crèches, "Devis D'Installation D'Une Crèche," *Bulletin des Crèches* no. 70 (1893): 190 ; La Société des Crèches, "Devis D'Installation D'Une Crèche," *Bulletin des Crèches* no. 70 (1893): 172.
[122] See, for example, La Société des Crèches, "Crèche de Courgain, à Calais," *Bulletin des Crèches* no. 18 (1880): 258.

"Hygienic expenses" comprised 41 percent of the total expenses and included equipment such as a water-closet and sink, baths, bottle sterilizers, a *bain-marie*, and a specialized infant scale. Health-related equipment was the most significant expense category, costing more than building, laundry room/*vestiaire*, kitchen, or bedroom equipment.[123] This new focus on the importance of equipment related to a larger change within other structures, such as hospitals, prisons, housing structures, and schools. These spaces made use of new inventions increasingly, such as the surgical antiseptics invented by Joseph Lister, sterilization apparatuses, and even more general technology such as sinks and indoor plumbing.[124]

Discussions of the ideal building layout, efforts to monitor and control heating and air quality, and attempts to integrate new technology in the crèche not only reveal reformers' attempts to frame the crèche as a preeminent hygienic institution but also their desire to differentiate this sanitized space from that of the surrounding city. Reformers described the crèche as a hermetic space in which, unlike the living and working conditions of the *ouvrière*, each aspect of daily life operated according to the rules of science and hygiene. As a result, they held a near obsession with sealing off the crèche from bodies, smells, and substances that might threaten infant health. *Vestiaires* or the use of laundry rooms separated infants from their filthy clothing and the used bedding of other infants, which could carry and spread disease.[125] Bathrooms and sinks allowed staff to wash themselves and the infants, removing dirt and the presence of "vermin" such as lice. Fearing that mothers coming to breastfeed their infants during the workday might carry disease or threaten the otherwise sanitary environment of the crèche,

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[123] So-called hygienic expenses totaled 1,055 francs out of a total anticipated expense of 2,600 francs (La Société des Crèches, "Devis D'Installation D'une Crèche," *Bulletin des Crèches* no. 70 (1893): 190-3).
[124] Gérand Jorland. *Une Société à soigner: hygiène et salubrité publiques en France au XIXe Siecle* (Lonrai: Gallimard, 2010), 250. La Berge, *Mission and Method*, 311.
[125] After the rise of germ theory, some Crèches used chambres à disinfection to rid infants' clothing of germs. For an example of disinfection rooms, see La Société des Crèches, "Crèche Fourcade, Compte Moral et Financier pour l'année 1906," *Le Bulletin des Crèches* no. 125-126 (1907): 421-2.

some establishments created designated breastfeeding rooms that could be accessed from the exterior of the building. Instead of walking through the crèche to retrieve her infant, the woman would sometimes be handed her baby in a separate room, limiting infants' exposure to disease and dirt.[126] In later years, this room often contained a sink where women "should wash their hands and their breasts."[127] Therefore, not only did efforts to control the crèche's physical features stem from popular disease prevention practices, but they were also thought to play a role in shaping infants' habits. With a regulated environment came the possibility of cleanly, hygienic, and orderly behavior. By transforming the space of the institution, reformers made possible a larger behavioral change project to reform the *moeurs* of the working class.

Moreover, through containing and neutralizing the external threats of dirt and contagion by regulating and reordering the physical environment of the crèche, contemporaries sought to exercise their control over the aspects of infant health within their power. Public health efforts to reform the built environment allowed reformers to justify confidently their ability to control health within the crèche. Shaping its structure ensured that infants were at least partially reared in a hygienic location and allowed reformers to rigorously monitor the practices and materials to which infants were exposed during the day. The counterpoint to the urban, working-class home, the crèche was instead a pristine space in which every aspect of the built environment played a role in advancing hygiene. Shaping the physical space of the crèche through the use of equipment, heating and airing techniques, and the medicalized arrangement of rooms allowed contemporaries to present the crèche as a living example of the possibilities of cleanliness to advance social change. Most importantly, hygienists attributed a direct causal relationship between efforts to change the environment and practices within the crèche and subsequent infant

[126] Bouve, 188.
[127] La Société des Crèches, "Crèche Madeleine Brés," *Bulletin des Crèches* no. 71 (1893): 220.

health outcomes. Because of the early public health assumption that changing the environment was sufficient to change health, careful attention to the structure of the crèche was supposed to relate to better health outcomes. This provided reformers with certitude that changes in the built environment of the institution would maintain and promote infant health, lending support to reformers' claim that the crèche could decrease infant mortality and morbidity. It further provided a counterargument to detractors' claim that crèches facilitated disease transmission, demonstrating the ways that, like other preeminent health institutions, it used science to minimize the threat of illness.

*Controlling Disease: Surveillance and Legal Reform*

Reformers' confidence that the careful manipulation of the physical environment of the crèche could reduce infant morbidity and mortality resulted in the need for a set of protocols meant to uphold the physical and medical integrity of the crèche. This focus on rules stemmed from a desire to address the concerns of its detractors, who associated the institution with disease. Critics argued that assembling infants in a single location would facilitate the spread of illness and incite epidemics. Conversely, supporters insisted that health outcomes were actually better within the crèche than amongst the general infant population.[128] Rules and surveillance were a means by which to assure the wider public about the healthfulness of the crèche and to marry scientific advice on childrearing with the daily operation of the establishment. The resulting proliferation in internal and external policies and personnel closely mirrored a similar expansion of general public health monitoring infrastructure, lending justification to the crèche's project. By establishing protocols meant to prevent and contain disease based upon modern

[128] La Berge, *Medicalization and Moralization*, 75.

public health and medicine, reformers could confidently assert that the crèche did not threaten infant health.

Given the relationship between contagion and poverty, surveillance emerged as a central concern in wider public health efforts to prevent the spread of disease in urban environments. A number of epidemics—including cholera—in nineteenth-century Paris raised new questions about the role of the government in protecting health and led to expanded monitoring and disease response mechanisms. In order to avert the potentially catastrophic impact of such diseases, the government began to play a larger role in health surveillance and data collection?. [129] The development of rigorous protocols meant to prevent transmission required a robust monitoring system in order to assure compliance. For the first time, bodies of medical professionals came together to talk about permanent, institutional approaches to managing population hygiene.[130] The government created a number of new institutions meant to ensure compliance, such as the la police du port (later la police sanitaire) and the *Conseil Supérieur de Santé* as well as many offices charged with regulating specific industries.[131] The personnel of these establishments intervened increasingly in the domain of private and individual behavior. Finally, this concern with surveillance tied closely to the methods of inquiry legitimized by the hygienists, who depended on the "skeptical testing of existing theories; direct observation; investigation *in situ* and in person; and quantitative analysis of relevant data."[132]

While in prior eras the government hesitated to intervene to regulate behavior within the family, as the nineteenth century progressed, the French government intervened increasingly to

[129] This included the creation of the *Bureau des Epidemies*, established in 1884 (Barnes, 116-7).
[130] This was as opposed to more reactive measures typically put in place to manage the spread of disease (La Berge, 21).
[131] La Berge, *Mission and Method*, 90.
[132] Barnes, 68.

protect health through legislation.[133] Hygienists successfully pushed for better health regulation measures, which challenged traditional notions of privacy and government non-intervention in the private lives of its citizens. It passed a number of important measures regulating occupational health as well as housing conditions, the wet nursing industry, and the urban environment.[134] Key areas for reform included lodging inspections, contagious disease reporting, the creation and enforcement of building codes, the use of construction and habitation permits, and better and more effective authority over health measures, amongst other projects.[135] Given that many doctors and hygienists occupied prominent positions on local, departmental, and federal bodies, they were able to shape French legislation to reflect contemporary health concerns.[136] Finally, linked to surveillance was a new appetite for statistical data on health. As Cole has explained, statistics created "the necessary portrait of inherent social aggregates" so that the "public and private reformers could present their activities as necessary measures to protect such 'natural' national priorities as public health, the integrity of families, and the well-being of the working class."[137]

As an institution, the crèche represented both the hygienic possibilities that proper care of infants might offer as well as the lurking threat of epidemics. As a result, the crèche worked to establish a set of rules that provided rigorous guidelines on even the minutest aspects of the institution's operation. Marbeau attempted to specify a number of crèche-specific statutes in his 1847 work for the *Société*, the *Manuel de la Crèche*, but because of the confederation-like

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[133] La Berge, *Medicalization and Moralization*, 326.
[134] These included policies such as the 1874 Roussel Law, the 1850 law regulating "insalubrious dwellings," and rules limiting work hours and reducing child labor amongst many other regulations.
[135] Shapiro, 125.
[136] Jack Ellis. *The physician legislators of France: medicine and Politics in the Early Third Republic, 1870-1914* (Cambridge and New York: Cambridge University Press, 1990), 2.
[137] Cole, 12.

organization of crèches, no establishment was required to implement these regulations.[138] As a result, each institution had its own set of regulations that it generated not only based on the Société's standards but also in response to the context of its location and clientele. Crèches created rules to police everything from the building's temperature to admission procedures, food quality, and personnel requirements. These policies integrated the most up-to-date science of childrearing with disease preventions strategies from both medicine and public health; as a result, they reflected the aspects of hygiene that reformers felt were most significant to infant health.

Creating mechanisms to ensure compliance was an important way to ensure that the rules the administrators set were actually carried out. Surveillance offered a way for crèches to assure the general public that they maintained strict hygienic conditions and acted proactively to lessen the possibility of disease transmission. As Dr. Napias, a member of the *Comité consultatif d'hygiène publique de France*, explained:

> …it [surveillance in the crèche] is not about anything other than the protection of young children [*enfants du premier age*] and the interest following this [subject] is too high not to justify well-defined conditions and an active surveillance on the part of the [government's] power. No doubt, the hygienic conditions to be imposed should be limited to a small number, since it would be advisable to refer [people] to *special instructions* [with] the indication of precautions and detailed measures, but there are a number of these measures which are fundamental, so to speak, so they must therefore be found in the regulation of Crèches, at least as an indication.[139]

Napias's call for "active surveillance" by the government connected to wider calls for better monitoring mechanisms to track infant mortality. In the last quarter of the nineteenth century, France had the most extensive wet nursing industries in Europe and suffered from extremely high infant mortality rates and low population growth.[140] Concern over national virility, especially following France's defeat in the Franco-Prussian war, turned the nation's attention to

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[138] Bouve, 94.
[139] Napias, Henri. *Réglementation des crèches publiques et privées, rapport présenté par M. le Dr Henri Napias* (Imprimérie Administrative: Paris, 1897), 5.
[140] Heywood, 120, 29.

its child rearing practices and institutions supporting children. This sparked a public outcry for the government to intervene to regulate the wet nursing industry and play a more active role in monitoring and preventing infant mortality, giving way to important policies promoting the health and rights of children.[141]

Prior to legislation passed in the 1860s, crèches were regulated via an 1828 police ordinance on *maisons de severages*. This specified that each establishment should be authorized by the *préfet de police* and needed to submit records tracking their profits, the number of children kept, children's birth certificates, information about the children's parents, and building features.[142] Marbeau, on behalf of the *Société des Crèches*, published a set of suggested internal regulations in the 1847 *Manuel des Crèche*, which were meant to serve as a blueprint for formal legislation.[143] However, it was not until February 26, 1862 that the French government issued a decree formally recognizing the crèche and placing their management under the direction of Empress Eugenie. A separate *règlement ministerial* from June 30, 1862, further divided the crèches into three distinct categories: private, free, and approved, each with a different set of rules. It placed the authority to monitor and regulate the crèche under the *préfet* of each *département* and required Ministry of the Interior approval for the funding of new public crèches.[144] It further specified minimum requirements crèches needed to fulfill in order to receive government funding, fixed the ratio of staff to children, made doctors' visits obligatory, specified data collection mechanisms, and outlined requirements for crèche personnel.[145]

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[141] Important policies included some of the first federal laws on child abuse, mandatory schooling, regulations to the wet nursing industry, and laws limiting child labor, amongst other policies (Stewart, *Women, Work, and the French State*, 44).
[142] Bouve, 94.
[143] Rollet-Echalier, 90.
[144] Caroli, 34.
[145] Bouve, 97; Caroli, 34.

