

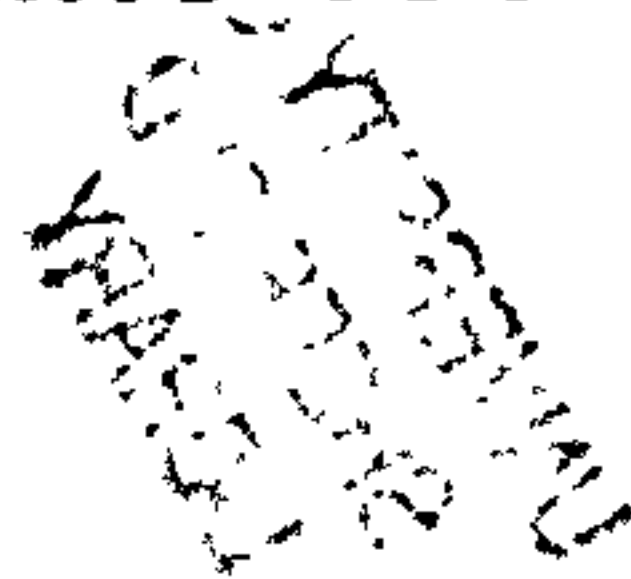
**'A Price Must Be Paid For Motherhood':
The Experience Of Maternity In Sheffield, 1879–1939.**

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PhD Thesis

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June 1997



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'A Price Must Be Paid For Motherhood':

The Experience Of Maternity In Sheffield, 1879–1939.

This study considers the reproductive experiences of women in Sheffield between 1870 and 1939, encompassing the development of concepts of maternal and infant welfare, and debates over birth control and abortion. It focuses on the impact of state and voluntary enterprise, on the development of health professions and hospitals, and on the position of mothers.

The study shows that high infant mortality was caused primarily by poor sanitation. Unlike other areas, Sheffield had low rates of both maternal employment and bottle feeding, suggesting that these were not significant factors. The decline in infant mortality was due to a combination of factors; the removal of privy middens and slum areas, and the development of welfare clinics and health visiting services.

High maternal mortality was prevalent mainly in areas of skilled working class employment; not middle class areas as in other cities. There was no inverse correlation between infant and maternal mortality in Sheffield. Maternal mortality was caused by high rates of sepsis following illegal abortion. The reduction in mortality was due to a cyclical decline in the virulence of the causative bacteria, and the application of sulphonamide drugs to control it. The development of antenatal and birth control clinics had little impact. Despite early action to train midwives in Sheffield, midwifery remained a largely part time, low status occupation throughout the period. The hospitalisation of normal childbirth occurred early in Sheffield, and demand for beds outstripped supply, demonstrating that women were able to shape the development of services.

Local authority and voluntary groups generally co-operated in the delivery of services, which were developed along pragmatic lines with little reference to debates about eugenics or national deterioration. The growth of welfare schemes was circumscribed by the available resources. Central government provided enabling legislation, but schemes were planned and implemented at the local level.

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Abbreviations

In the text:

BMA	British Medical Association
BMJ	British Medical Journal
CMB	Central Midwifery Board
GP	General Practitioner
IMR	Infant Mortality Rate [per 1000 population]
JHSS	Jessop Hospital Samaritan Society
LGB	Local Government Board
MCWC	Maternal and Child Welfare Centre
MMR	Maternal Mortality Rate [per 1000 population]
MOH	Medical Officer of Health
NBCA	National Birth Control Association
NCW	National Council for Women
NHS	National Health Service
NMR	Neonatal Mortality Rate [per 1000 population]
RHSS	Royal Hospital Samaritan Society
RSI	Royal Sanitary Institute
SCSS	Sheffield Council of Social Service
SWWC	Sheffield Women's Welfare Clinic
WSI	Women Sanitary Inspectors

In the footnotes:

BMJ	British Medical Journal
SI	Sheffield Independent (Newspaper)
ST	Sheffield Telegraph (Newspaper)

Acknowledgements

I am grateful to the University of Sheffield for granting me a part-time fees Bursary for this project, and to the Wellcome Trust for a grant towards research expenses.

