



SASKATCHEWAN POPULATION HEALTH AND EVALUATION RESEARCH UNIT

Saskatchewan voluntary sector early work on the determinants of health 1905-1950: Some unsettling questions inspired by history

[A document for discussion](#)

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January 2014

Forward

"A document for discussion"

This research report is the culmination of two years of geo-historical research. It is but one part of a larger historical research project consisting of five interrelated studies, all connected by two common research objectives:

1. to identify the underlying origins of health inequities in Saskatchewan, and
2. to assess the impact of historical interventions on health inequity of Saskatchewan's most vulnerable population groups including rural and northern seniors and children.

In order to reduce current health inequities, it is necessary to address their underlying origins. An historical approach provides an innovative method for identifying the origins of current health inequities in Saskatchewan. A cursory scan of the historical record reveals that many, if not most, of the inequities that we, in Saskatchewan seek to reduce are longstanding, some as old as the province itself. By examining the origins of health inequities we develop a better understanding of both the forces that caused health disparities and the success of the many interventions created to address them.

This report is posted on the SPHERU website with the goal of engaging readers in thinking about and critiquing, not only the specific results of this study, but also about how health inequities and the system of care evolved in our province with a view to interrupting the deleterious aspects of this legacy. To this end, we invite readers to critique this report and contact SPHERU with observations, comments and suggestions (send an email to spheru@uregina.ca). Thank you very much.

The views expressed in this document are those of the authors and do not necessarily reflect the views of their departments.



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INTRODUCTION

An appreciation of the contemporary voluntary human service sector working to enhance the health of populations in Saskatchewan requires an understanding of the past and the factors that shaped it. In general, the voluntary sector comprises organizations that exist to serve a public benefit, do not distribute profits to members, are self-governing and institutionally separate from governments and the private sector, and depend to a meaningful degree on volunteers (Government of Canada, 2002, p. 13). The sector provides a wide range of programs and services (e.g., prevention, crisis intervention, treatment) to diverse groups of people (e.g., people with specific illnesses, disabilities, vulnerabilities, shared interests and characteristics). Examples of these organizations include food banks, employment agencies, counselling agencies, childcare organizations.

Voluntary organizations existed in Saskatchewan before it became a province in 1905. Organizations such as the Salvation Army, Victorian Order of Nurses and the Red Cross were active in the territorial region. The purpose of this research is twofold: to offer a macro level description of the evolution, between 1905 and 1950, of several dimensions of the voluntary sector in Saskatchewan using a determinants of health lens and geo-historical research methods; and second, to draw links from the past to the present day configuration of the voluntary sector. This study is part of a larger health inequities study exploring the history of health in the province over the same period. This research focuses specifically on social service organizations that were working on the determinants of health.

This report provides the results of this historical review of voluntary social service organizations operating in communities in Saskatchewan between 1905 and 1950.¹ Both historically and today, the voluntary sector intervenes and provides services where the determinants of health are most deleterious. The determinants of health are the collection of influences that shape both individual and population health. Social determinants include food security, housing, education, employment and working conditions, health care services, early childhood development, income, social supports, and social exclusion, to name but a few (Hancock et al., 2000; Marmot & Wilkinson, 2006; Raphael, 2009; Wilkinson & Marmot, 2003). The voluntary sector has always acted and continues to act as a “social seismograph” leading the way in identifying social conditions requiring attention (Hall & Banting, 2000, p. 3); these social conditions are social determinants of health. A second collection of determinants of health are known as structural determinants of health. These include the dominant ideology and values of the time, governments and their policies, and social relations among people (Langille, 2004;

¹ Other types of organizations were intentionally excluded from this research. For example, co-operatives, especially health-oriented co-operatives like community health clinics, played significant roles in bettering human conditions over time. The decision to exclude co-operatives was made because much has already been written about them (see for example Fairbairn, 1997; Lawson & Thériault, 1999). As well, the sheer number and variety of co-operatives is vast, and inclusion would have dominated this analysis at the expense of other voluntary organizations. Consider the Davidson Co-operative Society in the town of Davidson, that began in 1914 with the distribution of coal, lumber and building materials. Within 30 years the Co-operative provided the following to the community: supplied oil and gas, supplied and repaired farm equipment, created a grocery and home furnishings store, helped to export locally raised animals and dairy products, and built a bakery ... " a 14-bed hospital, the eight-room brick school house, and the skating and curling rinks" (Kerr, 1945, p.27).

Mullaly, 1997). Both the social and structural determinants of health are explored in this research - a determinants of health lens is used to explore the early evolution of the voluntary sector.

The voluntary sector has always been a part of the Saskatchewan landscape, yet that landscape has shifted over time. By studying its origins, we may better understand both the forces that shaped the current configuration of the sector as well as our ongoing attempts to re-mould this configuration. It is known that policy, programmatic and funding choices of the past influence present day choices (Elson, 2011a). History is a powerful vehicle for seeking to understand complex relationships, exposing forces that created situations (Lincoln & Denzin, 2005), revealing past remedial attempts (McDowell, 2002), averting repetition of past mistakes (Cutler & Miller, 2005), overturning beliefs that ‘things have always been this way’, and inspiring our imaginations for the future (Tosh, 2008). Indeed, the past exists as a laboratory for natural experiments in order to better understand the importance of the voluntary sector to the evolving health of the people of Saskatchewan, as well as the impact of the sector’s many formulations (Fee & Brown, 1997; Perdiguero et al., 2001).

SCOPE AND RESEARCH QUESTIONS

Our research goal of tracing the evolution of the voluntary sector, led us to adopt three historical eras in Saskatchewan for the period 1905-1950 that are qualitatively distinct. These eras are commonly used by historians. The period that spanned 1905 to 1928 is generally known as the Settlement Era (Brennan, 1976), in which the province was settled by outsiders. This was an era that witnessed the formative years of the voluntary human service sector wherein religious, ethnic, social, farmer and secular groups were formed and formally incorporated. A second era, Era of Crisis Intervention, ran from 1929 to 1939. This era marked the end of the settlement era and began with a world-wide economic crisis and the onset of a 10-year drought in the prairies (Archer, 1980). This period saw growth in crisis intervention services for both urban and rural people in Saskatchewan, delivered by both government and the voluntary sector. The third era spans the decade of the 1940s; we have labelled this period, the Era of Rising Socialist Policy, given that there was significant socialist activity both before and after the Co-operative Commonwealth Federation (CCF) became the ruling provincial political party in 1944.

The main research questions are:

1. Using a determinants of health lens, how did the voluntary sector in Saskatchewan evolve between 1905 and 1950?
2. More specifically, what were some of the functional aspects of the sector between 1905 and 1950?
3. What were key historical influences that shaped the evolution of the voluntary sector during those eras?
4. What are the implications of this voluntary sector legacy for our present day work on the determinants of health?

To answer these questions, we carried out a historical literature review structured around the three eras outlined above. Within each era there is an illumination of government legislation

and service choices, major voluntary sector functions (i.e., service delivery, service convening/planning, and advocacy specific to the social determinants of health), voluntary sector-government relations, and highlights of the main forces that appear to have shaped the voluntary sector (e.g., crises related to economics, war and climate, specific ethnic/religious group affiliation needs, general community needs). An exploration of shifts in ideology over time, and differences across geography is also offered. This is followed by an analysis of primary historical data left by incorporated organizations, collected for the period 1905-1950. An emphasis was placed on collecting and analysing data concerning the voluntary sector for this forty-five year period in an effort to examine how these early organizational roots set the stage for the current configuration of the voluntary sector.

HISTORICAL LITERATURE

Prairie values and social relations

A brief review of religious and social values of the day reveals the context within which voluntary organizations operated. The "general social survey" is one vehicle that offers us a glimpse into this context. Between 1913 and 1917, the general social survey movement, shaped by a religious moral reform agenda, began in earnest in Canada. One such social survey was carried out in Regina, Saskatchewan, in 1913 by the Department of Temperance and Moral Reform of the Methodist Church and the Board of Social Service and Evangelism of the Presbyterian Church of Regina.² The social survey identified social problems by focusing on "troublesome populations and locations" with a view to regulating "individuals for their own benefit and for the well-being of the whole" (Hunt, 2002, p. 172). The surveys were intended to produce facts, which were presented to the public in order to convince them that new legislation was needed that would "remove the evils from the community and foster harmonious social relations" (Hunt, 2002, p. 173). In general, social survey reports,

“...argued that the moral condition of the cities was a multidimensional problem having ethical, philanthropic, political, social, and moral aspects. The list of symptoms of immorality reveals the interconnections within a diverse range of moral and social conditions: drinking, gambling, Sabbath desecration, vice, alien races and tongues, housing, sanitation, education, and recreation” (ibid., p. 172).

Today, many of these “symptoms of immorality” would be related to the determinants of health – both social and structural.

Ethnicity and religion are additional important features of the Prairie context. These tended to contribute to division and disparities, both in health and in the voluntary organizations that sought to improve it. Early frontier settlers were primarily of European descent.

² The western Canada survey differed from the surveys conducted in eastern Canada. For example, the primary targets of the Toronto survey were prostitution, venereal disease and accompanying medical and moral problems. Those conducted in the west, including the Regina survey, attempted to draw attention to the appalling socio-economic conditions found in the cities (Hunt, 2002, p. 177).