In 1897 and 1898, the government passed supplemental measures specifying the conditions within the crèche, such as heating and space, and forbidding certain practices such as the use of *biberons à tube*. While part of the impetus behind this legislation was to specify even the "most minute" hygienic prescriptions, its most unique contribution was expanded government power to ensure compliance.[146] These regulations allowed the *préfet* to close a crèche in the case of an epidemic and establish mechanisms for requiring health improvements.[147] They created formal inspection mechanisms and specified that the Minister of the Interior had the power to permanently close crèches who repeatedly failed to comply with existing regulations.[148] The government justified this expanded oversight function by referencing the dangers that assembling such a large group of children in one place might pose to the public's health.[149] Important "indispensable conditions" requiring compliance included the minimum cubic air requirements, door and window heights, rules on ventilation and disinfection, and rules relating to the daily operation of the crèche. It set minimum admission and readmission requirements, claiming that an infant who had not attended the crèche for eight days needed to have an additional medical certificate.[150] Finally, it revised the previous rule stating that a doctor needed to visit the crèche weekly, instead mandating the direct employment of a doctor in each crèche who would visit daily.[151]

On a departmental level, the *préfet* played an important role in assuring compliance. The responsibility to order inspections of the crèche resided with the *préfet* of the department as well as the Minister of the Interior. Acting upon the information gathered by inspectors, he could

[146] Bouve, 135.
[147] Ibid, 221.
[148] Caroli, 42.
[149] Ministère de l'intérieur, *Bulletin officiel du Ministère de l'intérieur*, 1898: 414.
[150] The idea behind this re-admittance policy was that an absence of eight days or longer was "abnormal" and could indicate the sickness of a family member (Ibid, 424).
[151] The rationale of changing medical visit requirements behind this was the widespread failure of doctors to comply with visitation requirements of the 1862 regulations (Ibid, 423-424).

provisionally close the crèche if the situation put in danger "the life or health of the infants." In reality, this typically happened only in the case of epidemics. The *préfet* needed to authorize the reopening of the crèche following the full disinfection of the establishment. He had the power to formally warn the crèche in case of non-compliance; after three notices and without action on the part of the crèche and upon approval of the Departmental Council on Hygiene, he could then withdraw his authorization for the crèche.[152] This oversight function was seen as advantageous, since "a regular surveillance has the advantage of holding the institution in suspense, of placing them on guard against routine, in order to incite in them reforms; lacking this surveillance, the penalties provided by the decree and by the *arrête* would be illusory."[153] Therefore, monitoring ensured that the crèches would continue to rigorously uphold important hygiene measures, safeguarding against complacency.

Alongside closing the crèche in the case of an epidemic, *préfets* played an important role in establishing departmental mechanisms for surveillance through health inspection. While it was at the discretion of each *préfet* to choose their inspectors, the Seine Department suggested using *surveillantes* who were already responsible for monitoring the *enfants assistés* (abandoned infants).[154] Therefore, inspectors of the crèche were part of a broader network of personnel assuring health compliance. In their reports, they commented on a wide range of issues that they saw as important to the health and wellbeing of infants in the establishment. Prior to the development of more robust government and *Société des Crèches* guidance on reporting, inspectors and crèches were free to set their own priority areas for surveillance. Earlier reports tended to comment on death and disease in the crèche, the spatial layout (furniture, windows, materials), and care by the *berceuses*. They combined moral commentary with observation, an

[152] Ibid, 431-432.
[153] Ibid, 431.
[154] Ibid, 431.

approach typical to public health inspection at their time of publication and engendered by the link between poverty and health.[155] In some cases, the crèche specified important areas for surveillance that were shared with inspectors. For example, the *Manuel de la Crèche Saint-Louis D'Antin* specified key areas for inspection, whether by public inspectors, inspectors for the *Société,* visitors, or even mothers. These included nine key aspects, such as ensuring the mats and beds were not wet; investigating the cleanliness of children to ensure they have warm feet and do not need to be changed; examining the lockers for orderliness and ensure that no dirty laundry is placed there; visiting the kitchen and ensure that the utensils are clean, even tasting the foods; and finally, asking to see the laundry room.[156]

While the government played an important role in assuring compliance, prior to 1862, the responsibility to properly surveille and monitor each institution often fell to the administrators in charge of each establishment. Within the crèche, institution-specific policies, administrative bodies, and professionals such as doctors worked to prevent and monitor disease. The administration of each crèche was supposed to include a *Directrice*, an administrative council, and a group of women called *les dames charitables* (often referred to *les dames inspectrices* or *les dames patronesses*), who advised on the daily operations in the crèche.[157] While the male administrative council played an important role managing the finances of the crèche, the women-led committee was supposed to visit the crèche daily to assure the quality of care, including monitoring food quality and the health of infants.[158] They were tasked with supervising the *berceuses*, recording their observations, and then comparing them with a "tenue journalier de la

[155] La Berge, *Mission and Method*, 15, 25.
[156] *Manuel de la Crèche Saint-Louis d'Antin*, 2nd ed. (1850): 34.
[157] La Berge, *Medicalization and Moralization*, 69.
[158] Bouve, 163.

crèche" which outlined the establishment's procedures.[159] Like the *dames inspectrices*, the *directrice*, as the head person responsible for day-to-day operations of the crèche, played an essential oversight role. She was supposed to supervise everything from food quality to the separation of each infant's possessions, building temperature, and infants' health status.[160] While she was supposed to have basic knowledge of infant hygiene and prescriptions, she was not a medical provider. She needed to meet certain age specifications, have a certificate of vaccination, and complete a short internship in another crèche in order to qualify for her position.[161] In spite of her lack of formal medical training, she nevertheless played an important health role through dispensing medications, determining when to seek doctor's help to for infants becoming ill while at the crèche, and assuring that proper quarantine procedures took place following the isolation of the sick child.[162]

While the *dames inspectrices* and *directrice* helped to maintain health and hygiene in the crèche, the majority of the responsibility to prevent disease and promote wellbeing fell to its associated doctors. As the key medical personnel affiliated with the institution, doctors' visits were an important means through which to guarantee health. As one reformer confidently stated, "We never need to fear that a Crèche will become an accidental site for epidemics, if above all one takes care to strictly conform to Article V of the ministerial ruling of February 26, 1862, which is therefore conceived of and passed in all authorizations: 'The Crèche will be visited every day by a doctor.'"[163] The growing professionalization of medical doctors and new scientific breakthroughs in medicine, such as anesthesia and sterilization, led to an expanded role

[159] *Manuel de la Crèche Saint-Louis d'Antin*, 34.
[160] See La Société des Crèches, "Crèche Municipal du Premier Arrondissement," *Bulletin des Crèches* no. 76 (1894): 357 ; and La Société des Crèches, "Crèche Fourcade, compte moral et financier pour l'année 1906," *Bulletin des Crèches* no. 125-6 (1907): 429.
[161] Napias, 19.
[162] Ibid, 21.
[163] La Société des Crèches, "La Protection des enfants du premier âge dans le Département de la Seine et les crèches," *Bulletin des Crèches* no. 46 (1887): 417.

for medical providers in managing the clinical health of individuals.[164] A medical committee composed of between two and six doctors were supposed to advise on health within the crèche, and physicians were tasked with visiting infants on a daily or weekly basis.[165] Moreover, the committee was charged with insuring the overall hygiene of the crèche and managing aspects such as food quality, aeration, and disinfection.[166]

Doctors needed to make sure that each infant admitted to the crèche possessed a valid document certifying that he or she was free of illness and vaccinated. They were also supposed to provide services in the event of accidents during an infant's time in the crèche, advise on disease outbreaks, and maintain detailed records tracking each infant's health status.[167] Even though the crèche was not supposed to admit sick infants, "…their [doctors'] assistance is necessary for hygiene precautions, to give some advice to parents and berceuses, to monitor the children, to vaccinate those who have not received them, and to warn if any small affliction would lead to a contagious or epidemic."[168] Finally, they were supposed make sure that sick infants were isolated from their peers and then immediately sent home. As one manual stated, "The crèche is not a hospital; one should not risk harming twenty children in order to treat one sick one, which one would not treat well enough, because there is no infirmary in the crèche."[169]

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[164] The Law of Ventôse, passed in 1803, created for the first time a licensing system for doctors. This certification system, which included medical school and qualifying exams, gave physicians the qualifications to practice based on their medical competency alone (Matthew Ramsey, *Professional and popular medicine in France, 1770-1830: The Social World of Medical Practice* (Cambridge, New York: Cambridge University Press, 1988), 79). Nineteenth-century doctors played a particularly important role in managing women's birthing and newborn care practices. Male doctors began to replace midwives as the primary providers of women's delivery care by the end of the century, especially as hospital-care for childbirth became less deadly and more accessible to women (Rachel G. Fuchs and Paul E. Knepper, "Women in the Paris Maternity Hospital: Public Policy in the Nineteenth Century," *Social Science History*, 13, No. 2 (Summer, 1989): 188-199.)

[165] La Berge, *Medicalization and Moralization*, 69.

[166] *Manuel de la Crèche Saint-Louis d'Antin*, 22-24.

[167] Louis-Silvain-Benoît Izarié, *Rapport médical sur la crèche S.- Louis d'Antin, fait au nom des médecins de l'établissement et lu à la Société médicale du 1er arrondissement, par le Dr Izarié (*Comptoir des Imprimeurs-Unis: Paris, 1846), 13.

[168] Fauconneau-Dufresne, Canuet, Siry et Izarié, 13.

[169] *Manuel de la Crèche Saint-Louis d'Antin*, 22.

As part of their surveillance efforts, doctors and the various committees outlined above needed to write detailed observations in several registers. In the 1862 regulations governing crèches in the Seine, all institutions were required to maintain an admissions register with information on the names and profession or the infant's parents and the child's health status upon admission; a register noting the *journées de présence* (the number of days that each child spent in the crèche); a medical register; and a register for observations by inspectors and visitors.[170] These records played an important role in assembling data for use by many stakeholders. Information contained in these registers was often used to keep benefactors and the wider public up-to-date on important health markers, such as illness in the crèche, medical visits, and admissions statistics.[171] Collecting data further alerted the government to the overall health of the crèche by allowing health inspectors to examine medical records and track the popularity of these establishments.

Rules and surveillance reflected reformers' optimism in the ability of rules and oversight mechanisms to enforce important health standards and thus limit disease within the crèche. They were situated within a similar proliferation of monitoring efforts by the national government, who intervened increasingly to ensure health. The expansion of rules and monitoring efforts was not only meant to assuage worried detractors who claimed that the crèche would actually engender disease, but also to reinforce reformers' confidence in the ability of science to manage illness. The use of evidence-based hygiene practices that public health reformers modeled in response to prevailing notions of disease allowed crèche administrators to assert that morbidity and mortality could be contained through science; the use of medical personnel, such as doctors, further reinforced the idea that the crèche could use a rigorous set of medical practices to prevent

[170] Seine, *Recueil des actes administratifs de la Préfecture du Département de la Seine*, 1863.
[171] La Société des Crèches, "Une Journée à la crèche," *Bulletin des Crèches* no. 30 (1883): 665.

and control disease. Finally, regulations played an important role in ensuring that scientific practices were scrupulously observed by promoting accountability and providing a mechanism to quickly identify any cases of non-compliance.