I would like to thank my Supervisor, Dr John Woodward, for his support, advice and encouragement. Thanks also to the many people who helped me and this project in various ways; Professor Mavis Kirkham; Ruth Tomlinson; Rachel Strong; Professor John Emery; Susan Jenkins; Linda Towers at the Children's Hospital, staff at the Jessop Hospital; staff at Sheffield City Archives, Sheffield Local Studies Library, Sheffield University Libraries, and Cambridge University Library.

On a personal level I would like to thank the Sheffield Students' Union Nursery for taking such good care of Owen and Sean; my parents for providing financial and moral support; and my husband Richard for help with all aspects of computing and for support and encouragement.

This thesis is dedicated to Owen, Sean, and Caitlin.

1: Introduction.

Maternal mortality and morbidity can never be reduced to zero...A *price must be paid for motherhood.*¹

This remark was made by Glasgow obstetrician JM Munro Kerr in 1933 and referred specifically to the apparently intractable issue of high rates of maternal mortality. Sheffield was one of the areas which experienced rising rates of maternal mortality in the inter-war period, and for that reason the comment is significant. However, it could also be taken as referring to the wider set of issues which this thesis will address. Particularly before the First World War, high rates of infant mortality were also part of the price of motherhood, as were considerable levels of infant and maternal morbidity, although these latter were almost impossible to quantify.

Beyond these personal factors was the price paid in terms of the health and future of the nation and the race, as seen by eugenists and others, and the possible costs in terms of the reduction of personal liberty with the encroachment of state welfare. Lastly was the literal price to be paid by the community, either the state or voluntary agencies, for any welfare which was perceived to be necessary.

This study will consider the reproductive experiences of women in Sheffield between 1870 and 1939, encompassing the development of concepts of maternal and infant welfare, and debates over birth control and abortion. It will focus on the impact of state and voluntary enterprise, on the development of health professions and hospitals, and on the reality of women's experiences.

The study of maternal and infant welfare in Britain touches on many different disciplines including women's history, medical history, and demography. The problem with such interdisciplinary work is the possibility of missing important facets of an explanation due to unfamiliarity with the historiography or the subject. This has in fact been one of the major arguments levelled against the study of the social history of medicine; that non-medically trained researchers overplay the role and influence of social factors such as nutrition, poverty or politics, at the expense of medical factors, simply because they do not understand the aetiology, or even the terminology, of

¹ JM Munro Kerr, *Maternal Mortality and Morbidity: A Study of Their Problems*, Edinburgh, 1933, p.xvi.

disease². However, a subject such as maternal and infant welfare cannot be understood adequately without reference to social, economic, and demographic factors. It was concern with the social aspects of infant and maternal mortality, including fears for the future of the race, as well as the health and well-being of individuals, that prompted debate. Efforts to alleviate infant mortality in particular were made primarily at the social level, and included nutrition and education; although maternal mortality did provoke a more 'medical' response with debate focusing on the care around the birth.

There have been several important general works on maternal and child welfare³. However, the use of local studies to illuminate particular aspects of issues offers many possibilities both in answering current and raising new questions about linkages between medicine, welfare, and society⁴. Pickstone has highlighted three of the major uses of local studies; first, the use of local data to illuminate or amend general claims made in secondary literature; secondly, the chance to link areas of debate which are normally treated separately in national studies; and thirdly '...to see medical practices as local social dynamics.'⁵ The restriction of geographical area should allow for a broader picture, which draws together not only different types of medical provision, and explores the linkages of place and personnel, but also studies the influence of other, not obviously 'medical' factors, in explaining health and illness. The inhabitants of, for example, an industrial town, would not have defined their episodes of health and ill-health in terms of medical institutions and services alone, but would also have included, possibly unconsciously, factors such as nutrition, housing, employment and poverty. Concentration on a particular town, city, or rural area allows the historian to assess the importance of such non-medical factors, and their linkages with health in that area. Jordanova has also stressed the importance of local studies in allowing for primary sources to be presented in a more accessible form for use in overviews⁶. These she has argued are necessary in allowing the social