Nevertheless, despite a perceived mythology of pioneer equality, Saskatchewan society appears to have been stratified along ethnic lines (Fairbairn, 1999, p. 5). Indeed, researchers have found that “inequities of land, capital and personal capacities were omnipresent in frontier society” (Gertler & Murphy, 1987, p. 243). Evidence of this is provided by Lipset (1950) who noted the serious conflict which occurred between the Protestants and the Catholics, especially when the Ku Klux Klan (KKK) arrived in the late 1920s. In Saskatchewan, the Catholics and certain non-British immigrant groups were targeted (Brown et al., 1999) through “a campaign of bigotry” (Smith, 2009, p. 43). Saskatchewan folklore indicates KKK membership was somewhere between 13,000 and 40,000 members in 125 local chapters across the province (Sher, 1983, p. 47-48).

While eastern Canada’s provincial governments and voluntary organizations were dominated by influences of the Catholic Church (Elson, 2011b), Saskatchewan was influenced by preachers of Protestant traditions (Lipset, 1950). Both traditions were steeped in moral and charitable convictions that differentiated between deserving (e.g., wives whose husbands died in the war) and undeserving individuals (e.g., unemployed single men) (Elson, 2011b; Lipset, 1950). Lipset explained that “cleavages in ethnic background and religion were more important than economic class divisions in separating agrarians into distinct social groups” (Lipset, 1950, p. 34). Groups of non-Anglo-Saxon settlers from parts of Europe (e.g., Germans, Ukrainians, French, Polish) endured much prejudice from the larger group of Protestant-based people of English, Scotch and Irish origins (Lipset, 1950). Thus, there was discrimination among settler groups in Prairie society.

Scholars have also described discrimination and a division between settlers and Aboriginal Peoples. During earlier eras, "Indians and non-Indians were two solitudes" given there were few references to First Nations and Métis peoples in public records and in newspapers, First Nations Peoples were physically separated from non-First Nations because they lived on reserves, and Federal government policies during this time "were based on repression of indigenous culture and coercive assimilation" (Pitsula, 2001a, p. 349-52). Further, racist policies within governments and discrimination across mainstream society were key factors in perpetuating gaps in both health outcomes and living standards between indigenous minorities and the mainstream majority (Daschuk, 2013, p. 3; Shewell, 2004) In a critique of northern Saskatchewan voluntary organizations, which were dominated by missionaries, there is evidence of discrimination too:

"in the patterns of membership and leadership in voluntary associations ... some organizations included both whites and non-whites, in others, membership was de facto restricted to one group of the other. Leadership was concentrated heavily among white people ... they gain control of the organizations ... discrimination interferes with the efficient utilization of human resources ... restricts the participation and activity of the individual for reasons which have nothing to do with his abilities” (Buckley et al., 1963, p. 28-29).

Nonetheless, there were also examples of healthier social relations. For example, a great "number of voluntary associations are organized and directed by the Métis themselves", at Cumberland House in the north-eastern area of the province (Buckley et al., 1963, p. 27).

Finally, some discussion about democratic socialism (or social democracy if one prefers) is warranted given that Saskatchewan elected the first ‘socialist’ government in North America in 1944, an event that even captured the attention of the New York Times. Under the banner of the Co-operative Commonwealth Federation (CCF) socialism in Saskatchewan was, in practice, a mix of the reformist non-Marxist socialism of Canadian intellectuals like F.R. Scott and Frank Underhill of the Fabian-inspired League for Social Reconstruction, agrarian populism rooted in social gospel Christianity and non-revolutionary elements of the early Canadian labour movement. It coalesces into a single national political party, the CCF (with the descriptor ‘Farmer-Labour-Socialist’ appended to its name), in the midst of the depression era of the 1930s.

The era that spans 1929-1939 saw a coalescing of energies toward a mixed human service delivery model. The CCF's democratic socialist orientation helps explain the early social policy environment and government relations with the voluntary sector. *The Regina Manifesto*, the CCF's founding statement of principle, was a key articulation of the party's principles and a map of its parliamentary road to democratic socialism: “the principle regulating production, distribution and exchange will be the supplying of human needs and not the making of profits” and its aim was to replace the capitalist system (Lewis & Scott, 1943, p. 163). *The Regina Manifesto* espoused the establishment of a welfare state that included universal pensions, health insurance and "prevention rather than the cure of illness" for all people living in both rural and urban communities (ibid., p. 171).

Although the CCF may have planned to create a socialist province following its 1944 victory, such was not wholly achieved (Lipset, 1950). It has been argued that the CCF's program was intended to preserve rural area social and economic structures; "the party has done nothing to change or to equalize the economic status of the poorer and smaller farmers” (Lipset, 1950, p. 226). The CCF/NDP has been credited with many radical reforms but there are some examples where radical social change was not sought.

In sum, Saskatchewan embodies a series of paradoxical traditions. Even the coalition of ‘farmer-labour-socialist’ members within the CCF is an attempt to bring together groups that do not always have the same political and economic interests. So on the one hand, it is the birthplace of Medicare, the co-operatives movement, Canada's first bill of rights and the first democratic socialist provincial government. But on the other hand, the province also possesses a history of social exclusion, inequality and individualism. Fairbairn (1999, p. 7) summarizes the Saskatchewan situation:

“Far from being naturally co-operative, I would say that Prairie people are naturally individualistic. It is through and out of their individualism, under certain ecological and cultural conditions, that Prairie people arrive at a deep, almost intuitive understanding of co-operation. There is a complicated and difficult relationship between individual and collective identity, individual and collective action.”

Highlights of the voluntary sector policy and political context

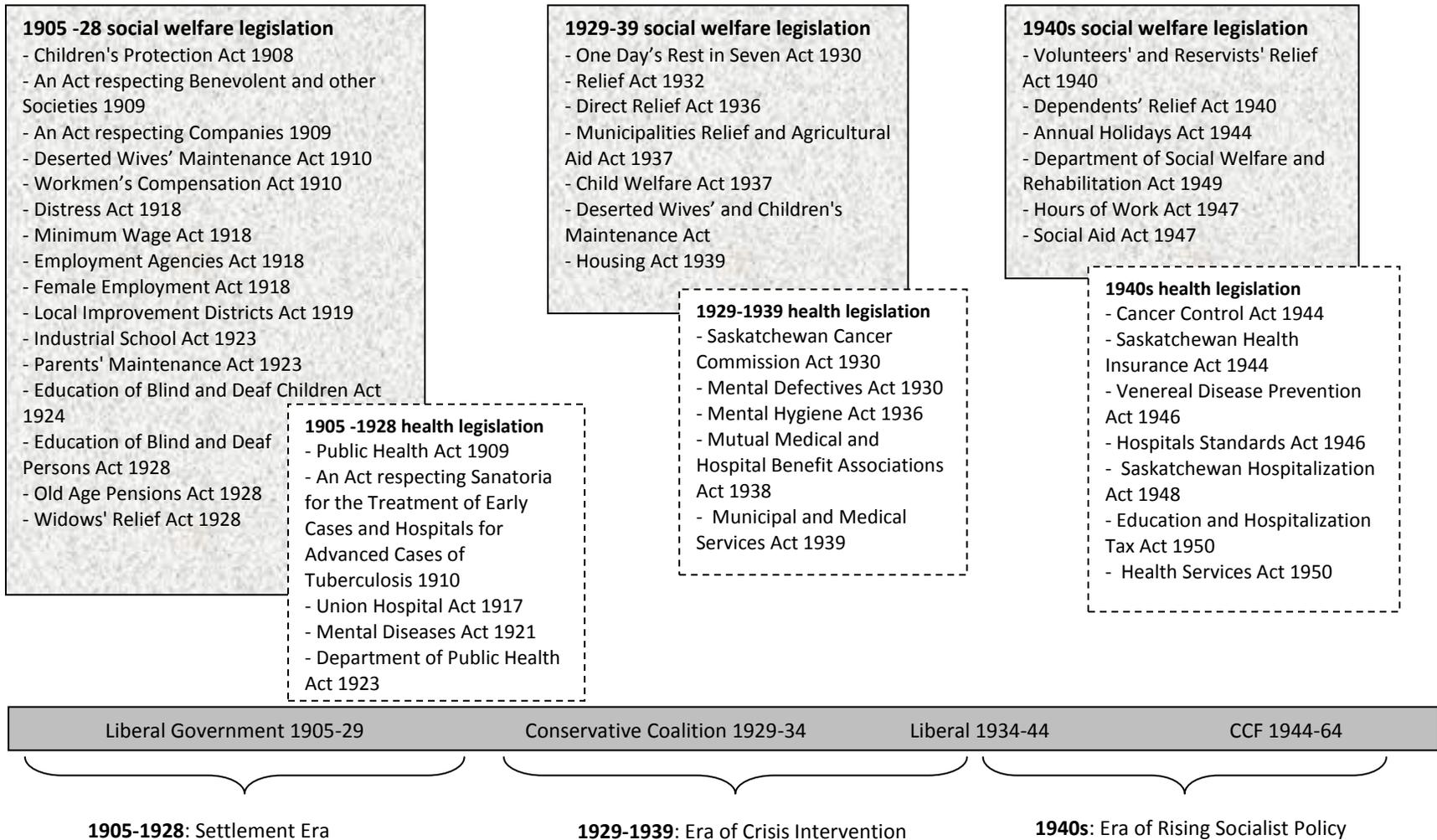
In order to understand the political and legislative context in which the voluntary organizations functioned and evolved, we conducted a survey of relevant *Public Acts* implemented in Saskatchewan. The summary results of this survey are presented in figure 1, which shows the dominance of the Liberal Party of Saskatchewan (40 years) over this period. The figure also shows some examples of the variety of *Public Acts* that were related to social determinants of health, including, for example, employment and working conditions (e.g., hours of work) and education.³

These Acts are considered structural determinants of health because they are the basis for public policies that influence people's health (for further explanation about how public policies are determinants of health, refer to Loppie Reading & Wien, 2009). For example, *The Deserted Wives Maintenance Act* (1910) was intended to provide financial support to married women whose husbands left them, and consequently, reduce the negative effects of poverty on women's lives. Further, through some of these Acts, voluntary sector organizations were granted provisions to become incorporated. For example, Children's Aid Societies came into being under the *Children's Protection Act* of 1908. A few health-related Acts are also highlighted in Figure 1 given that they too allowed for the evolution of voluntary sector health agencies; the Saskatchewan Anti-Tuberculosis League came into being via *An Act respecting Sanatoria for the Treatment of Early Cases and Hospitals for Advanced Cases of Tuberculosis* in 1911, the present-day Saskatchewan Cancer Agency originated through the *Saskatchewan Cancer Commission Act* in 1930 and nursing homes for the aged were governed by the *Hospital Standards Act* of 1946.