*Conclusion*

The crèche emerged during a period in which the rise of public health leant optimism to the movement's assertion that it could reduce infant mortality and morbidity. Drawing upon wider approaches to population wellness provided the crèche with concrete, validated techniques to managing disease. Like similar organizations meant to improve working-class health and morals, its practices were based on contemporaries' understandings of disease etiology and evolved out of a desire to create social change through improved health. Reformers were optimistic about the ability of the crèche to influence health and social wellbeing on three levels: in reformers' ability to control conditions within the crèche, including exposure to disease; in the crèche's capacity to change behaviors through the institution, and in the establishment's use of public health to reduce infant mortality and morbidity. Creating detailed rules, surveillance mechanisms, and procedures for controlling and containing disease within the institution supported reformers' confidence in all three domains by harnessing scientific approaches to childrearing and health to prevent and limit illness. However, while reformers framed the crèche as a preeminent institution formulated on the newest approaches to managing infant wellness, a closer examination of the crèche project reveals significant tension between reformer's outward projection confidence and their view of the health impact of the new establishment. This thesis now turns to address how the relationship between poverty and disease challenged reformers' optimism and forced them to confront both the limits of hygienism and of the crèche.

## Chapter II

### "The Crèche is Not a Hospital:" Poverty, Disease, and the Limits of Public Health

While the crèche promised a new vision of both social and medical hygiene, its creation raised a number of troubling health questions. At stake was not only the challenge of whether hygiene and surveillance could limit the epidemic potential of the crèche and similar institutions but also how best to understand the association between poverty, disease, and hygiene. As contemporaries grappled with new epistemologies of disease throughout the nineteenth century, some questioned whether the crèche might not actually endanger the wellbeing of infants. Changing understandings of disease causation led to troubling questions about the benefits and drawbacks of assembling many infants in a single location, a quandary that was debated within the pages of the *Bulletin des Crèches* and beyond. Critics of the crèche worried that it might incite epidemics by convening poor infants within one institution. Defenders believed that its health benefits outweighed the dangers of infectious disease; while they acknowledged the possibility of contagion, they believed that a healthful environment, combined with careful monitoring and the immediate isolation of sick infants, would control the spread of illness.[172]

Even though reformers situated the crèche within a larger network of emergent public health strategies aimed at reducing infant mortality, France's "social question" forced reformers to confront the limits of the crèche's project. In the larger public health movement, urban poverty created significant anxiety over the health and stability of society, leading to a general feeling of "dread" over the "profound and fearful disgust at the city's filth, smells, and overcrowding."[173] Because the crèche served poor infants and their families, in spite of administrators' initial

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[172] La Société des Crèches, "La Protection des enfants du premier âge dans le Département de la Seine et les crèches," *Bulletin des Crèches* no. 46 (1887): 417.
[173] David S Barnes, *The Making of a Social Disease: Tuberculosis in Nineteenth-Century France* (Berkeley: University of California Press, 1995), 25.

confidence in this new institution, challenges of changing the behavior of the poor and enforcing rigorous health standards in the crèche revealed reformers' anxiety and doubts about the ability of this establishment—as well as public health more generally—to fully contain, control, and neutralize social threats to health related to poverty. By examining the failed educational initiative of the crèche, the difficulty of operationalizing medical surveillance, and the debate over the statistical representation of morbidity and mortality in the crèche, this chapter places the challenges and failures of the crèche's foundational aims to improve infant wellness within the wider difficulty of public health to respond adequately and appropriate to the needs of the urban poor.

*Public Health, the Crèche, and the "Social Question"*

Industrialization made visible pressing health challenges, including polluted air and water, filthy and overcrowded dwellings, and epidemic diseases as well as urgent social problems, including changing gender roles, urban poverty, and civil unrest. From its inception, public health in France was decidedly social—that is, concerned with health as a mechanism both to improve population wellness and to resolve the "social question" occupying contemporaries.[174] By the middle of the nineteenth century in Paris, there were three working-class people for every one middle- or upper-class resident.[175] The population of Paris expanded from 550,000 people in 1801 to around 3 million people by 1911, leading to pollution, overcrowding, and squalid housing.[176] Health problems, such as filth, disease, and bad food and water quality appeared to disproportionately affect the poor. The root of this problem appeared to

[174] In fact, poverty was often conceived of as itself a public health concern, leading to a public health movement that was highly attuned to social issues (La Berge, *Mission and Method*, 15)
[175] Shapiro, 7.
[176] Fuchs, 152.

be the conditions to which the poor were exposed, especially bad housing and dirty neighborhoods.[177] The large urban working class and heterogeneous nature of Paris's neighborhoods meant that Parisians "…were forced to acknowledge poverty as a persistent, pervasive phenomenon which could not be ignored."[178]

The disproportionate focus on lower-class men and women stemmed partially from contemporaries' understanding of the relationship between environment and disease. Prior to germ theory, topographical, demographic, moral, and social "conditions" were believed to cause the human body to physically manifest disease through a bodily imbalance of the humors.[179] These conditions, such as miasmas, were not the *cause* of disease, per se, but what allowed for the bodily imbalance to become possible. As doctors and scientists alike continued to explore what definitively caused disease, conditions became so associated with disease manifestation that it was possible to talk about contagion "…without having to resolve the tension between cause and physiological laws in the production of disease; the contagious cause was always mediated by, indeed inseparable from, the domestic environment that served as the 'envelope' of the body."[180] Thus while contemporaries were aware that factors such as poverty did not directly *cause* disease, the prevailing environmentalist approach to illness focused extensively on the conditions which produced disease, leading to an association between poverty and illness.[181]

While the association of class and health justified charitable and governmental interventions in working-class districts, behind these humanitarian efforts lay a desire to enforce social control. Reformers envisioned health as a method through which to inculcate new practices in the working-class, making them more orderly and therefore resolving class tensions

[177] Shapiro, 15.
[178] Ibid, 7.
[179] Aisenberg, 21.
[180] Ibid, 21, 25.
[181] La Berge, *Mission and Method*, 20-1.

through the *rapprochement* of the poor and the wealthy.[182] The link between poverty and contagion provided a convenient justification for interventions to police the behaviors of the so-called "dangerous classes." As Aisenberg argues, by associating disease with poverty, "contagion made the elimination of poverty neither a matter of recognizing the demands of the unruly poor upon government and society nor of limiting the rights of individuals or the operations of a free market. Rather, it imposed the duty of government to protect a social interest that transcended the interests and rights of individuals."[183] The association between destitution and illness not only bolstered efforts by the government to intervene to change working-class morals and behaviors, but it also provided justification for philanthropic organizations to mobilize to prevent illness and reform morals. In the context of the crèche, reformers invoked the connection between poverty and infant health in order to justify the institutions' efforts to change working-class women's behaviors. Children's physical state was often interpreted as a way to gauge the overall health of the neighborhood "much like the canaries kept by miners to detect gas leaks…"[184] Their health not only symbolized the quality of care received by their parents and the environment of their *quartier*; but it also was seen by reformers as a testament to the link between poverty and disease and justification for the life-saving institution of the crèche. Reformers tended to describe poverty as physically manifested on the body of the infant. For example, the infants using the crèche were seen as a "…lamentable population of athrophics, of strumatics, of rachitics that one finds on site more or less still at the present: old faces, grimacing and shriveled; blinking, hungry red eyes, big batrachian stomachs of fetid diarrhea."[185]

[182] Rollet-Echallier, 90.
[183] Ibid, 4.
[184] Cole, 153.
[185] Izarié, 7.

Therefore, reformers' confidence and anxiety alike played out on the physical bodies of the children, the symbol of both poverty and potential? social renewal.

The crèches grew to prominence during a period in which ideas about the casual factors of disease were in flux. Partially at issue was confusion over whether poverty caused disease or disease caused poverty. Some of the most influential public health reformers of the nineteenth century took different stances on this issue. Louis-René Villermé, one of the leading early nineteenth-century French hygienists examining social issues, took the position that poverty caused disease, while his British and American contemporaries, Edwin Chadwick and Lemuel Shattuck, tended to view disease as causing poverty.[186] Villermé relied on the statistics to justify the correlation between poverty and disease thorough presentation of mortality tables, which demonstrated that working class men and women had higher morbidity and mortality than the rich, even when controlling for factors such as population density, altitude, and filth. His work, alongside that of other early nineteenth-century hygienists, established the idea that disease and death were "socially determined" insofar that "social status conferred relative susceptibility to or immunity from disease" within the modern public health movement in France.[187] As a result, hygienists turned their attention to the living conditions of the poor, which increasingly loomed as a "visible threat to both public health and public order."[188]

Like many efforts to promote population health in the nineteenth century, the crèche arose from a religious and philanthropic desire to address the health and morals of the poor. At the same time, this charitable function was closely tied to contemporaries' anxiety related to the moral, social, and health problems exacerbated by urbanization.[189] The living conditions of the

[186] Jorland, 120-1.
[187] Barnes, *The Making of a Social Disease*, 31.
[188] Shapiro, 15.
[189] Bouve, 49.

poor received special consideration in reports and efforts to improve urban health. In his 1846 medical report on the Crèche Saint Pierre de Chaillot, Dr. Canuet described the surrounding houses without windows or doors and infrequently exposed to sun and air, where, "Squatting around the dirty product of their night rounds, they [ragmen] count during the day how much rubbish it takes to make 30 *sous*, and piled up in the corners of their hideous garrets, and even beneath their bunks there are infected bones and old dirty and mud-covered laundry, the fetid miasma of which spreads through the street."[190] In this terrible environment of filth and illness, mothers might instead leave their children in *garderies* "…like in other times Athens sent a tribute each year of its children to the Labyrinth of Crete."[191] Unsanitary living and working conditions were believed to alter both a person's physical health and his or her morality; they also reinforced the conception of the working class as "pariahs living outside of social norms whose lodgings were sites of infection and sedition."[192]

Yet by linking disease and poverty, especially to housing and environmental conditions outside of the crèche, reformers were forced to acknowledge the limits of both public health and the crèche's ability to control and contain disease. If poor infants were contagious, both metaphorically and literally, reformers needed to be able to amass them without endangering their health or morals. At issue was whether the crèche could withstand, resist, and overcome disease through hygiene and a belief in the superiority of scientific care given within the institution. This question paved the way for the proliferation of surveillance mechanisms, laws, and operational procedures discussed in the previous chapter and ignited a long, unresolved debate on the ability of science to overcome both disease and poverty. While emergent public

[190] J.-U.-V. Canuet, *Rapport médical sur la crèche S.-Pierre-de- Chaillot (par le Dr. J.-U.V. Canuet)* (Comptoir des Imprimeurs-Unis: Paris, 1846), 7.
[191] Ibid, 9.
[192] Shapiro, 15.

health practices generated evidence to suggest the positive impact of environmental measures to limit disease, until the acceptance of germ theory, scientists remained divided on what caused illness and therefore how best to prevent it.[193] Therefore, although reformers professed confidence in the ability of surveillance, a healthy physical environment, and mothers' changing health habits to prevent the spread of illness within the crèche, a closer examination of these practices reveals anxiety about the ability of modern health science to overcome the unpredictability of both disease and poverty.

*A Difficult Lesson: The Limits of the Crèche's Behavioral Change Project*

The importance of behavior to the development of health habits led to the crèche's focus on both care for infants within the institution and instruction for mothers on childrearing practices at home. Unlike the physical structure of the crèche, which lay fully under the control of administrators, mothers' and infants' behaviors remained unpredictable and subject to external influences. Even young infants were seen as susceptible to internalizing bad habits and morals, so the routines employed at the crèche represented the "beginnings of an education."[194] Not only would healthful behaviors improve infant mortality and decrease infant morbidity, but they might also lay the groundwork for efforts to manage and transform the conduct of the lower classes. Moreover, providing children with a scientific, medicalized care routine from an early age reflected contemporaries' focus on the link between early infancy and adulthood. Towards the end of the nineteenth century, doctors and moralists alike viewed *l'enfance du premier age* as a key period in which infants developed habits of health and morality that would sustain them throughout their whole life.

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[193] La Berge, *Mission and Method*, 91-93.
[194] La Société des Crèches, "Le *Petit Journal* et la Crèche Bonne-Nouvelle," *Bulletin des Crèches* no. 33 (1884): 16.