² HM Marks, 'Fatal Years: An Introduction to the Symposium', *Bulletin History Medicine*, 68, 1994, 89-91; LG Wilson, 'Medical History Without Medicine', *Journal History Medicine*, 35, 1980, 5-7.

³ J Lewis, *The Politics of Motherhood: Child and Maternal Welfare in England, 1900-1939*, London, 1980; D Dwork, *War is Good for Babies and Other Young Children: A History of the Infant and Child Welfare Movement in England 1898-1918*, London, 1987.

⁴ For example Marks' study on the links between religion, ethnicity and welfare; LV Marks, *Model Mothers: Jewish Mothers and Maternity Provision in East London, 1870-1939*, Oxford, 1994.

⁵ JV Pickstone, 'Medicine in Industrial Britain: the Uses of Local Studies', *Social History Medicine*, 2, 1989, 197-203.

⁶ L Jordanova, 'Has the Social History of Medicine Come of Age?', *Historical Journal*, 36, 1993, 437-449, p.441; Weindling, P, 'Patients and Practitioners: Virtues and Vices of the New Social History of Medicine', *History Workshop Journal*, 24, 1987, 191-4.

history of medicine to become a more mature discipline with a wide field of available sources.

Woodward and Richards have drawn attention to the value of local studies in assessing the influence of national policy and trends on the local situation; for example, in the debate over the causes, consequences, and cures of high infant mortality⁷. Such studies can also highlight how local problems and solutions might have had an impact on national policy making. In the area of maternal and infant welfare, it was local government that led the way in terms of action, with central government lagging behind, and even then supplying only confirmatory or permissive legislation⁸. However, it is questionable how far local action, particularly with regard to public health, and the development of hospitals and of local council health departments, was truly responding to local problems. Marland has commented that hospitals, for example, rarely appear to have been set up in response to perceptions of local health needs, but rather in response to other social factors including professional and social ambition, civic pride, and attempts at social control⁹. Health services often seem to have been created in response to very disparate criteria, and had to take account of what was politically and economically acceptable.

As an area of study, Sheffield certainly meets Marland's suggested criteria of a 'typical' locale rather than one which was famous or pioneering in its work on maternal and infant welfare¹⁰. Primarily a one industry city, that of steel and metalwork in all its forms, it experienced major population expansion in the mid-nineteenth century, due both to in-migration and soaring birth-rates. It had a Hospital for Women, opened in 1864, a Children's Hospital opened in 1872, and its first Medical Officer of Health (MOH) was appointed in the same year¹¹. Both the Council and local charities appear to have become committed supporters of attempts to reduce infant mortality by 1900, and maternal mortality in the inter-war years. Although the City's experience

⁷ J Woodward and D Richards, 'Towards a Social History of Medicine', in J Woodward and D Richards, eds., *Healthcare and Popular Medicine in Nineteenth Century England: Essays in the Social History of Medicine*, London, 1977, 15-55.

⁸ FB Smith, *The Peoples Health 1830-1910*, London, 1979, p.11.

⁹ H Marland, *Medicine and Society in Wakefield and Huddersfield, 1780-1890*, London, 1987, p.2; see also, L Granshaw, 'Fame and Fortune by Means of Bricks and Mortar': The Medical Profession and Specialist Hospitals in Britain, 1800-1948', in Granshaw and Porter, *The Hospital in History*, 199-220.

¹⁰ Marland, *Medicine and Society*, p.2.