³ The date of the first version of each Act is captured in Figure 1, not subsequent revisions.

Figure 1: Some highlights of the Saskatchewan voluntary sector political and public policy context, 1905-1950

Provincial political organizations in office
 Social welfare Acts by date of effect
 Health related Acts by date of effect



Era 1905-1928: Settlement era

The period that spanned 1905 to 1928, can be labelled as formative years for human service organizations. During this time, Saskatchewan experienced rapid population growth, settlement of farmsteads by diverse ethnic and religious groups, waves of prosperity and economic failure, and an uneven emergence of a variety of voluntary organizations. In particular, there were very few early references found regarding Aboriginal-based voluntary organizations. Further, Saskatchewan's sparse, rural population “required state led action to ensure basic infrastructure was available” (Rasmussen, 2001, p. 96) including human services because the private sector was not interested in providing services especially in remote, northern areas (Lipset, 1950; Meinhard & Foster, 2002). In addition, when the province joined confederation in 1905, there were already voluntary organizations playing a service delivery function. For example, the Victorian Order of Nurses was providing homecare and running hospitals, the Salvation Army was aiding immigrants to settle in the prairies and find jobs, the Canadian Red Cross was running outpost hospitals, the Women’s Christian Temperance Union was providing services to needy people, Yorkton Queen Victoria Hospital was providing inpatient services and the Regina Council of Women was instrumental in establishing other voluntary organizations to provide human services (e.g., Regina Children's Aid Society, Regina YWCA).

There was much volunteer-led activism demanding the development of a variety of human services. Many pioneers had experience with socialism, co-operatives and public service activism in their European birth countries (Lipset, 1950), and these were quickly transferred to their new home province. Early grain grower and farmer movements played advocacy roles in the development of public services (Fairbairn, 1997). The voluntary organizations and associations of this era played an activist function advocating for services. The organized farm movement – groups like the Saskatchewan Grain Growers’ Association, later the United Farmers of Canada, Saskatchewan Section - played key roles in spreading ideas of social and political innovation and in motivating farmers to organize new services. Women in particular, advocated for human services through volunteer-led, church and/or farmer groups (e.g., Women Grain Growers Association) and through early Homemakers Clubs and Women’s Institutes, even though their original focus was on providing companionship for rural isolated women and enabling them to learn to “master [their] own profession as homemaker” (Saskatchewan Women's Institute, 1988; see also Taylor, 1997).⁴ These groups were responsible for the early evolution of the voluntary sector. As this voluntary organizing was taking place, the care of the sick and elderly was predominantly the responsibility of families, particularly women, but churches also provided informal human services to those in need (Dusel, 1990; Leger-Anderson, 2005).

During these first two decades, two major factors led to the development of the first municipal doctor plan in 1915 which was lay-controlled and born of community activism. First, many people could not afford to pay for physicians’ care and, second, the population distribution was sparse and doctors were not interested in rural practice. The 1916 *Rural Municipality Act*

⁴ They advocated within a context of “patriarchal ideologies of male superiority” (Rollings-Magnusson, 1999, p. 171).

was amended to provide free medical services; it was the first legislation providing for municipally funded doctors.⁵ In addition, although this study does not focus on the evolution of Union Hospitals in Saskatchewan, it should be noted that the 1917 *Union Hospital Act*, allowing rural municipalities to build and finance hospitals through public taxation, came as the result of financial exhaustion of voluntary organizations, such as the Victorian Order of Nurses, that were struggling to support the development of hospitals (MacKenzie, 2002). This is an example of early transfer of responsibility from the voluntary sector to the government sector.⁶

During this time, relationship roots were established between some municipal governments, the provincial government and some voluntary organizations. For example, Family Service Regina, a nonprofit organization known as the Bureau of Public Welfare in 1913, became a central player in child welfare, reducing juvenile delinquency, sheltering homeless men and assisting with income distribution (Pitsula, 2001b). It is with this last aspect that the Bureau worked most closely with the City of Regina; "City Council agreed that all the relief to be paid for by the City during the winter of 1913-1914 should be distributed by the Bureau" (*ibid.*, p. 10). Thus, some early organizations were active in addressing a key determinant of health, income, and accomplished this by enacting a convening function in order to facilitate the collective planning of services.

It was also during this time that both the provincial government and the voluntary sector made their first series of choices to build large institutions instead of smaller community-based care facilities and, in general, shifted away from focusing on the social influences on health. Large psychiatric institutions were built despite government staff research and recommendations for small cottage-style facilities and travelling mental hygiene clinics (Dickinson, 1989). The first psychiatric hospital was opened in North Battleford in 1914. Two main schools of thought about mental illness ebbed and flowed over time: a medical system that promoted the use of medication and physician supervision and a non-medical system that espoused that when people have severe struggles with daily living and survival, mental or emotional disorders occur, which require community based responses (Dickinson, 1989). Similarly, large tuberculosis sanitariums were built and operated by the Saskatchewan Anti-Tuberculosis League – a voluntary organization (McCuaig, 1980). The first sanitarium was opened in Fort Qu'Appelle in 1917. Further, during the social reform era (1900-1914), Sir William Osler stated tuberculosis was "a social disease with a medical aspect" but by the 1920s, tuberculosis had become a medical disease with a social aspect - the focus shifted toward the germ itself and away from the social conditions that nurtured it (McCuaig, 1980, p. 480-88). In sum, both psychiatric and tuberculosis treatment became part of the institutionalization and medicalization movements, which also signaled a corresponding shift away from the social determinants of health. This shift has persisted for the greater part of Saskatchewan history.

⁵ Encyclopedia Saskatchewan, http://esask.uregina.ca/entry/municipal_doctor_system.html.

⁶ The *Municipal Hospital Act* was introduced in 1916 permitting the formation of Union Hospital Districts and the *Union Hospital Act* was introduced the next year, broadening the services and allowing taxes to be collected to provide "pre-paid" hospital service plans (http://esask.uregina.ca/entry/union_hospital_and_municipal_hospital_care_plans.html)

Era 1929-1939: Era of crisis intervention

The stock market crash of 1929 and the ensuing Depression of the 1930s, as well as the concomitant prolonged drought on the prairies, sparked a new era in Saskatchewan. These were catalysts for both the emergence of new voluntary organizations and government expansion into the funding and delivery of a broader range of human services (Canadian Welfare Council, 1938; Dusel, 1990). This era is best characterized by the expansion and bureaucratization of crisis intervention services. Driven by crises, voluntary organizations reached beyond their own membership to help others in need too. During this period of time, many of the member-serving organizations became increasingly more active in organizing and providing an expanded array of services to both their own members as well as non-members (e.g., Women's Homemaker Clubs). Some services also moved away from private charity-run programs to government-run programs and "provision changed from voluntary and nonprofessional to bureaucratic and professional" (Meinhard & Foster, 2002, p. 2; Rice & Prince, 2003).

The need for government support and intervention was dire given that an estimated two thirds of the rural population was receiving relief services in 1937 (Lipset, 1950). The Saskatchewan Relief Commission was formed in 1931 and was financed by the provincial government to administer direct relief (e.g., food, fuel, clothing, shelter, medical assistance), but municipalities acted as field distribution agencies (Dean, 1934, p. 2-3). In 1932, a Central Voluntary Relief Committee, initiated by Premier Anderson, comprising representatives of churches and other organizations, was formed to assist the Commission to collect donations as well as distribute relief (ibid.). Thus, both voluntary organizations and governments were responding with interventions focusing on social determinants of health during this time. However, it has also been noted that during the Depression, expenditures on relief for Aboriginal Peoples were between two and three times lower than for non-Aboriginals (Mosby, 2013).

It appears this era also witnessed the continued growth of institutions. Some reports written during this era, lamented about the need for smaller "homes" close to where elderly people resided given the lists of elderly people waiting for residential placement (Canadian Welfare Council, 1938). Wolseley Home for the Infirm was the only Department of Health run facility in the province at the time (ibid, p. 16). Similarly, there was a recognition of the importance of boarding homes and foster care homes instead of institutions for children (ibid.).

Further, evidence of tension was found between prevention and intervention. A glimpse into the tension between prevention and intervention services may be offered using the case of Children's Aid Societies (CAS). These Societies were voluntary agencies however they were only permitted to incorporate with government approval under the *Children's Protection Act* 1908. Government grants were provided for "legal minimum of responsibilities" (Canadian Welfare Council, 1938, p. 30). Further,

"Almost the entire income of The Society is received in grants and board fees from the city and the provincial government. For that 'second mile' of preventive and protective work a CAS must look to the community for voluntary support and the limitation of its income to public grants and payments severely circumscribes its work and tends to limit

its efforts largely to those cases where the point of breaking has been reached" (ibid., p. 39).