Regulating mothers' habits was especially important to the crèche's larger efforts to promote maternal breastfeeding and reduce child mortality. This focus on the impact of the mother on infant health outcomes had its basis in a number of emergent trends. First of all, the nineteenth-century proliferation in the maternal advice genre demonstrated the medicalization of both motherhood and childhood. Publications drew upon "new" understandings of hygiene and cleanliness to combat what some doctors perceived as a deficiency in women's education regarding their maternal duties, especially those directly related to infant health.[195] Moreover, this focus on mothers' behaviors coincided with larger governmental efforts to supervise the previously impenetrable sphere of the family under the auspices of health. Through the anticontagionist framework, environmental causes were seen as the root of most infant deaths; in turn, the mother was viewed as the person most directly in charge of the infant's exposure to physical substances, such as bad air, ill-suited foods, and polluted water, making infant mortality a direct reflection of the quality of motherhood.[196] By blaming the high infant mortality rates on maternal irresponsibility, the government rationalized its intervention within the family in order to protect the child's wellbeing, laying an important basis for subsequent policies regulating behavior within the private sphere.[197]

Efforts to inculcate new morals and practices in women related to a larger desire to promote social stability, health, and order through *embourgeoisement*.[198] Particularly before the rise of germ theory, "the progress of civilization" became a unifying mantra for sanitarians, with many

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[195] These writing often aimed to dispel ingrained "prejudices" that had been practiced for centuries, leading to a medicalization of childhood. While women had gained a limited amount of authority due to their role in childrearing, physicians, moralists, and reformers quickly assumed the role previously held by the male patriarch of the family, eroding women's power over matters of childrearing by questioning their competence. As Heywood explains, especially in the late nineteenth century, the tone in child-rearing manuals changed. Instead of providing advice, doctors now wrote to establish rules about the hygiene and upbringing of children. In short, "child rearing was too important a matter to be left exclusively in the hands of women" (Heywood, 121).
[196] Cole, 153.
[197] Ibid, 19.
[198] Ibid, *Medicalization and Moralization*, 82-85.

reformers believing that epidemics might be prevented through the steady march of human advancement.[199] In this "battle of civilization against backwardness," reformers believed that hygiene should no longer be relegated to a select few with money and resources, but instead reach each and every individual, irrespective of social class.[200] Mothers, in particular, played an important role in developing new habits and morals in their children. However, like many similar programs addressing poverty in the nineteenth century, the goal was not so much to provide the poor with opportunities for social mobility as much as it was to make the lower classes more orderly and manageable while continuing to preserve the existing social order.[201] Health education became a key means through which to instill notions of bourgeois morality, and with it, the promise of a more logical, controllable, and predictable working-class population.

Finally, the change in approaches to motherhood coincided with a shift in focus from just addressing individual hygiene to evaluating the interplay between personal hygiene and issues shaping public health.[202] Constructing personal health behaviors could now be linked to the public health imperative of protecting the wider population. Not only did germs fail to respect the boundaries of the individual, but shared public spaces and systems, including waste management and water systems, also depended on the behaviors of the larger population to function. During the Third Republic, health reformers acknowledged that "public hygiene required private hygiene and would involve public education for adults as well as children."[203] As a result, health and social reformers alike spent significant time and energy trying to improve the *moeurs* of the working-class through education. In equipping working-class mothers with

[199] La Berge, *Mission and Method*, 13.
[200] Barnes, *The Great Stink of Paris*, 3.
[201] Ibid, 67.
[202] La Berge, *Mission and Method*, 10.
[203] Mary Lynn Stewart, *For Health and Beauty: Physical Culture for Frenchwomen 1880s-1930s* (Baltimore: Johns Hopkins University Press, 2001), 59.

bourgeois notions of childhood health, the crèche attempted to become a site of "…educational renewal as a promise of social renewal."[204]

Reformers viewed the crèche as an *École des Mères* that would combat harmful childrearing practices through education. Not only did this approach reflect the growing public health focus on the individual and her behaviors, but it also reflected prevailing techniques to managing the problems associated with urban poverty. As a "school of hygiene" or "maternal school," the crèche attempted to improve infant welfare by combatting the so-called "prejudicial" behaviors of mothers that they believed contributed to infant morbidity and mortality.[205] Some writers even went as far as to claim that the crèche had, "…less in view the children than the parents; the education of mothers, such is the goal that it proposes."[206] As one reformer explained:

> We believe, however, that the mission of the crèche does not only consist of physically minding the child during the absence of the mother; it is necessary to teach parents these notions of hygiene which are too often unknown to them; it is necessary to combat by repeated and patient explanations the prejudices which play so large a part in the great mortality of infants [*de la premiere enfance*]; it is necessary to arrive, undoubtedly not by violent means, but by persuasion, in order [for parents] to obtain and to give this healthy [*salutaires*] care.[207]

The above passage is typical of writing about the educational aims of the crèche. In it, modern notions of hygiene are "unknown" to the working-class parents. The reformer uses education to combat the "prejudices" causing infant mortality, leading by persuasion and example. Such a configuration presupposes that education alone is sufficient for mothers to provide "healthy care" and positions the knowledgeable, affluent reformer as a teacher to the childlike parents. Any reference to the mother's environment or limited resources is conspicuously absent, suggesting

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[204] Bouve, 121.
[205] La Société des Crèches, "Les Ecoles de bonnes d'enfants," *Bulletin des Crèches* no. 40 (1885): 250.
[206] La Société des Crèches, "Crèche de Grenoble," *Bulletin des Crèches* no. 53 (1889): 144.
[207] La Société des Crèches, "Des Bains dans les Crèches," *Bulletin des Crèches* no. 29 (1883): 624.

that the root problem behind the parents' behavior lay not within larger structural forces such as poverty but instead within the individual through her lack of education.

At the crèche, reformers sought to teach mothers a number of important behaviors that they believed would most directly contribute to a reduction in infant mortality and morbidity. To begin with, placing infants in the crèche was itself a health behavior to be cultivated. In the second half of the nineteenth century, wet nursing and infant abandonment both remained widespread solutions to women's need to earn wages.[208] As the century progressed, both practices drew criticism from health and social reformers, leading to a number of important child welfare reforms, such as the 1874 Roussel Law. The crèche framed itself as a convenient alternative to infant abandonment or sending infants to the countryside to be nursed.[209] However, very few women relied on the crèche in its earliest period, placing their infants there sporadically and inconsistently, if at all.[210] The low uptake of the crèches' services puzzled reformers and ignited a lively debate on the reasons for women's failure to enroll their infants in these institutions. Almost all conversations on this subject focused on the barriers that prevented women from using the crèche; however, very few reformers offered suggestions on how to address these impediments in order to enable women to this institution more frequently.

Teaching women to use the crèche was part of a larger effort to encourage women to employ new standards of cleanliness—closely tied to health—outside of the crèche. With cleanliness, reformers saw the ability of the lower classes to adopt middle and upper-class values.[211] A

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[208] It is important to note that wealthy women similarly chose to send their infants to wet nurses as well even though most did not work; however, by the end of the century, the majority of upper class women hired live-in nurses or breastfed their infants themselves (Heywood, 128). As wet nursing came under increasing scrutiny towards the end of the century, however, it was much more common for poor women to rely on a wet nurse because the wet nurse's wages were often much lower than those a woman might obtain working in other professions.

[209] Marbeau claimed that the crèche prevented approximately 50,000 infants from being placed with wet nurses or abandoned (Caroli, xiii, 15).

[210] La Berge, *Medicalization and Moralization*, 77; Caroli, 40.

[211] La Berge, *Mission and Method*, 42.

hygienic crèche environment and clean bodies were necessary prerequisites that allowed the infants and their families to eventually adopt more hygienic behaviors by cleansing them of the physical and metaphorical dirt associated with the disorderliness of poverty. Germ theory gave cleanliness a new valence. While hygiene originally referred to a set of practices meant to maintain health, bacteriology led to "…the modern notion of cleanliness, with dirt as 'the visible manifestation of the invisible, or the hidden bacterial agents of disease.'"[212]

Reformers therefore spent significant time and energy discussing the appearance of infants, emphasizing the need for infants to look clean each day upon admission to the crèche. Some institutions employed specific regulations that were meant to police cleanliness. For example, a number of crèches employed some variation of the rule that infants needed to be "…washed, combed, and properly dressed, under penalty of being refused."[213] This preoccupation with immaculateness translated to larger, state-wide efforts to assess and address the washing habits of working-class families using the crèche. An 1888 memo by the Minister of the Interior called for routine data collection in the crèches on a number of hygienic subjects, including "Did infants enter [the crèche] in a satisfactory state of cleanliness?"[214] Women drew frequent criticism about their perceived inability to keep themselves and their infants clean. This consternation stemmed from the belief that it was the duty of mothers to teach their children about personal hygiene.[215] Discussions on this subject typically focused on mothers' responsibility to bathe and comb their infants and dress them in newly washed, age-appropriate clothing. While cleanliness was central to conversations about hygiene, authors rarely elaborated on what "propreté" meant, leaving open the possibility of different interpretations of it. As one

[212] Stewart, 57.
[213] La Société des Crèches, "Crèches de Bilbao," *Bulletin des Crèches* no. 33 (1884): 25.
[214] La Société des Crèches, "Circulaire du ministère de l'intérieur, paris, 17 décembre 1888," *Bulletin des Crèches* no. 53 (1889): 123.
[215] Stewart, *For Health and Beauty*, 56.

frustrated author wrote, "They [the children] are brought [to the crèche] clean, we are told, but we fear that, for them as for the crèche itself, it is only a relative cleanliness."[216]

Alongside its efforts to change maternal behaviors related to health, the crèche strove to promote new behaviors within infants and children through the employment of a strict, healthful regimen of care. As a result, they focused a substantial amount of energy recommending precise, often elaborate, methods for early infant care. Grounded in *puericulture* and bolstered by a rising infant welfare movement, such recommendations typically focused on cultivating good habits in nutrition, sleeping, bathing, cleanliness, and morality through childrearing. Because the crèche was supposed to lay the basis for the infant's hygienic education, the *Bulletin* devoted significant time to discussing the infant-minding routines employed within the crèche. Each institution needed to implement a rigid schedule of care that corresponded to the age-appropriate health and care needs of infants. Descriptions about the necessary steps for cleaning, infant bathing, and infant feeding included an elaborate set of guidance, each step of which was justified through contemporary understandings of health and hygiene. For example, infants were often subject to a rigorous protocol upon arrival: "… the children are undressed, their shoes removed, and their clothing placed in a *vestiaire*. Then the children are washed, not with a sponge or a rag, but with hydrophilic cotton which is thrown out as soon as it is used. Each infant has its brush and its comb, placed in his case, and which, thanks to the special surveillance of the *directrice*, is for his use alone."[217] This description, along with other similar ones examining protocols on everything from disinfecting clothing to the sending home of sick infants, is a typical example of authors using an elaborate set of practices in order to reinforce cleanliness. Often resembling a ceremony, these elaborate sets of rules were meant not only to demonstrate the crèche's

[216] La Société des Crèches, "Crèches de Montpellier." *Bulletin des Crèches* no. 18 (1880): 263.
[217] La Société des Crèches, "Crèche Municipal du Premier Arrondissement." *Bulletin des Crèches* no. 76 (1894): 357.

awareness of modern health procedures (such avoiding sharing utensils to limit contagion) but also to teach children the importance of hygiene.

Removed from their dwellings and stripped of their outside clothing, the infants were often viewed as blank slates upon which new habits of health might be written instead of individuals subject to a complex network of influences. The crèche project envisioned a similar transformation in working-class mothers, who they believed played an important role in reinforcing in their children the habits necessary to adapt bourgeois morality and garner bourgeois respectability and therefore required education as well.[218] However, contemporaries failed to adapt the newest scientific advice on childrearing to be feasible for poor families. Repeatedly, the public health movement during the nineteenth century generated evidence-based health policies, but especially because the hygienists often focused more on identifying problems than solving them, it rarely adapted such policies to be feasible to people without the time, money, and education to engage in these practices.[219] In this way, reformers were predisposed to center their efforts on the newest hygienic practices while ignoring the resource and environmental constraints facing poor families.