¹¹ The MOH was, however sacked in 1877, and there was no full time appointee or any published annual reports until 1885; see also JV Pickstone, *Medicine and Industrial Society: A History of Hospital Development in Manchester and It's Region, 1752-1946*, Manchester, 1985, p.114. see *Appendices 2 & 3*.

of infant mortality followed a common urban pattern, the causes of its high maternal mortality were more unusual; both of these features will be considered in detail.

In order to highlight possible linkages, or lack thereof, between different groups or agencies, and also in order to place the role and influence of women and their attitudes to different policies in the centre stage, this study will be arranged according to the reproductive stages of a woman's life. However, in common with the development of debates and their corresponding policies, the experience of reproduction will be considered in reverse. Attempts to explain and alleviate infant mortality first began in the c.1870s, in Sheffield. These were followed by concern over childbirth, with reference to the health of the neonate, but also to the mother, and should be considered in the context of debates over midwifery training and registration, the hospitalisation of childbirth, and high levels of maternal mortality in the 1920s and 1930s. After 1910 the concept of antenatal care began to develop in Sheffield, and finally in the 1920s and 1930s came debates over birth control and the opening of the first birth control clinic in 1935. All of these issues cut across several debates, including those over the development of state welfare, and the position of women as professionals and mothers. These broad issues will be considered thematically through the thesis in the specific context of infant and maternal welfare. Although the study considers the three major areas of debate; infant welfare, maternal welfare, and birth control; across the whole period, it is inevitable that different aspects are highlighted at different times. For example, although the use of contraception and abortion is considered for the earlier part of the period, it was not until the inter-war period that the debate assumed major public significance and provoked policy initiatives. From the chapter on infant welfare, an area of debate primarily before c.1920, to that on birth control the time frame does shift to a certain extent, reflecting the developing debates.

This general introductory chapter, which highlights the main themes, is followed by a background chapter which will focus on two of the important debates of the period, those of eugenics and racial degeneration, and the development of state welfare. These provided not only a potential framework for policies, but the ideas that they raised permeated the language used to discuss such disparate issues as childbirth in hospital and birth control.

Chapter 3 will look at the development of Sheffield as a city, and the impact of its social, economic, and political position on health and welfare, particularly that of women. It will seek to ground the specific experiences of

fertility, birth and early motherhood in a more general context of health and welfare, relating problems and policies to local conditions and culture.

The following three chapters comprise a detailed study of specific issues in maternity and welfare. The first (Chapter 4) will focus on attempts to alleviate infant mortality, and the impact which this had both on the development of local government as a provider of welfare, and on the role of women as suppliers and consumers of voluntary and state action. Chapter 5 will look at the issue of maternal mortality, and at efforts to tackle this. Beyond the issue of mortality, the subject of childbirth was important in demonstrating the growing commitment of local government to the provision of hospital and home based services (for example, municipal midwifery services), and to the growing legal control over independent health practitioners; in this case midwives. The impact of legislation and regulation on the midwifery service, including its professional development will be considered. Finally, Chapter 6 will study debates and practice in birth control; both abortion and contraception. This is in many respects the most speculative of the chapters, as so much of the evidence, including motivation and intention, is hidden from the historian's view.

These areas collectively demonstrate the growing primacy of local government in the day to day administration of welfare policies. They also show that although the language used by providers of welfare, and by women, was often very different, there was consensual support for welfare clinics, trained midwives, and hospital beds for birth. It is mistaken to argue that women were marginalised and coerced into particular choices by a male dominated state. In fact, the concept of a traditional womens' culture appears to have been over played, and support for particular policies was very strong.