Local voluntary groups also fulfilled important functions in organizing meetings to discuss, plan and develop responses to problems relating to the determinants of health and human service integration. For example, in Saskatoon, this work was undertaken in 1931 when the local Council of Women formed the Family Welfare Council with financial assistance from the men's service clubs. In 1935 the Community Council of Saskatoon, comprising 40 member organizations, was formed "as a medium of cooperation and social planning for social agencies and public departments in all branches of welfare work" (Canadian Welfare Council, 1938, p. 4). Thus, there was an awareness of the need for co-operative relationships between the voluntary and government sectors in order to better plan a system of services.

"[We]... emphasize again that the public departments in health and welfare activities should participate equally with the voluntary agencies in the cooperative and social planning activities of the Council. The City Relief Department, the Health Department and the public hospitals would fall within this category. These departments and institutions are responsible for the expenditure of large proportion of the taxpayers' money and they have a right and a responsibility to contribute to the work that will promote effective relationships between public and voluntary efforts, and build a well balanced program in which both the public and the voluntary agencies have a vital part to play" (ibid., p. 69).

It is noteworthy that the report defines community welfare broadly given the coverage of programs from basic necessities like income, food, shelter and clothing, through to medical, school/education, and recreation programs. In closing, one recommendation is notable - government departments should participate equally with voluntary agencies to "build a well balanced program" (ibid., p. 69).

Era 1940s: Era of rising socialist policy

According to Cassidy (1945, p. 7) "the Canadian system of health and welfare services is the product of haphazard development extending over many years". It is best characterized as a fragmented system of service delivery for those in need (Elson, 2011b). Saskatchewan appears to be no exception. As noted in the previous era, there is evidence of both government and non-governmental human service agents delivering services in Saskatchewan. This is the "mixed social economy" referred to by some scholars (Elson, 2011b).

1944 is often touted as a watershed year for socialism in Saskatchewan because that is when the CCF was elected to the provincial legislature. The election of the first CCF government in 1944 is often identified as the critical moment when a socialist movement in government began to take hold in the province. Given the foregoing events, it is clear that by the time the 1940s arrived, numerous structures that may be characterized as socialist in nature were already in place. Nevertheless, the trend towards openly socialistic policy in Saskatchewan accelerated in 1944. The CCF, the predecessor to the New Democratic Party (NDP), was elected to office in

1944 and is recognized for creating a positive role for the provincial government in striving to build a more secure future, reduce social inequities, and encourage innovation (Marchildon & Cotter, 2001). The CCF began its term of office with a democratic socialist orientation including a clear focus on public and co-operative ownership (Larmour, 1985). During this time, both old and new organizations worked with the provincial government to serve the needs of people without incomes (e.g., United Hebrew Relief), while other groups provided services beyond financial assistance (e.g., Children's Aid Societies, homes for the infirm and aged, Lebreton Oblate Fathers Métis Farm) (Saskatchewan Government Department of Social Welfare, 1946).

The growth in organizations devoted to ensuring income security was paralleled by the expansion of medical and educational facilities. By 1944, the province had a growing network of medical services. The residents of 101 of the province's 374 rural municipalities, villages and towns were receiving medical services from salaried municipal doctors (as differentiated from fee-for-service, private practice physicians) (Lawson & Thériault, 1999). There were 79 hospital boards and 5,184 school boards across the province which offered opportunities for residents to volunteer in shaping public policy (Courtney, 2007). Despite the growing importance of government funded medical services, the province, and specifically the CCF government, was not ready to take the next step. In 1945 the CCF rejected a plan from its own health planners that recommended the expansion of the "municipal doctor system into a state-salaried medical service stationed in group practice clinics" (Lawson & Thériault, 1999, p. 256).

Later in the 1940s, the CCF established the Department of Co-operatives, the Department of Welfare and created a *Trade Union Act*. However, the CCF soon became cautious about the language of socialism and modified its goal of total socialization. Its newer ideology and programs focused on the following: co-operativism instead of socialism; government ownership of natural resources and utilities but not financial institutions; the importance of land security and wheat prices; extension of social services offered by the state including social security, health and education (Lipset, 1950). By the end of the 1940s, the government had come to realize that it lacked the necessary resources to carry out its original plan and in the early 1950s there was a gradual shift away from solely government and co-operative services to those involving private agencies which included government funded voluntary sector services (Larmour, 1985).

Geography – a salient concept in health research

During the 1905-1928 era, Saskatchewan was composed of more small towns, villages, hamlets and reserves than large urban communities. In the 1926 census year, 70% of the population lived outside urban centres (Statistics Canada, 1953). The following were considered "cities", or urban areas, during specific years: Regina and Moose Jaw were declared cities in 1903, Prince Albert in 1904 and Saskatoon in 1906, North Battleford and Weyburn in 1913, Swift Current in 1914 and Yorkton in 1928.⁷ Most of the towns and villages were settled by relatively homogenous ethnic and religious groups (Lipset, 1950). In addition, First Nations peoples were required by federal law to live on reserves. Métis people were not required to live in certain communities although numerous towns and villages were dominantly Métis at this

⁷ Source: <http://olc.spsd.sk.ca/de/saskatchewan100/2005extras.html>.

time (e.g., Green Lake, Lebret). During this time, Saskatchewan's population grew from 257,763 to 820,738 (Statistics Canada, 1953). The majority of the immigrant population was young; the median age of the population was 21.2 years old in 1921 (Statistics Canada, 2011). The rural settler population continued to grow, peaked in 1936, and then steadily declined over the ensuing decades. The rural First Nations population followed a similar rural-to-urban migration path, but their migration began in the 1960s and continued after the federal government changed its policies and no longer forced them to remain on reserves (Shewell, 2004).

There are unique differences between the northern and southern areas of the province too. The two areas comprise roughly the same land area but have radically different topographies (i.e., prairies versus boreal forest and Canadian Shield) and types of people (Bone, 2009). The initial waves of European immigrants settled the southern half of the province long before they began to populate the northern area, although First Nations and Métis Peoples were already living in both the northern and southern areas of the province. In terms of settlement the new province quickly came to be characterized by a sort of geographic dualism, which is still operative today. More specifically,

"... their basic demographic characteristics form opposites. For example, the North has witnessed a steady growth of its population, a high rate of natural increase, youthful population, and a majority of Aboriginal people, while the South has the opposite characteristics" (ibid., p. 16).

This brief geo-historical consideration of the demographic context is important because it helps to explain the presence and shifts in the voluntary sector and its work on the determinants of health. We can glean some sense of the early voluntary sector given research reports published about specific aspects of rural and urban life and specific communities. First, Lipset (1950) explained that volunteers were required for a vast array of rural organizations which helps explain the high rural volunteer rate. For example, volunteers were needed for rural town councils, farmer groups, local co-operatives, school and hospital boards, churches, and political parties. "The conditions of rural life gives rise to a lively and highly participatory politics, traditions of mutual aid and public service, and useful institutions ... the very smallness of the rural municipality was a boon to local democracy ..." (Spafford, 2007 p. 31). Higher than average province-wide volunteerism rates appear to have persisted into the 1980s when Saskatchewan had the second highest rate of people volunteering in Canada (Duchense, 1989; Pearce, 1989).

Second, individual towns provide interesting case studies. The town of Biggar is such a case study. It was a small town of approximately 2,662 in 1961 (Laskin, 1961), yet 84% of its men and 70% of its women belonged to voluntary organizations, while in the countryside outside the town, it was 76% for women and 98% for men" (Willmott, 1975, p. 30). It was hypothesized that, at that time, "Saskatchewan may in fact, have the highest saturation of rural organizations of any region in the world" (ibid., p. 28).

Third, there is evidence of qualitative differences between rural and urban voluntary organizations. Certain voluntary organizations did not establish themselves in towns, villages and the countryside. For example, Children's Aid Societies were formed and operated in urban

areas but the provincial government had to adopt the child welfare and protection function in rural communities (Dornstauder & Macknak, 2009). Interestingly, by 1959 all Children's Aid Societies ceased to exist in Saskatchewan. The child welfare and protection function was taken over by the provincial government because the Societies could not afford to provide the high standards of care required with the amount of government funding allotted (ibid.). Thus, there were differences between the services provided by the voluntary sector and the government sector across rural and urban areas and over time.

Finally, an observation about differences between the northern and southern areas of the province is offered for the period 1905 to 1950. Church missions and trading stores were the nuclei of small settlements in the North (Buckley et al., 1963); missionaries brought other services such as schools and medical services. In Buffalo Narrows for example, the following voluntary organizations existed: "a ratepayers association, a co-operative store, a sawmill co-operative, a school board, a credit union, the Buffalo Narrows Advancement Club, two different church organizations and a trappers fur block council" (Buckley et al., 1963 p. 28-29). However, it appears both the paid and volunteer-oriented skills that were required to run these associations, "were found almost exclusively among southern whites" (Buckley et al., 1963 p. 28).

"The class structure of the North is remarkable, first, for its close adherence to ethnic divisions and second for the fact that upper-class members are recruited primarily from outside the community ... Leadership was concentrated heavily among white people ... Thus many an attempt to build up the involvement of Métis and Indians in community affairs through voluntary associations has failed ..." (p. 28).

Thus, geography is a tool that aids in examining qualitative differences of the voluntary sector across space and different populations. We have already alluded to the presence of racism in Saskatchewan and it appears that the voluntary sector was no exception.

METHODS

Historical geographers often use a method referred to as vertical theme analysis. This analytic approach exposes and emphasizes spatial change over time (Warkentin, 1963-64). This method was adopted for this research because it maximized the potential to illuminate pathways between the past and the present. The focus was on organizations that were health and/or social service related, those that helped spawn health/social service organizations, and those that were in place to support and offer mutual aid to its members.⁸ Essentially, the focus was on collecting data about voluntary organizations that were implicated in the determinants of health as service deliverers, advocates and/or convenors.