The practice of eschewing a woman's context in discussing her behavior was especially relevant in descriptions of her family's living conditions. As Aisenberg contends, discussions on the relationship between disease and the home revealed "…anxiety about the inability to know the behavior and whereabouts of so many, diverse urban inhabitants…In their [hygienists'] view, urban inhabitants lacked not only the moral, socializing function of the home. They also escaped these extraordinary policing measures…"[220] The home represented not only the physical health environment, through which disease and contamination might be spread, but also invoked a

[218] La Berge, *Medicalization and Moralization*, 67.
[219] Ibid, 4.
[220]Aisenberg, 120.

distinctly moral function as the space in which families raised and socialized their children. Aside from cursory descriptions of the impoverished, unhealthful environment of the home, more frequently, authors tended to generalize *ouvrières*' living conditions, contrasting them with those of the crèche:

> The crèche is always in a better hygienic condition than the majority of workers' lodgings; care is better known, the regimen more regular than in families; the frequent visit of the doctor assures care and hygiene. In all the crèches, the children who are regularly admitted are in general in better health [*mieux portants*] than the others; in all [crèches], one remarks that the infants are less well on Mondays due to the deviations in their regimen for Sundays spent outside of the crèche. This experience allows us to affirm that the child of the worker has more chances to live and to remain robust if he is raised in the crèche than if he is raised by a wet nurse, or even if he is cared for in the lodgings by his mother.[221]

The complex link between environment and behavior in the above passage reflects the "anxiety" Aisenberg and others have associated with the space of the home. The author associates "deviations" in care with the workers' lodgings "outside the crèche," and compares it to the "better hygienic conditions" inside the crèche, in which "care is better known, the regimen more regular than in families." The workers' lodgings—abstractly framed as less healthful than those of the crèche—were associated with divergence and disorder, forming a simple counterpoint to the regular, healthful environment and conditions of the crèche. Women's behavior it not seen as a reflection of her living conditions or resources, but instead, as something inherent to her situation. This leads to the author to assert that the crèche is "always" more hygienic than most working-class lodgings, and justifies the contention that care within the crèche is superior to infant care "in the lodgings by his mother."

Reformers' inability to problematize the connection between the material and social conditions surrounding poverty and working-class families' behavior ultimately led to the inability of crèche reformers to meaningfully change women's childcare and infant health

[221] La Société des Crèches, "Petit Guide-Manuel de Comptabilité," *Bulletin des Crèches* no. 25 (1882): 496.

practices. First of all, this failure took place on a policy level. Interestingly, while several prominent health reformers supported the institution of the crèche, at least within the *Bulletin*, there was no allusion to regulations or reform efforts meant to reduce poverty and ill health in the crèche population through housing or social reforms.[222] Thus the crèche's activities supporting working women remained limited and tied to the institution itself. Moreover, efforts to educate women failed to adequately acknowledge and respond to the many demands upon their time, resulting in poor scheduling and low attendance at events. One author described the failure of a number of Bordeaux crèches to attract working-class mothers to their medical "conferences" where doctors discussed infant hygiene. He claimed that this poor attendance was largely because one crèche held the classes in the evening, while the other conducted them during the day. As a result, very few working-class women attended due to their inability to leave work during the day and their evening responsibilities at home; however, the classes were well attended by *femmes du monde*.[223]

Furthermore, hygienic advice was often untenable for women to implement outside of the crèche, whether due to cost, difficulty, or constraints, such as lack of time or other resources. For example, the crèche's foundational goal "…to help workers to nurse and raise their children themselves" was only met with limited success.[224] While using the crèche instead of sending their infants to a wet nurse may have allowed some women to feed their infants in the evenings and early morning, very few women were able to leave work during the day to nurse. Because few workplaces had policies that permitted women to leave to breastfeed two or three times a

[222] Towards the end of the century, the *Bulletin* did share the results of a number of conferences touching upon infant wellbeing, such as the Congrès international de la protection de l'enfance and the Congrès de bienfaisance de Weimar, but it only shared finding that directly related to the crèche as an institution, not general legislation attempting to improve poor families' conditions (See La Société des Crèches, "La Question des crèches au congrès de bienfaisance de Weimar," *Bulletin des Crèches* no. 43 (1886) and La Société des Crèches, "La Protection de l'enfance et des crèches," *Bulletin des Crèches* no. 74 (1894).
[223] La Société des Crèches, "Crèches de Bordeaux." *Bulletin des Crèches* no. 80 (1895): 501-2.
[224] La Société des Crèches, *Bulletin des Crèches* no. 25 (1882): 1.

day, which the crèche advised, the nursing women often came during the lunch hour, if at all.[225] While some organizations sought to make crèches more numerous so that mothers "could not refuse to come breastfeed with the pretext that the crèche was too far from the place where they worked" and some offered lower pricing for breastfeeding mothers, there was no discussion of workplace policies that impeded breastfeeding.[226] Authors rarely discussed the possibility of women being unable to breastfeed, whether due to malnutrition or disease, a fairly common occurrence amongst working-class women.[227] Instead, the fault lay with the mother, whose laziness and prejudice alone influenced her nursing frequency. As one reformer explained, "it was impossible to obtain from them [the mothers] a larger effort"[228] than breastfeeding at noon.

Especially at issue was the tension between the highly regulated, routinized schedule of the infants in the crèche and the perceived disorderliness of the infant's schedule in the home. Depictions of the care practices used by the crèche related to the growing emphasis of routine on positive child development. Reformers believed regularity was key to influencing habits and promoting health.[229] Routine was closely linked to the civilizing mission behind nineteenth-century public health efforts, which led reformers to focus on the habits of the poor in their attempt to solve France's "social question." Through hygienic reform, reformers expressed "the larger vision of the well-ordered society" that could be more productive, and secure.[230] The fixed schedules and rigid protocols of the crèche are themselves reflections of the growing importance of regularity on both population health practices and child development. This regularity could be contrasted with the perceived unstructured, undisciplined schedule of the infant at home. As La

[225] La Société des Crèches, "Crèches de Lyon." *Bulletin des Crèches* no. 38 (1885): 176.
[226] Ibid, 173 ; La Société des Crèches, "Ouverture d'une second crèche à Beauvais," *Bulletin des Crèches* no. 32 (1883): 716.
[227] La Berge, *Medicalization and Moralization*, 76.
[228] La Société des Crèches, *Bulletin des Crèches* no. 25 (1882): 176.
[229] La Société des Crèches, "Une Journée à la crèche," *Bulletin des Crèches* no. 30 (1883): 663.
[230] La Berge, *Mission and Method*, 42.

Berge and others have stated, crèches were structured around an orderly, habitual lifestyle which stood in stark contrast to the "irregular, disordered lives" of many working-class women.[231] The reality of working-class women's experiences contradicted prevailing notions of childrearing that claimed babies thrived under regularity. Instead of attributing mothers' inability to rear their children with a similar reliance on routine to the structural and material challenges of poverty, authors instead associated mothers' irregularity with ignorance or indulgence. They believed that the threat of disorganization so associated with poverty not only left the infant susceptible to bad influences, but it also threatened the vary health of the infant.

Women drew criticism from reformers for their "failure" to implement a number of practices used within the crèche, ranging from methodical feeding to cleanliness and the use of sterilized milk. Although articles in the *Bulletin* acknowledged the importance of the crèche as a philanthropic organization providing services to working-class women, it nevertheless held women directly responsible for their failure to employ recommended hygienic practices outside of the crèche. Instead of seeing their actions as reflections of poverty, education, access, and other social determinants, they were framed in a discourse of individual choice. This separation of behavior from environment—and from context more generally—resulted in reproaches and advice that failed to meaningfully engage women's situations. Authors complained about women's care practice, placing them in opposition to those of the crèche. Women's deviation from the crèche's feeding practices were a source of consternation to reformers. One article opined, "[In the crèche] The meals are fed at a regulated time, which stokes the appetite and favors digestion. On the contrary, with his family, the child eats everything at any time."[232] Whereas the use of "methodical feeding" within the crèche promoted access to healthy, age-

[231] Ibid, 79.
[232] La Société des Crèches, "Crèche Saint Marguerite—Rapport Médical du Docteur Legrand." *Bulletin des Crèches* no. 18 (1883): 253.

appropriate food, "It is without doubt that this ["methodical" feeding] is poorly observed in families because one remarks upon the notable augmentation of digestive troubles Mondays and days that have been preceded by a holiday, during which time the parents gave to their children food that does not suit their age."[233] Almost no authors sought to understand why mothers might give their infants "defective food."[234] The few who discussed this tended to see it as a result of mothers responding to the whims of the infant "in order to calm its cries and satisfy its caprices."[235] Women received criticism for not bathing their infants, although by the turn of the twentieth century, only four percent of homes had bathtubs, one million Parisians lacked running water, and very few had hot water heaters.[236] With few exceptions, hardships experienced by the working-class mother tended to be associated with "moral disorder" as opposed to factors such as low wages, lack of access, or unhealthy surroundings.[237] In spite of their frequent references to the "poor" working-class women, authors rarely acknowledged the ways that poverty might affect the quality of the infant's nutrition. Instead, the focus was on the behavior itself.

While the crèche initially envisioned itself as playing a leading role in transforming working-class attitudes towards childrearing, its actual impact on women's behaviors took place on a much smaller scale, if at all. Reformers' rigid adherence to the newest and most effective health measures failed to take into account the ability of women to engage in these new practices. Moreover, key tenets to the science of childrearing, including routine, presupposed certain living conditions and lifestyles. The inability of the crèche to adapt its policies to account for its clients' context was not limited to the institution itself but instead reflected a wider

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[233] La Société des Crèches, "Crèche de Sedan," *Bulletin des Crèches* no. 55 (1889): 214.
[234] La Société des Crèches, "Crèches de Suisse," *Bulletin des Crèches* no. 30 (1883): 656.
[235] La Société des Crèches, "Crèche Saint Marguerite—Rapport Médical du Docteur Legrand," *Bulletin des Crèches* no. 18 (1883): 253.
[236] Stewart, *For Health and Beauty*, 66.
[237] Ibid, 64.

medicalization of practices, such as birth, childrearing, and physical health. While working-class women received the brunt of the attention about changed child care practices, ironically, they were the least able to adapt their behaviors. As a result, poor women often rejected the medicalized advice of health institutions in favor of accessible, affordable, and timely practices passed down by neighbors and family members.[238] Reformers met this perceived "refusal" to adopt the newest practices with both frustration and consternation, placing the blame squarely on the mother herself for her failure to engage new behaviors. Most importantly, the failure of the crèche and similar institutions' early efforts to educate the poor demonstrated that science alone was not enough to transform the practices of this population. The crèche project remained limited in its efforts to transform working-class behavior due to its inability to understand the ways that its hygienic advice was often opposed to the realities of working-class families and life outside of the crèche.