1.1: Welfare: the State and the Individual:

The decades either side of 1900 saw the emergence of social policies, either volunteer, local or state, centred around women, particularly around women as mothers. Koven and Michel have suggested that women played a significant role in this development:

Women focused on shaping one particular area of state policy: maternal and child welfare...they transformed motherhood from womens' primary *private* responsibility into *public* policy. During periods when state welfare structures and bureaucracies were still rudimentary and fluid, female reformers, individually and through organisations, exerted a

powerful influence in defining the needs of mothers and children and designing institutions and programmes to address them.¹²

Recently, it has been argued that most histories of welfare states have downplayed the influence of women in shaping policy before 1939, and also their role as recipients of benefits and other aid. Work by feminists has contributed to this neglect by downplaying the centrality of motherhood to the lives of women. Much of this work has tended to see the situation in oppositional terms:

Thus the solution to a national problem of public health and of politics was looked for in terms of individuals, of a particular role – the mother, and a social institution – the family. This obscured to an extent which now seems astonishing the effects on child health of poverty and the environment.¹³

The reality of the situation probably lies somewhere between these two extremes of women as passive victims of welfare, and as crusading and successful campaigners for change. It is likely that the majority of women lacked the time and energy for broad campaigning. Even working women such as midwives failed to act in a coherent way to secure change and benefits, or to resist developments which they did not welcome. However, concepts of social control, such as those used by Davin, perhaps oversimplify a situation in which so many agencies became involved, including, to a certain extent, working class women themselves. This situation has been characterised by Jane Lewis as 'the mixed economy of welfare', whereby there was no state take-over of welfare at any point, but a continued mix of state and voluntary, public and private provision. Lewis has drawn attention to the importance of the family as a provider as well as a recipient of care, and, within the family, to the pivotal role of women. Most of the work done by local government, voluntary organisations, or the state focused on working class mothers as the agents of change within the family and, by implication, within society¹⁴.

The authority of state over individual, of professional over amateur, of science over tradition, of male over female, of ruling class over working class, were all involved in the redefining of motherhood in this period...¹⁵

¹² S Koven and S Michel, eds., *Mothers of a New World: Maternalist politics and the Origins of Welfare States*, London, 1993, p.2.

¹³ A Davin, 'Imperialism and Motherhood' *History Workshop Journal*, 5, 1978, 9-65, p.12.

¹⁴ J Lewis, 'Family Provision of Health and Welfare in the Mixed Economy of Care in the Late Nineteenth and Twentieth Centuries', *Social History Medicine*, 8, 1995, 1-16.

¹⁵ Davin, 'Imperialism and Motherhood', p.13.

Again this understates the role of the 'mixed economy of welfare' and the extent to which the groups Davin perceives as passive wielded influence. Feminists of 1900 generally saw no tension between maternity and the possibility for women to be involved in public life. Indeed there was much stress on the 'womanly' qualities of nurturing and gentleness as effective counterpoints to male competitiveness and aggression in the modern state. 'Maternalism' exalted these qualities. In many cases women's own experiences as mothers informed their work on maternalist policies¹⁶. The women's movements of Europe and the USA also stressed the value of maternity to society, both in terms of racial survival, and the rearing of socially worthy children¹⁷. From the point of view of ordinary women at the local level, maternity was a fact of life and had to be dealt with on those terms. The language of maternalism was not invoked at a local level, where maternity continued to be seen as a personal problem, albeit requiring of concerted help, rather than an issue which acted on society as a whole. The only exception to this was perhaps the work of local birth control campaigners who used the language of eugenics and racial worth. However, it is difficult to know how far they were simply using phrases in common currency, rather than with any specific intent.

There have been several recent collections of work which help to illuminate similarities and differences between countries, and which have attempted to explain these with regard to a theoretical framework¹⁸. Skocpol, Sklar, and Koven and Michel have all drawn attention to an important distinction between 'weak' and 'strong' state structures in relation to the role and influence of women and the development of maternalist policies:

...the power of women's social action movements was inversely related to the range and generosity of state welfare benefits for mothers and children.¹⁹

¹⁶ M Ladd-Taylor, ' "My Work Came Out of Agony and Grief": Mothers and the Making of the Sheppard-Towner Act', in Koven and Michel, *Mothers of a New World*, 321-342.