Data were collected from *The Gazette* and the *Office of the Provincial Secretary Annual Reports* which contain the official records for the Province of Saskatchewan. All organizations

⁸ Present day "charitable corporations" are incorporated to "carry on activities that are primarily for the benefit of the public" whereas membership corporations "carry on activities that are primarily for the benefit of its members" (Canadian Centre for Philanthropy 1990, p. 45).

that incorporated between 1905 and 1950 were listed in these two sources. The Provincial Secretary annual reports for the period from 1905 to 1919 were detailed. Each incorporated organization was listed by organization name, date of incorporation, location of head office, and type of voluntary activity. After this time, these annual reports did not contain this detail; they simply contained the total number of organizations that incorporated that year. Thus, in 1919 and onward into and including 1950, *The Gazette* was used to find the names of organizations and their registration year. Each organization was entered into a separate row in the Microsoft[®] Excel spreadsheet; the dataset was built in chronological order by row. The specific variables chosen for analysis were: date of incorporation, location of main office in a rural or urban area and northern/southern areas of the province, type of organization (e.g., religious, ethnic, club-oriented, community-serving or secular), and class of incorporation (i.e., through *The Companies Act* and as *Joint Stock Companies* some with share capital and some without, *The Benevolent and other Societies Act*, or under *Private Acts*).⁹

Data analysis was conducted on the completed Microsoft[®] Excel dataset of 899 voluntary organizations. After all organizations were entered into the dataset, two coders coded the same master file sequentially. The key criteria for coding organizations into five distinct categories were their primary cause for registration and who they served. The coding process comprised a series of iterative loops wherein the first coder, colour coded each organization for each era. There were five colour codes which are defined as follows: religious organizations served specific religious denominations; ethnic organizations served specific ethnic groups; club-oriented organizations had exclusive members based on specified characteristics (e.g., the Masons, the Elks, homemakers); secular organizations provided services to those in need without explicit ties to religion, ethnicity or clubs; and community-wide benefit organizations were incorporated for the intention of serving entire towns or villages (e.g., community centres, village halls). This coded dataset was then sent to the second coder who read each row of the Microsoft[®] Excel spreadsheet and made adjustments as necessary; the second coder is an expert in the voluntary sector field having worked in the sector for 20 years and then completed doctoral research on the sector. There were approximately 100 organizations that required internet and scholarly searches to discern their primary cause for registration and who they served. Thus, the iterative loops entailed multiple meetings between the two coders to finalize the coding.

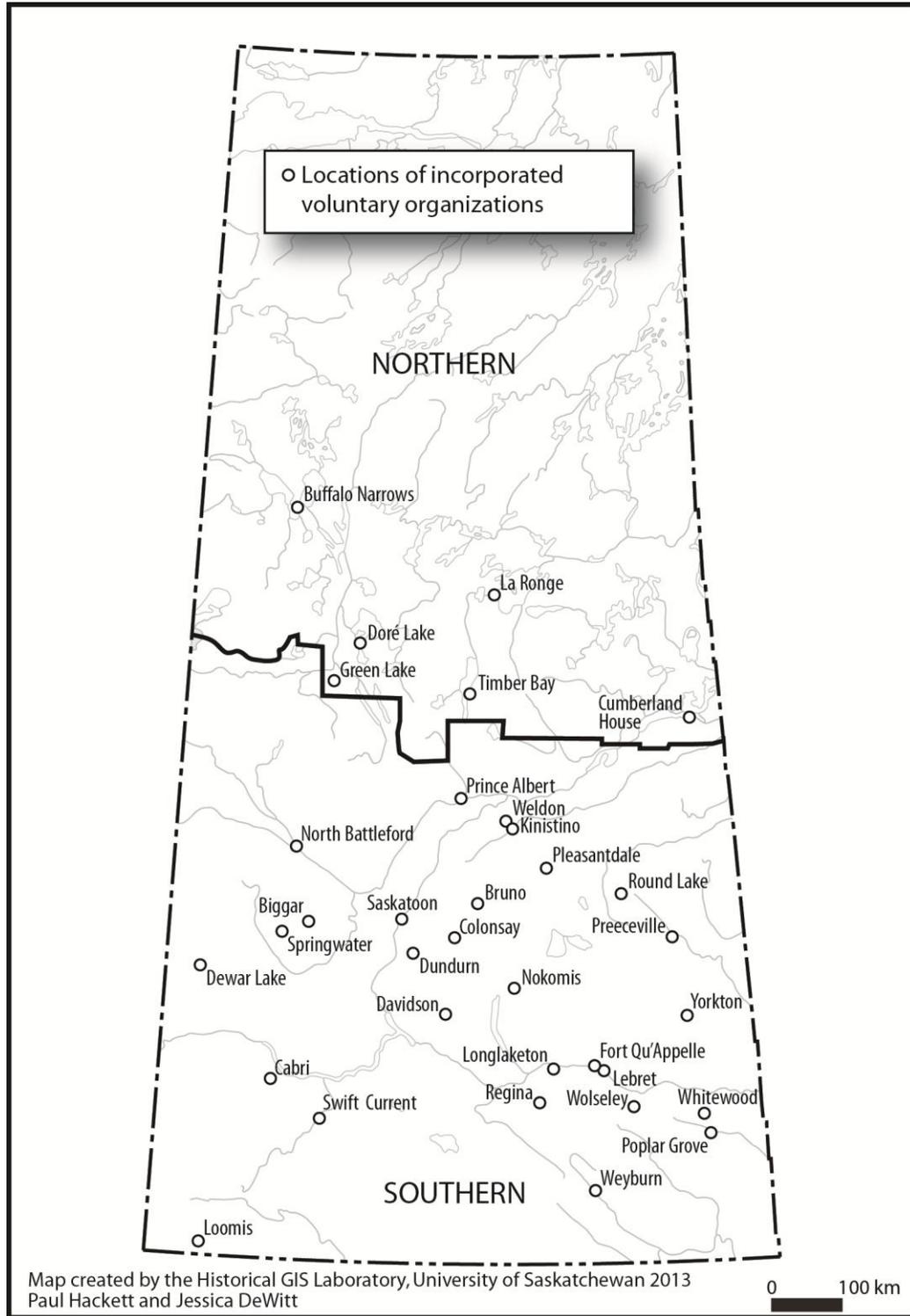
In terms of geographic variables, urban and rural as well as north and south were considered salient. Thus, the two coders repeated the same coding process for geography. In order to differentiate between urban and rural, we adopted the definition used in the provincial *Town Act* of 1908; section 405 of that Act states the population must be 5000 or more for a municipality to apply to the provincial minister for city status. We adopted the term “urban” instead of “city” for these communities. Organizations were coded urban if they were located in a community containing more than 5000 people and rural if they were located in a community with less than 5000 people. Rural communities included reserves, towns, villages, and hamlets in both the southern and remote northern areas of the province. Data coding for the urban and rural locations of organizations was done based on the status of the community at the time of the organization’s incorporation. Census totals for each community were used to divide communities

⁹ *Public Acts* were not part of the study.

by urban/rural. Thus, coding was dependent on both organization date of incorporation and community population total.

In addition, given the province has distinct northern and southern areas, organizations were coded based on where they were located in the province. The northern area begins where the boreal forest starts and agriculture land ends, the population densities are lower, and there is a higher proportion of Aboriginal peoples (Bone, 2009). Figure 2 shows the dividing line runs east to west just south of Cumberland House, Timber Bay and Dore Lake. All organizations that were located in communities north of this line were coded northern, while those south of the line were coded southern. Figure 2 also shows the locations of incorporated voluntary organizations that were found in the data; these data are described more fully in the results section.

Figure 2: Map of Saskatchewan showing northern/southern areas and locations of incorporated voluntary organizations



Note: This map shows only the locations where incorporated organizations existed during the study period. It is for this reason that there are very few locations in the northern area of the map.

Finally, we had intended to find and gather the names of voluntary organizations that were listed under the *An Act respecting Benevolent and other Societies (1909)* which is a provincial government act.¹⁰ However, upon reading the first few annual reports, it became clear that voluntary organizations were not only registering under this Act, but were also registering under *Private Acts*¹¹ or under *An Act respecting Companies* (section 25 in 1909 and section 9 in 1930 that had provisions for “charities”) and as *Joint Stock Companies*, some with share capital and some without.¹² It appears that early legislation offered some special provisions and protections for these voluntary organizations; depending on the legislation, some organizations had exemptions from paying federal, provincial and municipal taxes and had limited liabilities for board members despite the fact that some legislation subjected charities “to many of the same rules as share companies” (Canadian Centre for Philanthropy, 1990, p. 5). As we already noted, provincial public acts were not included in the data collection, nor were organizations that incorporated federally.¹³ Thus, as we collected organization names, we also noted their incorporation classification in the Microsoft[®] Excel inventory.

There are numerous limitations to conducting this kind of geo-historical research. The limitations include:

- a) some organizations may have been in existence prior to Saskatchewan becoming a province, thus they would not be listed in any of the government records that we checked for that period of time because those records only contained new registrants;
- b) some organizations may not have registered themselves with the Province of Saskatchewan during the study period, but did exist and did provide services;
- c) some organizations may have been registered in other provinces yet worked in Saskatchewan (e.g., scholarly reports refer to missionaries operating in the North, but there is no record of them having registered/incorporated in Saskatchewan);
- d) our focus was on *Private Acts* and those organizations that incorporated as *Joint Stock Companies*, or under *Benevolent Societies*, or the *Companies Act*; no *Public Acts* or federal legislation were included. Some organizations formed under the auspices of provincial Public Acts, thus they were not listed in *The Gazette* or the *Office of the Provincial Secretary Annual Reports* (for example, the Saskatchewan Anti-Tuberculosis League came into being via *An Act respecting Sanatoria for the Treatment of Early Cases and Hospitals for Advanced Cases of Tuberculosis* in 1911, Children's Aid Societies came into being under the *Children's Protection Act* of 1908, nursing homes for the aged were governed by the *Hospital Standards Act* (section 3) of 1946).