*The Limits of Medical Surveillance*

Just as the availability of education did not always result in transformed childrearing behaviors, the existence of elaborate regulations and rules on the daily operation of the crèche did not always lead to healthier establishments. As within the larger public health movement, in spite of the rapid proliferation of surveillance mechanisms related to the crèche, reformers and government officials struggled to implement the regulations that they created.[239] Part of this stemmed from the nature of the early public health movement. Public health reformers were often "good on diagnosis but weak on therapy." This related to the "meliorist stance" held by many modern hygienists, which left the identification of health problems to the purview of the

[238] Barnes, *The Great Stink of Paris*, 165. This has been posited as a reason for the underuse of the crèche in its early period (La Berge, *Medicalization and Moralization*, 81).
[239] La Berge, *Mission and Method*, 325.

hygienist; once the problem was identified, reformers believed that it was the responsibility of either authorities or "long-term socioeconomic change" to resolve the issue. [240] The resultant French movement to promote population wellbeing therefore resulted in the rapid scale-up of rules and laws without functional enforcement mechanisms.[241] Many historians have criticized the nineteenth-century public health movement in France for its interest in generating policies it could not administer.[242] While such policies revealed hygienists' priorities and partially laid the basis for expanded compliance mechanisms in the early twentieth century, weak enforcement hampered efforts to link data collection with government action.[243]

One of the most widely critiqued lapses in surveillance was the doctors' lack of observance of the daily inspection rule. While reformers saw these professionals as the key to ensuring more healthful institutions, in the years immediately following the creation of the first crèche, these services were supposed to be provided free of charge, which meant that few actually visited the crèche daily, as specified in most regulations.[244] A report on the number of doctors affiliated with the Crèches in the Seine Department shows that, of the twenty-five establishments in 1873, five had no doctor affiliated with the crèche and seven had a single doctor; moreover, six institutions did not require a doctor to inspect an infant upon his or her admission.[245] Data on the Crèche Saint-Gervais shows that most doctors visited frequently in the beginning and gradually began visiting less frequently, coming weekly, bimonthly, or occasionally even monthly; unlike the founding guideline that doctors would volunteer their services, beginning in 1858, this crèche experimented with providing the doctor an honorarium in exchange for providing services,

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[240] Ibid, 4.
[241] Ibid, 325.
[242] See La Berge, *Mission and Method*, 325.
[243] La Berge, *Mission and Method*, 325.
[244] Prochner, 271; La Berge, *Medicalization and Moralization*, 71.
[245] Léon Duchesne. *Rapport General sur les Crèches du Département de La Seine, Fait au nom de la Société protectrice de l'Enfance de Paris* (Paris: Felix Malteste et Cte : 1873) 5, 9.

which increased the regularity of his visits. [246] Across institutions, the responsibility to diagnose illness in the crèche often fell to the *Directrice*, who often had little to no formal medical training.[247]

A small number of crèches had the opposite issue and struggled to coordinate care between the too many doctors affiliated with their establishment. An 1873 report showed that, of the twenty-five crèches in the Seine, six had between four and eight doctors responsible for the establishment.[248] This did not necessarily improve infants' access to medical services, since one crèche, which had six doctors affiliated with the institution, only received doctors' visits every two months.[249] In 1896, difficulty with doctor disinterest as well as the challenges of coordinating care between multiple providers led the *Conseil d'Hygiene Publique et de Salubrité du Départment de la Seine* to recommend different medical protocols. Dr. Napias, the lead investigator, defended the *Conseil*'s recommendation of these new practices:

> Currently, crèches choose their doctors, and often … they share the medical service between them … they thus have only a limited responsibility and are not interested in a service where they only have partial authority. Each in his role brings to the crèche his ideas, his habits, his special connection to infant hygiene [l'hygiène de la premiere enfance] … the personnel and management employed in the crèche therefore do not attach themselves to any habits … persuaded that it will be necessary to become unaccustomed to the practices of the previous evening the morning after.[250]

As a result, the *Conseil* recommend that a single doctor be associated with each crèche and that visits take place daily, further specifying that the doctor inspect all infants before their initial admission to the crèche.[251]

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[246] E. Beluze (Dr), *La Crèche Saint-Gervais (11 mai 1846-15 juin 1867), par le Dr E. Beluze* (Paris: Honoré Champion, 1911), 38.
[247] La Société des Crèches, "Le Congrès de 1889 et les crèches," *Bulletin des Crèches* no. 56 (1889): 236.
[248] Duchesne, 9.
[249] Ibid, 5.
[250] Napias, 18.
[251] Ibid, 19.

Alongside doctors' failure to carry out their daily inspections, discussions in the *Bulletin* and in medical reports demonstrate many examples of non-compliance with accepted standards of care within the crèche. The *Dames Patronesses*, who were supposed to oversee the daily operations of the institution, were another example of key monitoring personnel who visited infrequently. The case of the Crèche Saint-Gervais shows that while in the earliest period in 1846 these women would visit multiple times a day, sometimes for up to six hours, by 1855, they only visited every two or three days.[252] Data from an 1873 report on the twenty-five crèches in the Seine Department marked nine crèches as having rare or very rare visits from these women and six as having no *dames patronesses* affiliated with the institution at all.[253] Alongside the failure of certain personnel to comply with standards for oversight, crèches differed over the rigor of entry requirements meant to protect health, such as vaccination certificates and the admission of infants only in good health, and internal policies around food and milk quality.[254] *Berceuses* and *directrices* often engaged in behavior that directly contradicted standards of care within the crèche, such as using the same feeding equipment for multiple infants or ?. As one reformer lamented, "Haven't we sometimes seen children washed with the same sponge and with water from the same tub? Has it not happened that someone has made in the lavatory a milk depository where one keeps, in an open container, the milk destined to the children under the pretext that it was the coldest location in the house?"[255]

Finally, even in institutions where the best hygienic conditions could be observed, sometimes the most scientific health practices were unable to neutralize the threat of disease.

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[252] Beluze, 30-1.
[253] Duchesne, 9.
[254] The *Bulletin* detailed the practices of many crèches and explained their key features, such as the cost, the type of infants admitted, and the quality of medical services and care. An overview of articles on different crèches reveals a wide discrepancy in the operational policies for each crèche—it appears that many recommended standards by the Société des Crèches were often waived if the administrative body supervising the crèche felt that they did not apply to the context in which the crèche was based.
[255] La Société des Crèche, "Le Congrès de 1889 et les crèches, "*Bulletin des Crèches* no. 59 (1889): 239.

While the crèche environment might help slow down disease transmission, it was nearly impossible to eliminate it. As Dr. Napias, a member of the *Comité consultatif d'hygiène publique de France*, stated:

> Crèches with too numerous [infants] have as a disadvantage the more rapid diffusion of contagious diseases so common in children so that the isolated case becomes almost surely the start of an epidemic in the conditions of crèches with numerous [infants], cluttered, poorly designed and poorly surveilled, and even . . . in the best kept crèches sometimes, as a result of extreme contagion in a population that has not acquired a certain degree of immunity.[256]

Some reformers expressed similar statements about the contagious nature of childhood diseases, which often defied even the best practices to prevent them.[257] Because health reformers did not agree upon an etiology of disease until years after germ theory was introduced, it was not always clear whether even the most popular illness prevention methods could fully prevent and contain sickness. Thus, while crèche reformers attempted to establish and enforce detailed monitoring mechanisms, they were sometimes forced to acknowledge that the nature of childhood diseases—often worsened by the negative health effects of poverty—could at times overpower even the most rigorous surveillance.

Financial, practical, and political impediments prevented the enforcement of many of the most central tenets meant to protect health, such as the daily doctor visits, crèche layout, admission of only healthy infants, and practices surrounding food, milk, and care for the infants. Deficient implementation fueled anxiety on the part of both crèche reformers and the institution's detractors, who struggled to assure the wider public of the institution's healthfulness in the face of a number of epidemics as well as reports that pointed to the general failure of certain institutions to create a safe and healthy environment for children.[258] Even in instances

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[256] Napias, 8.
[257] La Société des Crèches, "Une journée à la crèche," *Bulletin des Crèches* no. 30 (1883): 663.
[258] *Medicalization and Moralization*, 75.

where administrators carefully observed the best tenants of hygiene, the unpredictability of both disease and working-class families gestured towards the inability of surveillance to fully contain and control illness. Therefore, while an expanded set of rules and monitoring systems was meant to guarantee compliance and thereby health, in practice, some of the most central aspects remained either unenforced or were themselves insufficient to guarantee health. And the limit of the crèche project to fully control health outcomes would lead to challenging questions about how to measure its impact.

*Morbidity and Mortality in the Crèche and the Problem of Data*

In spite of the proliferation of monitoring and surveillance efforts at an institutional, governmental, and stakeholder level, tracking and reporting health data in the crèche to determine its impact proved especially difficult. The rise of statistics as a new "language" through which to represent population-level phenomena created a number of quandaries for the emergent discipline of public health.[259] Calculating morbidity and mortality figures, in particular, complicated narratives of disease causation within establishments such as hospitals and prisons. Within the crèche, the question of how (and whether) data should be collected on disease incidence and infant mortality exposed reformers' anxieties about the cause of—and hence how best to prevent—illness. Statistics and larger questions about the effects of poverty on health challenged contemporaries' efforts to measure the health impact of the establishment. Collecting robust information on the practices of the crèches and health outcomes was important to convincing the government and wider public of the institution's utility. At the same time, the use of statistics and quantitative data suggested the ways that the crèche might negatively impact health, igniting a robust debate on the crèche's responsibility for both good and bad health

[259] Cole, 1.

outcomes. This paper now turns to address the challenges that expanded surveillance created for collecting health data within the crèche. Through a focus on mortality and morbidity data reporting, it demonstrates contemporaries' unease about the power of science to overcome both disease and poverty, raising troubling questions about the crèche's ability to intervene to protect health.

Efforts to monitor disease transmission and ensure the healthfulness of the crèche raised questions about how best to collect, interpret, and report health data. Partially at issue was the new role of statistics in establishing a link between social factors and disease as well as questions over the expanded role of the government in protecting population wellbeing. As Joshua Cole states in his hallmark work on nineteenth-century statistics in France, "Once captured and tabulated in statistical tables, this understanding of social cause and effect [through statistics] invited calls for government intervention to defend the newly conceived collective interests against both harmful external effects and unwanted behaviors in the population."[260] Put differently, statistics were important to helping mobilize and justify government action against harmful behaviors. They bolstered efforts for social and health reform by revealing the magnitude of health issues, such as infant mortality. Importantly, quantitative, statistical data helped establish a link between morbidity and mortality and disease treatment or prevention efforts, from puerperal fever to cholera transmission. They also reflected "…an impulse to assign rank and value to the vicissitudes of individual fortune, while simultaneously calculating the costs and responsibility for alleviating these uncertainties at the collective level."[261] This link between disease, numbers, and mortality was a mechanism by which to establish the bounds of "acceptable" and "unacceptable" levels of disease within the population. In this respect, statistics

[260] Cole, 212.
[261] Ibid, 13.

were a way to generalize "social standards of well-being in the place of individual measurements of self-satisfaction."[262]

Data reporting and statistics were powerful tools harnessed by the wider infant protection movement. They were an essential mechanism for focusing the government and public's attention on France's high infant mortality rates. While reformers were aware of high mortality rates since the eighteenth century, the government hesitated to intervene in the private domain of the family. The use of statistics allowed reformers to correlate high infant mortality with the wet nursing industry in France and infant feeding practices more generally; most importantly, they helped lay the basis for government intervention by justifying the regulation families' practices in the name of health.[263] This, in turn, lead to the creation of important legislation to regulate and reduce the practice of wet nursing, such as the 1874 Roussel Law.[264] Especially during the Third Republic where concern over depopulation became closely linked to national strength, virility, and security, statistical data on mortality and morbidity played an important role in later government efforts to prioritize and protect child health.[265]

For the crèche, surveillance and reporting both played important roles in shaping public and governmental support for the institution. One of the most common methods of documenting disease incidence within the crèche was through surveillance reports. Before the establishment of government-generated requirements, medical reporting in the crèches took a number of formats. Early medical reports tended to combine both empirical observations and moral commentary and were often republished for a wider audience than just government officials. The *Bulletin* charged doctors, inspectors, and administrators with providing commentary on "… diseases,

[262] Ibid, 65.
[263] Ibid, 160.
[264] Ibid, 153.
[265] La Berge, *Mission and Method*, 326.

vaccinations, nutrition, the special hygiene of children, the general health of the establishment, [and] the operations of staff."[266] While inspectors were supposed to attend to all of these features, early documents tended to focus most extensively on the structure of the crèche and the quality of the building's conditions. This included door and window placement, information on air circulation, and commentary on *berceuses*' behaviors, such as rocking infants.[267] Others focused on overall impressions of hygiene in the crèche and tracked data on the frequency of medical visits, food quality, and admissions statistics.[268] Many excerpts of these reports were republished in the *Bulletin des Crèches* and were meant to show the generally healthy conditions of the crèche while demonstrating new areas for improvement.