¹⁰ This Act was proclaimed in 1909, but it was almost wholly replicated from the 1898 Ordinance of the North West Territories under the same name.

¹¹ There are important differences between public and private acts. In general, public acts are passed for the benefit of the community at large whereas private acts deal directly with the affairs, power and objectives of a defined group based on their application for incorporation. It has been postulated that an advantage to incorporating under a private or public act was that the organization “might be relieved of the requirements of [these other Acts] with respect to reporting, filing, investigation, etc.” (Canadian Centre for Philanthropy p. 47).

¹² Joint Stock Companies were originally governed by *An Ordinance respecting the Incorporation of Joint Stock Companies* (1898) of the NWT which later became *The Companies Act* in 1909 when Saskatchewan became a province.

¹³ Voluntary organizations could also incorporate federally as “charities” and were governed by the *Income War Tax Act* (1917, revised in 1930) and later, *The Income Tax Act*.

- e) given we only consulted government documents made publicly available, and not the original sources, some may have been missed (e.g., during the 1930s and early 1940s there were some gaps in records);
- f) given the search through *The Gazette* spanned almost 50 years, we had to undertake a careful examination of numerous sections for which the layout changed and sub-titles were modified. For example, we had to read the following sections in order to not miss any organizations: Certificates of Incorporation, Certificates of Incorporation under the Companies Act, Certificates of Registration, Change of Name of Companies, Companies Restored to the Register, Certificates under the Benevolent Societies Act, Joint Stock Companies. However, given the nature of this search, human error is possible.
- g) our interest in this SPHERU history project was in “health/social/welfare” organizations and Acts (e.g., hospitals, housing, poor relief, etc.) thus we omitted organizations that did not appear to be related (e.g., omitted community parks, recreation and sports leagues and buildings, music groups, etc.) however, we may have made errors in judgement given we seldom had detailed information for each organization and had to make assumptions about whether to include them or not.

RESULTS

Between 1905 and 1950, a total of 899 voluntary organizations that fit our criteria were entered into the Microsoft® Excel dataset. Data for each era are now presented in turn.

Categorization of voluntary organization types by era

Between 1905 and 1928, 402 organizations that fit the parameters of this study were incorporated. Figure 3 shows the categorization of this collection of organizations by type for this era. The following list offers some examples of each category in order of most to least common:

- religious organizations (149, 37%) (e.g., Ursuline Nuns of Bruno, Moose Jaw Young Women's Christian Association, Catholic Orphanage of Prince Albert)
- club-oriented (74, 18%) (e.g., Elks Clubs, Homemakers Clubs, Railway Men's Club),
- secular (63, 16%) (e.g., Benevolent Aid Society of Whitewood, Longlaketon Memorial Hospital, Winter Ladies Aid),
- ethnic or cultural groups (62, 15%) (e.g., Indian Mutual Improvement Association, Ukrainian National Home Association, Hing Chung Mutual Improvement Association) and
- community-wide benefit organizations (54, 13%) (e.g., Springwater Community Hall, Poplar Grove Community Club, Nokomis Community Hall Association).

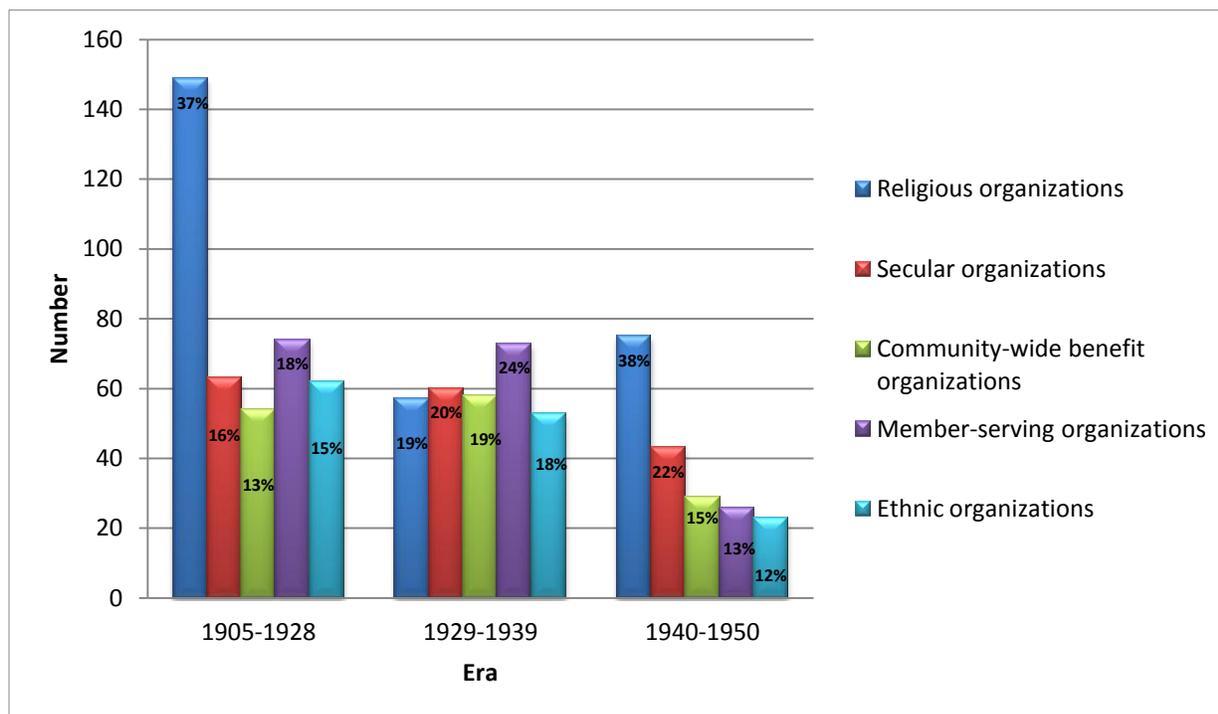
Taken together, the largest collection of voluntary organizations, 70%, were those that formed primarily to support people who shared certain characteristics (e.g., shared religion, shared ethnicity). The remaining 30% of incorporated organizations served the broader population without regard for ethnic or religious characteristics.

Between 1929 and 1939, 301 organizations incorporated. Figure 3 shows there was a different profile of organizations that incorporated when compared to the previous era. During this period, the largest proportion of organizations that incorporated were club-oriented organizations (73, 24%), followed by secular (60, 20%), community-wide benefit (58, 19%), religious (57, 19%), and then ethnic (53, 18%) organizations. Taken together, the largest collection of voluntary organizations, 61%, were those that formed primarily to support people who shared certain characteristics (e.g., shared religion, shared ethnic group).

During the 1940s era, 196 organizations incorporated. Figure 3 shows a profile of these organizations that is almost reminiscent of the 1905-1928 era given the high percentage of religious organizations. The highest proportion of those that registered were religious (75, 38%), followed by secular (43, 22%), community-wide benefit (29, 15%), club-oriented (26, 13%), and ethnic (23, 12%) organizations. Interestingly, a closer look at the dataset for this era shows that the majority of these religious organizations registered after 1945 after Tommy Douglas, a Baptist Minister, was elected Premier of the province.

While the numbers presented in Figure 3 show the relative importance among these different types of organizations over time, the percentages show the actual magnitude of shifts in these categories over time. Across these eras, there was a clear, but small rise over time in the proportion of secular organizations that incorporated. Second, across the sample and eras, on average, 64% of all organizations were member-serving, not community-wide benefit. Third, over time, the total number of organizations that incorporated decreased.

Figure 3: Number and percentage of voluntary organization by category and era



Sources: *Saskatchewan Office of the Provincial Secretary annual reports 1905-1919*; *The Saskatchewan Gazette 1920-1950*.

Geography

There were some clear geographical distinctions found in the data. In general, there was a prevalence of rural organizations from the southern area of the province. Figure 4 shows the rural/urban trends. Between 1905 and 1928, the largest percentage of organizations that incorporated was from rural Saskatchewan; 237 (70%) of the organizations had head offices located outside urban areas.¹⁴ All but one of the organizations that incorporated was located in the southern area of the province. During the 1929-39 era, once again, the largest percentage of organizations that incorporated was from rural Saskatchewan; 164 (67%) of the organizations had head offices located outside urban areas.¹⁵ All but one of the organizations that incorporated was located in the southern area of the province. During the 1940s era, once again the largest percentage of organizations that incorporated were from rural Saskatchewan; 92 (66%) of the organizations had head offices located outside urban areas.¹⁶ All of the organizations that incorporated were located in the southern area of the province. When comparing over time, there was a small decrease in the proportion of rural organizations and corresponding increase in the proportion of urban organizations. This change over time parallels the change in rural and urban populations as shown in Figure 5.

¹⁴ Of the 402 organizations that incorporated during this era, only 340 had a head office specified in *The Gazette*, thus this percentage is based on a total of 340, not 402 organizations.⁹

¹⁵ Only 245 organizations had head offices specified, thus this percentage is based on 245, not 301.

¹⁶ Only 139 organizations had head offices specified, thus this percentage is based on 139, not 196.