As the government expanded its support to and funding of the crèches in the 1860s, it began to specify key health concerns and data that inspectors needed to collect. The *Conseil d'Hygiene Publique et de Salubrite du department de la Seine*, for example, had inspectors examine the crèches in the Seine in order to write an official position paper on the impact of the crèche. This report focused on a number of key health questions, including "Are the crèches' premises unhealthy?" "Is the agglomeration of young infants dangerous?" and "Is one *berceuse* enough for 8 to 10 infants?"[269]As the federal government broadened its oversight mechanisms for the crèche, it sent out a request for data gathering on fourteen important health questions addressing "the conditions more or less hygienic of its setup and its functioning." *Préfets* were asked to have inspectors address key questions, such as "Do infants enter in a satisfactory state of cleanliness?" "Is there a room where infants who suddenly become indisposed can be isolated

[266] La Société des Crèches, Crèche de Sedan, *Bulletin des Crèches* no. 55 (1889): 210.
[267] Izarié, 6-9.
[268] Duchesne, 9.
[269] Firmin Marbeau, *Avis du Conseil d'hygiène publique et salubrité du Département de la Seine sur l'institution des crèches* (Imprimerie Guiraudet et Jouaust : Paris, 1856), 2-3.

while waiting for their parents to arrive?" "What is the provenance, quantity and quality of the milk consumed?" and "What type of bottles are used?"[270]

While inspectors tracked qualitative data related to the overall hygienic state of the crèche, the collection of quantitative data on disease incidence and deaths was of particular significance, especially in later reports. This desire to record and analyze morbidity and mortality figures drew its justification both from the rising importance of statistics to the general infant protection movement as well as the criticism that caring for many infants in a single location would lead to epidemics and other negative health outcomes. Contemporaries acknowledged the ability of data to positively or negatively impact women's use of this establishment as well as donors' interest in supporting the institution.[271] While crèches frequently relied on data to demonstrate the superiority of their care, medical professionals expressed an uneasiness about the degree to which such statistics actually reflected the crèche's impact on infant morbidity and mortality. Dr. Legrand, a medical inspector examining the Crèche Saint Marguerite, expressed his uneasiness with tracking data on disease and deaths in the crèche, stating "… I believe that statistics, the goal of which is to show the superiority of raising [infants] in the Crèches, proves nothing in favor of this and, even to a certain point, may prejudice people against them." His reasoning was that infants were not exclusively cared for in the crèche, making reporting morbidity or mortality in the crèche inaccurate and detrimental to mothers wishing to place their

[270] La Société des Crèches, "Circulaire du ministre de l'intérieur, Paris, 17 décembre 1888," *Bulletin des Crèches* no. 53 (1889): 123.
[271] La Société des Crèches, "Crèche Saint Marguerite—Rapport médical du Docteur Legrand," *Bulletin des Crèches* no. 18 (1880): 251; Bouve, 199.

infants in these establishments.[272] Finally, some doctors similarly urged people to ignore mortality figures, claiming that even more children would have died at home.[273]

The belief that statistics might misrepresent the crèche's impact on mortality and morbidity raised thorny questions about the ways that data reporting could lead to bias.[274] Establishing a causal relationship between care in the crèche and mortality posed a particular challenge. First of all, the populations using the crèche were transient, making tracking data on disease-based mortality extremely difficult.[275] Infants sick with contagious illnesses were, at least in theory, sent home from the crèche or never admitted from the beginning. Moreover, while some establishments had staff that visited the infant at home, more often, children who subsequently left the crèche and later died from illness were generally lost to follow up.[276] Also at issue was the location in which the infant contracted the disease. Because infants only spent the day at the crèche, it was possible that their illness could have been contracted at home in the evening or may have stemmed from a preexisting condition. Crèche administrators attempted to anticipate the latter by noting infant's health status upon admission in the medical registrar. [277] In case the infant later died, they could then make the case for the death stemming not from the crèche but from factors outside of the establishment. Finally, very few mothers used the crèche

[272] La Société des Crèches, "Crèche Saint Marguerite—Rapport médical du Docteur Legrand," *Bulletin des Crèches* no. 18 (1880): 251.
[273] La Société des Crèches, "La Protection de l'enfance dans le département de la Seine en 1892, read to the Académie de Médicine le 7 Aout 1894," *Bulletin des Crèches* no. 77 (1895): 402.
[274] Even amongst historians, there is no consensus on whether mortality and morbidity in the crèche was lower than in other institutions; this stems partially from a lack of aggregate data across institutions. La Berge, for example, claims that it was roughly similar to that in the wet nursing industry (*Medicalization and Moralization*, 273); Caroli only provides figures for 1903 and 1904, which were between 4.5 percent and 8.6 percent, well below the 25 percent mortality rate she cites for infants born to working women (45). Both claim that these numbers varied significantly by institution.
[275] Bouve, 200.
[276] La Berge, *Medicalizaiton and Moralization*, 75.
[277] *Manuel de la Crèche Saint-Louis d'Antin*, 23.

in its earliest period, and many who did use the crèche relied upon it infrequently.[278] The infants admitted on any day, week, or month changed constantly so reporting accurate, proportional mortality figures was, by necessity, nearly impossible.[279]

Part of the desire for precise mortality data stemmed from an interest in comparing care within the crèche to other childcare institutions, such as foundling hospitals, *garderies*, and care with wet nurses, as well as to infant rearing within the home. Statistics were central to conversations on how best to protect infant health and had played an important role in establishing standards of care for other infant care practices, such as the wet nursing industry.[280] Referencing the (usually higher) infant mortality rates of the wet nursing industry was one way to point to the superiority of the crèche and minimize the significance of any deaths that occurred as a result of the institution. Comparing mortality rates placed any infant deaths within the crèche within a larger web of significantly more deadly institutions and practices. As one inspector stated, "If we consider that all the infants who were admitted belong to the poorest class in society, the majority of which suffer the misery of their parents and even more the awful industrialism of their wet nurses, we would be astonished by the advantageous result procured by the crèche."[281] Yet the question of whether collecting and comparing mortality rates between institutions established the superiority of the crèche or further engendered confusion or misinformation led some institutions to reject even comparative mortality rates. The *Conseil d'Hygiene Publique et de Salubrité du Département de la Seine*, for example, listed its position

[278] The crèches were almost chronically underfilled, and those infants attending visited the institution infrequently. La Berge found that, between 1849 and 1853, there were 788 places for infants, yet only 544 were occupied at any one time. (*Medicalization and Moralization*, 77).
[279] Ann La Berge gives the example of a measles and croup epidemic which killed 26/30 babies at the Crèche St-Gervais. However, while there was an average of thirty babies at the crèche at any one time, more than 150 had been enrolled in the crèche over the period of the year, meaning the "30 babies" average reported did not necessarily refer to the same group of infants (*Medicalization and Moralization*, 75). However, it is clear that contagious diseases did lead to significant mortality in some crèche locations.
[280] Cole, 153.
[281] Izarié, 15.

on the question "What is the proportion of mortality between crèches, the Bureau des Nourrices [for wet nurses] and the Hospice des Enfants Trouvés?" It demonstrated the futility of asking this question, stating, "…this question escapes any measure of a solution…the first term of comparison, mortality in the Crèches, does not exist, so it becomes fruitless to occupy oneself with any proportional details."[282] Because of the difficulty of collecting accurate mortality figures and the question of whether to collect them to begin with, reporting techniques varied. Some sources suggested that mortality be used as a way to gauge the general wellbeing of infants in the crèche as compared to mortality for infants in the same age group and neighborhood not admitted to the crèche; the goal was not to establish causality but instead to demonstrate the lower *rates* of mortality within the crèche.[283] Other crèches reported proportional mortality, while some organizations simply reported crude mortality.

Some reformers took an extreme position against childhood mortality in the crèche, arguing that it was inaccurate for Crèches to be held responsible for any infant deaths. As one reformer wrote, reporting deaths resulting from the crèche was erroneous since children were not exclusively raised and treated there and only received its care during the day. Any reporting of mortality statistics, even those that are meant to show the superiority of the Crèches, would therefore risk misleading the public.[284] The *Conseil d'Hygiene Publique et de Salubrite du department de la Seine* expressed a similar sentiment, instead focusing on the foundational mandate that no sick infants were ever to be admitted to the crèche. They claimed that "There are

[282] Marbeau, 12.
[283] Notably, they stated that few crèches had tried to track this data. Moreover, they acknowledged that comparing infants in the crèche to those in the overall quartier was also inaccurate, since the crèche tended to admit poor infants who may have received worse care in their homes than the typical infant, counteracting the influence of the crèche (Ibid, 11).
[284] La Société des Crèches, "Crèche saint marguerite—rapport médical du Docteur Legrand," *Bulletin des Crèches* no. 18 (1880): 251.

no sick children in the Crèche; therefore there is no mortality."[285] These sources typically recommended that crèches not report any mortality data, even if the data reflected the superiority of care within the crèche, since it erroneously established a causal relationship between mortality and the crèche. Finally, the quality of data was frequently called into question. Dr. Beluze critiqued the Crèche Saint-Gervais's practice of progressively recording fewer and fewer diseases in its registers, observing that "…precision disappears in the face of the single and blatant concern of not supplying weapons against the crèche and always and above all assuming its effects are harmless."[286]

Similarly at issue was the question of whether crèches increased infants' exposure to contagious diseases. This question received significant attention from philanthropists and government officials alike, with detractors and defenders offering different interpretations of the data. On the one hand, it was widely accepted that assembling groups of infants together was medically risky since it allowed for the transmission of disease to vulnerable populations with poor existing resilience to disease.[287] Certain childhood diseases, such as measles, were seen as almost impossible to prevent, even under the best hygienic conditions.[288] For detractors, no set of policies or environmental conditions were sufficient to overcome the epidemic threat that contagious disease posed. Supporters, on the other hand, acknowledged the epidemic potential of children in the crèche but claimed that its surveillance mechanisms and healthful conditions would sufficiently minimize any threats of disease. They asserted that the crèche was no more deadly than other existing institutions for infants and that doctors' visits sufficed to identify and

[285] Notably, they stated that few crèches had tried to track this data. Moreover, they acknowledged that comparing infants in the crèche to those in the overall quartier was also inaccurate, since the crèche tended to admit poor infants who may have received worse care in their homes than the typical infant, counteracting the influence of the crèche (Marbeau, 11).
[286] Beluze, 51.
[287] La Berge, *Medicalization and Moralization*, 75.
[288] La Société des Crèches, "Crèches de Gentilly," *Bulletin des Crèches* no. 75 (1894): 344.

isolate any causes of illness in the crèche.[289] Others pointed to the organizational-wide rule that no sick infants were admitted to the crèche in order to demonstrate the vigilance the *Directrice* and other administrators exercised in admitting infants for the day.[290]

For morbidity, establishing a causal relationship between the crèche and either aggravated or reduced disease incidence was especially difficult. Crèches generally kept good records on the number of type of illnesses doctors discovered during their medical visits. Common diseases noted by inspectors included opthalmia, scarlet fever, measles, varicella, and stomach illnesses with a number of rare cases noted, including eczema, prolapsed rectums, and impetigo.[291] At issue was *where* the infants had contracted the disease. Some reformers suggested that crèches should not report morbidity data, much like mortality data, often citing the mandate that no infants were admitted when sick.[292] Other medical personnel, such as Dr. Legrand, eschewed any causal link between the crèches and illnesses by stating, "Outside more than inside [the crèche], [they are] exposed to contracting illnesses, either by contagion or by lack of care or any other cause."[293] Finally, some reformers suggested placing morbidity figures in conversation with rates of illness outside of the crèche. One approach was to demonstrate that the diseases afflicting the infants within the crèche were "…absolutely the same as those that are generally around, especially within the lower class."[294] This called into question whether the diseases were spread within the crèche itself, compared to the larger neighborhood.