Figure 4: Percentage of organizations incorporated by location

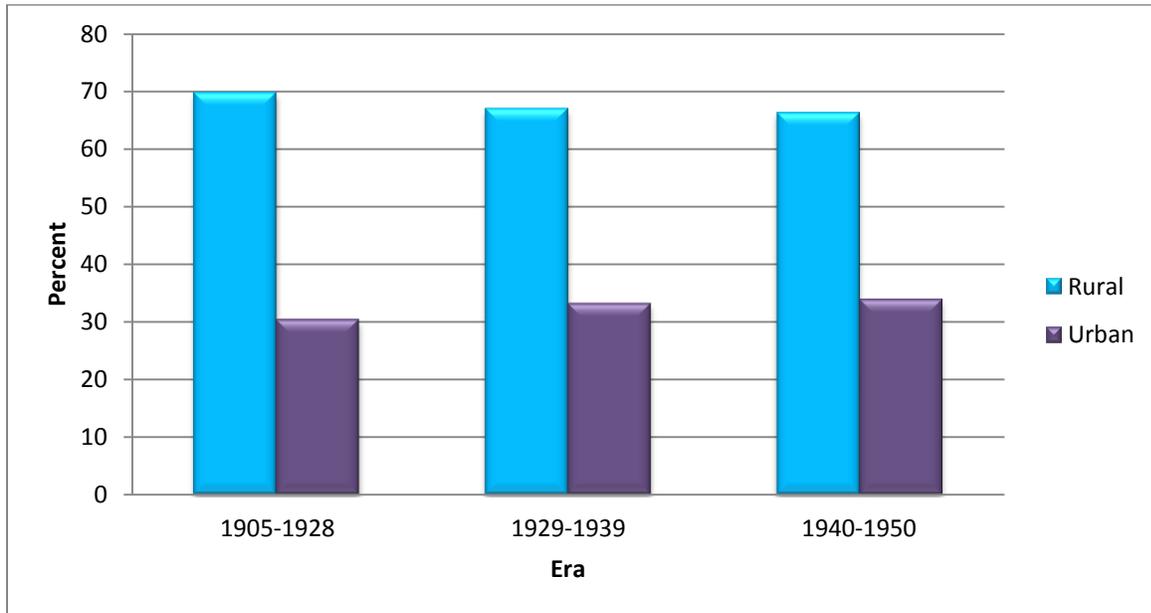
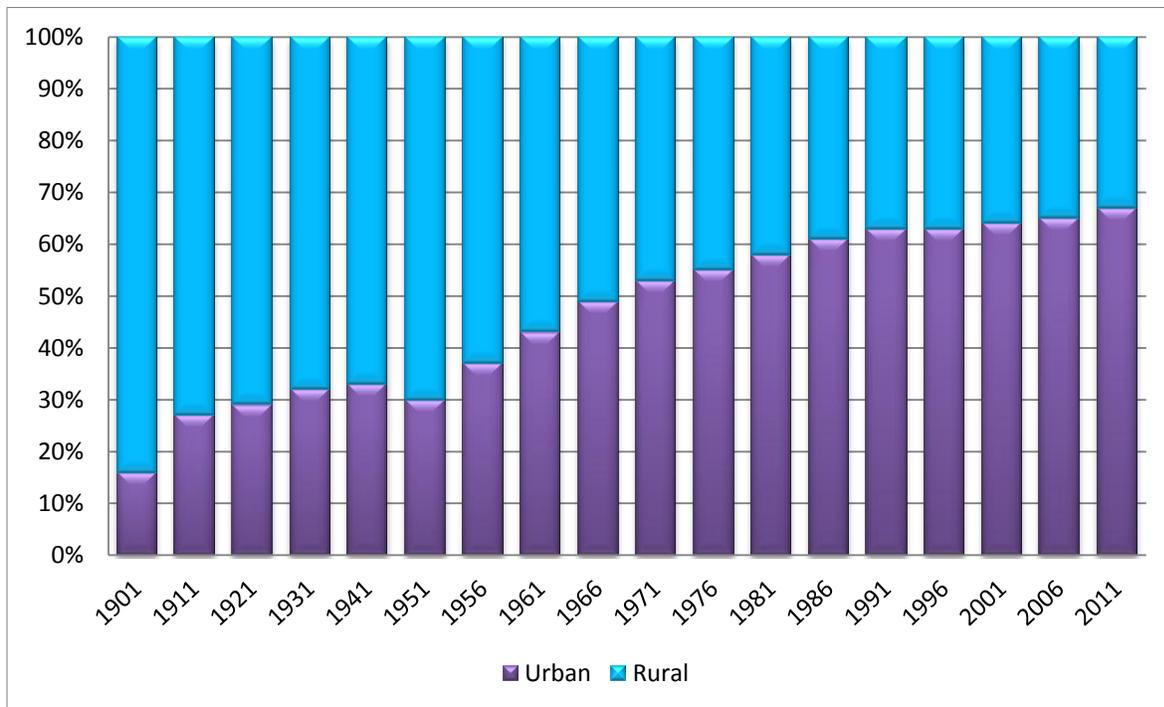


Figure 5: Percentage of total Population, urban and rural, for Saskatchewan by decade



Source: <http://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/demo62i-eng.htm>

Incorporation classification

Figure 6 presents the results of incorporation classification over time. The three main Acts under which voluntary organizations incorporated¹⁷ were:

- *An Act respecting Benevolent and other Societies (1909)* (referred to as *Benevolent Societies Act* from here on)
- *Private Acts*
- *An Act respecting Companies* (section 25 in 1909 and section 9 in 1930 had provisions for “charities”).

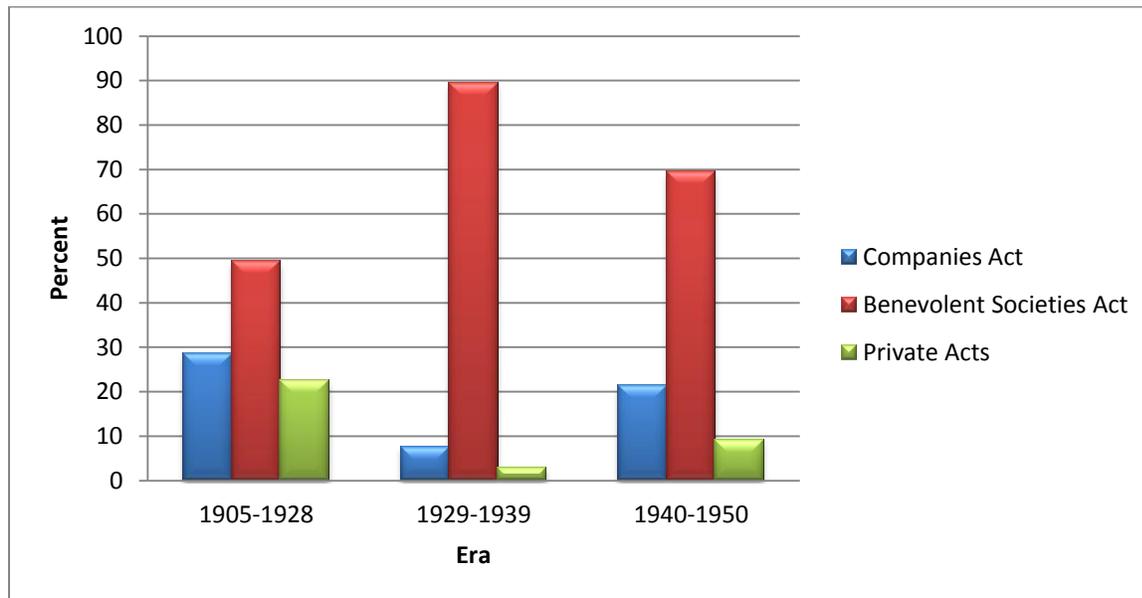
During the first era, from 1905-28, the sub-sample of 402 organizations incorporated under diverse auspices. The largest number of the 402 organizations, 198 (49%), incorporated under the *Benevolent Societies Act* of 1909 (e.g., Prairiedale Benevolent Association at Deware Lake in 1918, Aneroid Hospital in 1919, Women's Section of the Colonsay Grain Growers' Association of Saskatchewan in 1920). This was followed by organizations that incorporated via the *Companies Act* (114, 28%) (e.g., Dundurn Moravian Church in 1910, Young Women's Christian Association in 1911, Indian Mutual Improvement Association at Round Lake in 1919) and those that incorporated through *Private Acts* (90, 22%) (e.g., Salvation Army Act 1909, Saskatoon YMCA Act 1912, Moose Jaw Providence Hospital Act 1913). Some of those that incorporated under the *Companies Act* were Joint Stock Companies that had shares with no monetary value, while others had shares with monetary value. There appears to be no pattern by which organizations chose to register under these different Acts. Essentially, within this collection of 402, religious, ethnic, club, community-wide and secular organizations all incorporated under these various Acts.

From 1929 to 1939, as in the earlier era, the sub-sample of 301 organizations incorporated under diverse auspices as well. During this era, when the economic depression and drought on the prairies was in full swing, the largest number of voluntary organizations, 269 (89%), incorporated under the *Benevolent Societies Act*. This was followed by 23 (8%) that incorporated under *The Companies Act*, and 9 (3%) incorporated under *Private Acts*. The large volume of benevolent organizations formed during this time is not surprising given this sector is known to be the first to respond to community needs. Some examples of organizations are: Weldon Norwegian Evangelical Lutheran Congregation in 1931, Pleasantdale Community Hall Association in 1933, Kinistino District Hospital in 1938, and Saskatchewan Métis Society in 1938.

During the 1940s, the majority of these organizations (138, 70%) registered under the *Benevolent Societies Act*. This was followed by 40 (21%) of the organizations incorporating via the *Companies Act* and 18 (9%) incorporating via *Private Acts*. It is interesting that as late as the 1940s some voluntary organizations were still registering under the *Companies Act* instead of the *Benevolent Societies Act*. Some examples of those that incorporated as “companies” are: Preeceville Community Hospital 1940, Cabri Men's Social Club in 1944, Ukrainian Cultural Association in Prince Albert in 1944 and Loomis Community Hall in 1947.

¹⁷ However, recall that *Public Acts* were excluded from this study. Thus, there are some organizations, such as the Saskatchewan Anti-Tuberculosis League, that are not included in the Figure because they were governed by *Public Acts*.

Figure 6: Percentage of organizations by incorporation class



OBSERVATIONS, IMPLICATIONS AND UNANSWERED QUESTIONS

In sum, Saskatchewan has a rich history of voluntary organizations that have attempted to address issues concerning the determinants of health while acting as human service deliverers, service planners, and healthy public policy advocates. They incorporated at different times and under a diversity of Acts in Saskatchewan, expanded and contracted at different speeds, and took on different forms depending on where they were located (i.e., urban or rural, northern or southern areas of the province), and which populations they served (e.g., First Nations women, children with disabilities, isolated seniors). They were shaped by crises (e.g., economic disasters, wars, droughts), shifting values and the demands of a variety of groups (e.g., ethnic groups, religious groups).

Based on our analyses, there are nine macro level observations and implications to offer about this history of voluntary organizations' work on the determinants of health. There are also numerous unanswered questions which form the foundation for future research. Each of these nine main observations is presented in turn.

First, there has been an uneven evolution of the voluntary sector over space and time. The first half of the century revealed a voluntary sector driven by the people of towns and villages and not urban centres. However, over time the data showed a later shift toward fewer rural voluntary organizations, which coincided with the rural to urban migration pattern of the 1930s. This uneven evolution of organizations over space and time is also reflected in differences

between the northern and southern areas of the province as well as evidence of almost no incorporated Aboriginal voluntary organizations. The one example found in the registry was the Indian Mutual Improvement Association that incorporated at Round Lake in 1919. In addition, the reviewed literature showed there were many Métis organizations in some communities such as Cumberland House that were not found in the registry. What remains unknown is, how did early forms of voluntary association that existed in Aboriginal communities in the north differ from southern models created by the settlers and how can these Aboriginal paradigms broaden our conceptualization of volunteerism in Canada?

Second, the early registry of incorporated voluntary organizations was predominantly member-serving, not general public or broad community-focused. Religious, ethnic and club-oriented (e.g., men's and women's clubs) organizations were the most prevalent over this early period. During this first half of the century, there was steady growth in the proportion of secular organizations, but the member-serving and member-benefit organizations far out-numbered public benefit organizations. If almost two thirds of the incorporated organizations were member-serving and not intended for community-wide benefit, does this point us to some historical roots that may help explain present-day health inequities (i.e., certain groups received aid while others did not)?

Third, there was an uneven emergence of different incorporation classes of organizations. Organizations incorporated under the *Benevolent Societies Act* (1909), *The Companies Act* (1909) and various *Private Acts*. Further, it was found that the same types of organizations incorporated under different Acts. For example, hospitals were found registered under *Private Acts*, *The Companies Act* and the *Benevolent Societies Act* – even within the same era (e.g., Community Hospital at Oxbow incorporated in 1931 as a Joint Stock Company with shares, Lady Minto Hospital at Melfort incorporated in 1937 under a *Private Act*, Kinistino District Hospital incorporated in 1938 under the *Benevolent Societies Act*). Over the years, scholars have referred to this development of the voluntary sector as “haphazard” (Cassidy, 1945), reflecting an “erratic history” (Watson, 1985) and governed by “a hodge-podge of seemingly unrelated and uncoordinated statutes and rules” (Canadian Centre for Philanthropy, 1990, p. 2). Do these structural aspects help to explain the present day lack of clarity about the roles and responsibilities of the voluntary sector generally? Further were organizations that worked within the medical model with closer ties to government policies and funding (e.g., under private and public acts) valued more than those working on the social determinants of health (e.g., food security, housing)? It has been hypothesized that if the voluntary sector exists “on the margins ... then all their efforts may not amount to more than ... palliative measures for those most hurt or least able to cope” (Browne, 1996, p. 82).

Fourth and related to these different types and classes of voluntary organizations is evidence for the existence of both social inclusion and social supports as well as exclusion and discrimination. The large number of member-serving organizations is evidence that people who shared specific characteristics came together to support one another. This would have been especially important in order to survive the isolation of rural life. This likely created internal bonds and cohesion within these groups that contributed to their mutual well-being. Nonetheless, there is also evidence that across groups, there was social exclusion, discrimination and distinctions drawn between deserving and undeserving groups. Today, social inclusion and its

companion social processes are considered salient in the health literature (see for example Baum et al., 2010; Brunner & Marmot, 2006) and oppression is a recognized determinant of health (McGibbon, 2012). We are left wondering, what were the actual impacts of these voluntary organization interventions on health status across population groups and the subsequent health inequities that emerged?

Fifth, the analysis shows evidence of both human service silos and fragmentation among government departments and among voluntary sector organizations, yet there is also evidence of interdependencies and attempts at integrated service planning, often driven by the voluntary sector, not governments. Today we know that service fragmentation exists, yet the social determinants of health concept espouses that myriad social conditions influence the health of communities and these conditions are inherently interconnected and require integrated planning (Daghofer & Edwards, 2009; Health Council of Canada, 2010). For example, people-in-need seldom have just a need for food or for housing or for income. Aboriginal health scholars explain this holism and interconnectedness well: "life stages, socio-political contexts and social determinants of health" are "nested spheres of origin, influence and impact" on people's health (Loppie Reading & Wien, 2009, p. 25). This leads us to speculate. It is clear that a siloed approach prevailed, but what if Saskatchewan had embraced Aboriginal Peoples' holistic conceptions of health and the importance of health determinants instead of ignoring them, would the province also have become an innovator in integrated health and social planning as it was with Medicare?

Sixth, there is evidence of shifts over space and time in the adoption of human service delivery models (e.g., both institutional and community care) and ongoing challenges surrounding evidence-based policy-making. At times the government's approach embraced institutional care programs that centralized services in a few locations, while at others it favoured service provision focussed on decentralized community care. For example, large orphanages were opened for children in the early eras, but later foster homes and smaller group homes became the norm. Further, there is evidence that provincial government staff had actually researched and recommended small, cottage-style hospitals, yet elected officials approved large, rural-based tuberculosis sanatoriums and psychiatric institutions - a decision that would seem to have provided political credit rather than more effective health care (e.g., North Battleford Mental Hospital in 1914, Fort Qu'Appelle Tuberculosis Hospital in 1917). Does this reflect an enduring struggle between evidence-based policy choices and politically-based choices in the human service sector?

Seventh, there were temporal variations in the degree of interactions between the voluntary sector and different levels of government, which also revealed a multiplicity of human service delivery agents over time. In the period spanning 1905 to 1928, the voluntary sector interacted primarily with municipal governments regarding human services. The era between 1929 and 1939 saw a higher degree of interaction between the voluntary sector and municipal, provincial and federal governments – depending on the issue – as people came together to deal with multiple crises (e.g., the depression) that created large scale human needs. The 1940s era showed a continuation of these relationships. There was “movement back and forth” between voluntary organizations and governments delivering various services and relationships were often ambiguous (Thériault et al., 2002, p. 141); “government and nongovernment agencies ...

have played roles of varying importance in various fields of service delivery depending on the particular issue and on time and place” (see also Canadian Welfare Council, 1938; O’Sullivan & Sorensen, 1988, p. 79). The enduring ambiguity and lack of consensus on the division of responsibilities among human service delivery agents within the voluntary sector and between the sector and different levels of government persists today. What are the ramifications of a system that lacks intentional and explicit roles among the agents delivering essential human services intended to positively impact health?

Eighth, the funding formula for the present day voluntary sector has its roots in the 1905-1928 era wherein organizations sought funding from numerous sources. Organizations sought out government grants, donations from the community and wealthy philanthropists as well as ran fundraising events. During the 1930s, Community Chests also incorporated and organized community-wide fundraising efforts to support the voluntary sector. This, taken together with the reviewed literature, shows early voluntary organizations were cobbling together numerous sources of funding to deliver services to those in need (Canadian Welfare Council, 1938). Today the funding formula for the system of voluntary organizations is best described as piecemeal, uncertain, short-term and lacking in sufficiency (Hall et al., 2005; Scott, 2003). Given voluntary organizations are central players in work on the determinants of well-being (Danaher, 2011; DeSantis, 2013), should the health of populations depend so much on an unstable voluntary sector that relies on piecemeal, uncertain, and insufficient funding?

Ninth, under the Canadian Constitution, health care became a provincial government responsibility early in Canada’s history. “Far in advance of its acceptance of responsibility in many fields of welfare service, the state accepted the care of the public health as a public responsibility” (Canadian Welfare Council, 1938, p. 40). However, responsibility for the determinants of health (e.g., income, housing, food) has ebbed and flowed over time, across both the government and voluntary sectors. For example, food security has not been a government responsibility; the voluntary sector has been supplying groceries and meals to people since Saskatchewan became a province. Why does the principle of “universality” only apply to health care interventions and not to the determinants of health?

In closing, this study offers but a brief glance at this complex world of the voluntary sector and its early work on the determinants of health. It exposes historical tensions between the voluntary sector and governments active in the human service system, evidence-based versus politically-based policy choices, both human service silos as well as attempts at integrated service planning, and social inclusion/exclusion. This study also leaves us with unanswered questions about the shift from rural to urban organizations, about member-serving and community-wide benefit organizations, about haphazard and uncoordinated voluntary sector legislation, about voluntary sector funding models and about universality. A glance at history does indeed inspire unsettling questions about our present human service system and the social determinants of health, but it should also inspire us to choose our future.

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