As a whole, contemporaries tended to attribute negative health outcomes to conditions external to the Crèche. Referring to the infant's prior health was a method of displacing blame

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[289] Marbeau, 6-7.
[290] Ibid, 6.
[291] Izarié, 14; Canuet, 14.
[292] See, for example, Marbeau, 11-12.
[293] La Société des Crèches, "Crèche saint marguerite—rapport médical du Docteur Legrand," *Bulletin des Crèches* no. 18 (1880): 252.
[294] Izarié, 12.

from the crèche by invoking the association between poverty and disease; in this formulation, most bad health stemmed from external sources to the crèche. As a result, reformers focused extensively on describing the infants' (generally poor) health conditions before they were admitted. Such descriptions focused on the infants' physical disposition in order to show their improvement within the crèche environment. Such descriptions were then contrasted with infants' improvement while in the crèche, where they became healthier and better behaved. Other times, focusing on infants' physical health served to prevent any causal link between the crèche and subsequent illness or death. As one author stated, "The crèche is not a hospital. The child needs to enter it well and leave the same way, and in the course of the day, if there is a serious indisposition or symptoms of illness, he must be returned immediately to his family. The crèche is therefore not responsible either for the sicknesses or for the deaths of its residents."[295] One doctor described the clientele as "a majority of sick people," discussing how "More pains than satisfaction await the doctor, the inspectors, the staff devoted to the relief of these evils; and, however mediocre their success may be, they cannot be consistently kept up."[296] Establishing the clients as sick from the beginning therefore became a rationale for the "mediocre" successes of doctors and high failure rates, framing medical providers and staff as attempting to positively impact infants while also debarring them from any responsibility for negative health outcomes. A different doctor expressed a similar sentiment, claiming that children who attended the crèche and later died were "…victims that desperation and misery had already assured before the opening of the crèche…"[297] Finally, reformers urged people to seek

[295] La Société des Crèches, "Crèche saint marguerite—rapport médical du Docteur Legrand," *Bulletin des Crèches* no. 18 (1880): 252.
[296] Beluze, 41.
[297] Canuet, 17.

explanations for mortality in the infant's environment outside of the crèche.[298] When epidemics happened, they were generally seen as the result of a lack of compliance with existing policies or the failure not of the institution itself but of its structure or lack of surveillance.[299]

By entrenching the association of poverty with disease and death and conceptualizing this relationship as external to the crèche, reformers could claim responsibility for any subsequent improvements in infant health. But they failed to acknowledge that if they attributed to the crèche alone a causal role over good health outcomes, they also needed to recognize that this same institution could cause poor health outcomes. The challenges reporting morbidity and mortality reveal a profound unease about contemporaries' conceptualization of the causal relationships between health, poverty, and the crèche. While technically part of the neighborhood, the crèche was supposed to be distinct in its environment and hygienic practices. The idea was to insulate infants from the polluting effects of poverty on their physical and moral development by removing them from their home environments and exposing them to a consistent, hygienic routine. Yet the assemblage of poor infants in a single location imperiled the health mission of the crèche. The infants' bodies were a constant physical reminder of the health effects of poverty and the unpredictability of disease, threatening to disrupt the insular nature of the crèche. They placed into question reformers' belief that only good health outcomes could be attributed to the crèche by demonstrating how, even in the most controlled conditions, the crèche could also engender epidemics and disease.

[298] La Société des Crèches, "Petit guide-manuel de comptabilité," *Bulletin des Crèches* no. 25 (1882): 492
[299] See, for example, Napias, 8.

Reformers' anxiety in their framing of the behavioral change function of the crèche, attempts to bolster medical surveillance, and the difficulty of reporting mortality and morbidity figures called into question whether faith in modern science and health protocols could fully overcome the volatility of contagion and poverty. Unpredictability, long associated with poverty itself, lay at the heart of debates about how best to preserve health and prevent disease in the crèche. While the crèche was meant to be a space in which contemporaries shaped and tamed the lower classes, the constant threat of disease exposed the limits to which even the most exacting scientific standards could fully ensure health. Therefore, even though public health provided reformers with validated, scientific strategies through which to control and limit disease, urban poverty challenged the ability of the crèche to fully control health, and in turn, placed into question its capacity to master poverty itself.

## Conclusion

The widespread underuse of the crèche at the end of the nineteenth century and its subsequent transformation into an institution more concerned with education and child minding embodied the tensions inherent to the crèche's struggle to reform the health and morals of the working class. Across the twenty-one Parisian crèches available in 1849, each was attended by an average of 13 infants despite a typical capacity of 25-30.[300] This trend continued throughout the nineteenth century in spite of the rapid proliferation of new crèches throughout France and internationally. In spite of the importance of the crèche in public health efforts to reduce infant mortality during the Third Republic, throughout the 1890s in Paris, the 70 crèches typically admitted only 1,316 infants out of a total of 2,304 available places.[301] Moreover, mothers tended to place their infants in these institutions inconsistently. In 1868, the average child who attended the crèche spent only 56 days per year in this institution, with many attending for a far shorter period of time.[302] Reformers cited a myriad of reasons for women's underuse of the crèche: distance, the requirement that mothers clean infants' clothing and bedding, the establishments' exclusion of sick infants, poor mothers' prideful rejection of charity, and the use of hygienic practices such as bathing that some women opposed.[303]

Even though the institution's popularity wavered in its earliest period, a public health focus on depopulation in the Third Republic led to a renewed interest in the crèche as a method of combatting infant mortality.[304] Building upon the legislative changes of the late nineteenth century, the government continued to pass new regulations to enforce better hygienic practices

[300] La Berge, *Medicalization and Moralization*, 77.
[301] Caroli, 40.
[302] Ibid, 33.
[303] La Société des Crèches, "Des Bains dans les Crèches," *Bulletin des Crèches* no. 29 (1883): 624.
[304] La Berge, *Medicalization and Moralization*, 82.

within these establishments, the most important of which passed in 1917, 1923, and 1924.[305] By the turn of the twentieth century, there were more than 100 crèches in Paris alone and over 400 throughout France; in 1946, there were 544 crèches caring for over 11,000 children; as of 2014, France had a total of 960,400 infants placed in 11,968 crèches or similar institutions catering to children under the age of three.[306] As the institution spread, the nature of the crèche changed. In the mid-nineteenth century, most were freestanding institutions, but beginning in the 1870s large businesses began to offer a modified form of the crèche *in situ*. Coupled with the rise of the factory crèche, the creation of the *pouponnières*—crèches that functioned overnight and on weekends—led to expanded opportunities for childcare.[307] As time progressed, the militant health aims of the crèche gradually gave rise to more relaxed policies and a concentrated focus on the developmental care of infants. Increasingly, the crèche became a simple site of childcare that lacked its initial robust health aim.[308]

While it is ultimately outside the scope of this paper to determine the proximate causes for this transformation, a more robust examination of confidence and anxiety of the crèche project—especially in relation to the larger public health movement and activities of similar organizations catering to the working class—might help historians understand the limitations of the crèche's larger efforts to transform women's hygienic behaviors related to childrearing. This thesis has suggested the ways in which measures addressing infant mortality magnified limitations in the

[305] Rollet-Echallier, 90; Caroli, 53-54.
[306] Bouve 41, 52. Caisse Nationale des Allocations Familiales, *Résultats du Rapport 2016 de l'Observatoire national de la petite enfance : Dossier de Presse (*Paris: 2016).
[307] Factory crèches arose in the 1870s as a response to the problem of the distance between the crèche and the institutions in which mothers worked. They were meant to allow mothers to breastfeed their children during work hours. By setting up feeding rooms or subsidizing milk dispensaries within the factory, businesses attempted to contribute to a reduction in infant mortality for infants of working mothers. These establishments were generally less concerned with health and more concerned with childminding (Caroli, 29, 44). While the impetus behind these organizations was economic, not philanthropic, and the conditions were generally more modest than those of freestanding crèches, these sites provided important childcare alternatives for working women, especially before the French state began enforcing its maternity leave law in 1913 (Caroli 44).
[308] Many authors have pointed to the crèches' inability to increase maternal breastfeeding as a "failed" effort to decrease infant morbidity and mortality (Caroli, 40, 56; La Berge, *Medicalization and Moralization*, 77).

tenets and practices of the nineteenth-century public health movement. In this context, reformers' own preoccupations with the interrelationship between poverty and disease emerge as overwhelming barriers to an effective focus on the stated goal of combating infant mortality—a goal which ultimately would have depended on the project's successful attraction of working-class mothers. The public health focus on identifying and critiquing health issues instead of focusing on generating solutions meant that reformers were predisposed to concentrate their efforts on the newest hygienic practices while ignoring their adaptability. In this way, the crèche project demonstrated the limits of the nineteenth-century public health movement.

Just as the crèche sought to make sense of the relationship between poverty and health, so too did the wider hygienist movement. Reformers initially derived optimism about transforming society through health from a belief in the applicability of the latest scientific measures. This trust in the capacities of evidence-based measures connected with hygiene and disease control conflicted with positioned reformers as managers of the resources and experiences of the poor. Such a position inherently placed reformers in loosely antagonistic relations with the poor; the adaptation of public health practices to the conditions of the poor would have symbolized public health's limitations. In this sense, adaptations to suit conditions of poverty could have indicated the ideological failure of the crèche perhaps as much as the project's ultimate actual failure in retaining and serving poor families. Moreover, from a practical standpoint, the inability of even the most rigorous health measures to fully eradicate sickness—especially in light of a debated disease etiology—may have resulted in a lack of confidence amongst parents in the crèche's capacity to protect infant health. The discordance between reformers' confidence in the institution and the effective limits of the crèche to actually transform infant health might further explain why this institution did not resonate with poor families in its earliest period.

This thesis has argued that attempts to limit the spread of disease and promote healthfulness in the crèche were shaped by the rise of public health and philanthropy, including these discourses' respective scientific and moral association of poverty with contamination. Not only did prevailing ideas about science and hygiene integrally shape the form of the crèche and its services, but the attempts to grapple with the rise of the urban working-class also influenced the nature of the institution. The linkage between poverty and disease, in particular, justified the institution's exercise of social control under the auspices of public health and hygiene and led to their optimism about the ability of the crèche to reduce infant morbidity and mortality. However, the dual project of health and social reform led to troubling questions about whether the crèche should be held responsible for negative health outcomes, such as illness and death. While rules and regulations constructed the crèche as an idealized site of both physical and medical control through science, reformers' simultaneous anxiety over the relationship between poverty and disease led them to question the impact of this institution, especially whether it could control contagion and disease—and by extension, the unpredictability of poverty. The challenges of the crèche project—including the difficulty reconciling scientific advice with infants' and mothers' lived experiences, the inability to define the relationship between poverty and disease transmission, and the uncertainty regarding the efficacy of scientific advancements in hygiene—therefore reflect larger social and medical questions that occupied hygienists at the turn of the century.

Today, contemporaries still face a number of challenges related to the health role of the crèche. Beginning in 1975, these establishments reversed the protocols that required children to be redressed in the uniform of the crèche and to have his or her temperature and weight checked daily, and parents were finally permitted to enter the heart of the building, a practice that was

previously outlawed for health and safety reasons.[309] While for most of the twentieth century the crèche's role was to care for children in a safe environment, following a decree in 2000 that redefined the nature of these institutions, today's institutions have moved increasingly towards a framework of "early prevention" with more robust health and development aims. Much like the nineteenth-century crèche, their modern counterparts aim to socialize young children in order to prepare them to adopt normative social and health practices. However, the accompanying practices, such as monitoring and testing children for disability or social disorders, have led to renewed questions about the crèche's role in health promotion, especially in relation to the assumptions that administrators may hold related to disability and development.[310]

Today's crèches, much like those of the nineteenth century, reflect how society currently understands disease, as well as complex issues such as class and behavior. The contemporary crèche points similarly to the challenges and limits that guide administrators' assumptions about health. By demonstrating the ways that nineteenth-century crèches sought to respond to social and health challenges by institutionalizing practices generated by the public health movement, this study invites today's practitioners to reflect upon our own assumptions and the ways that our framing of disease and societal and class norms impacts the nature of the resulting interventions. In understanding the crèche as part of a wider response to promote health and social wellbeing, we may challenge ourselves to recognize the benefits, limits, dangers, and difficulties in improving infant health.

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[310] For example, such assessments carry with them the danger of defining normative health standards for young children, a practice which often pathologies certain groups, such as "at risk" children (Ibid, 200).

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