¹⁷ G Bock and P Thane, eds., *Maternity and Gender Policies: Women and the Rise of the European Welfare States, 1880's-1950's*, London, 1991, p.14.

¹⁸ Koven and Michel, *Mothers of a New World*; Bock and Thane, *Maternity and Gender Policies*; V Fildes, L Marks and H Marland, *Women and Children First: International Maternal and Infant Welfare, 1870-1945*, London, 1992; T Skocpol, *Protecting Soldiers and Mothers: the Politics of Social Provision in the United States, 1870s-1920s*, Cambridge, 1992; KK Sklar, 'The Historical Foundations of Women's Power in the Creation of the American Welfare State, 1830-1930', in Koven and Michel, *Mothers of a New World*, pp 43-93.

¹⁹ S Koven and S Michel, 'Womanly Duties, Maternalist Politics, and the Origins of Welfare States in France, Germany, Great Britain, and the United States, 1880-1920', *American History Review*, 95,1990, 1076-1108.

The USA had a relatively weak central state structure, allowing for considerable influence and autonomy by women in the shaping and implementation of policy. By contrast, France and Germany both had early and well developed welfare programmes which left little room for the efforts of voluntary groups. Sklar has argued that the British case lay somewhere between these strong state/ weak state extremes²⁰. It is suggested that Britain did possess a relatively strong state policy, but that this was embellished, and in many cases implemented, by voluntary agencies which consisted mainly of women. Lewis has argued that the state delegated to volunteer groups only that work which it considered less vital²¹. Although women were well represented at the level of local government and voluntary groups, Lewis has suggested that they failed to influence national policy and to become involved in the development of state welfare. She has also questioned the relevance of the greater influence that women had in a fairly 'weak state' such as Britain, compared to a 'strong state' such as France. In the latter, benefits and assistance were provided through the state, and were much higher and more comprehensive at an earlier period than was the case in Britain²².

Pedersen has drawn a distinction between 'female' voluntarist groups and the 'male' statist view which argued that welfare work was more efficiently and fairly organised through the state. Obviously there is a need for local studies to illuminate tensions and co-operation between the state and voluntary agencies on the ground, and indeed between 'state' as local and national government. The distinction between state and voluntary initiatives becomes very blurred at local level, with individuals involved in both types of activity²³. The contention of Sklar, and Koven and Michel, that Britain had strong central government control over the direction and content of welfare policy, perhaps overstates the case, and it could be argued that the strength of the 'state' lay in its work at the level of *local* government, such as the town or

²⁰ K K Sklar, 'A Call for Comparisons', *American History Review*, 95, 1990, 1109-1114; see also Susan Pedersen, 'Gender, Welfare and Citizenship in Britain During the Great War', *American History Review*, 95, 1990, 983-1006.

²¹ J Lewis, 'Gender, the Family, and Women's Agency in the Building of "Welfare States": the British Case', *Social History*, 19, 1994, p.40.

²² Reynolds suggested that conservative pro-natalist groups in France achieved more tangible benefits for women in the form of crèches etc than did feminists in Britain; S Reynolds, 'Who Wanted the Crèches? Working Mothers and the Birth Rate in France, 1900-1950', *Continuity and Change*, 5, 1990, 173-197.

²³ For example, in Sheffield the MOH from 1903-1918 was Harold Scurfield. His wife was Secretary of and prime mover behind, the Sheffield 'Motherhood League'; a voluntary organisation specialising in lectures and baby show. It often involved the Women Sanitary Inspectors (WSI's); Council employees who were the forerunners of health visitors.

borough council. Welfare policies formulated and put into practice at the local level depended very little on philosophical underpinning, but developed in response to pragmatic concerns about health. They were also dependent on, and circumscribed by, available financial resources. As Peretz has found through a comparative study of different localities, the range of resources varied widely across areas, putting definite limits on the schemes which could be attempted²⁴.

One of the difficulties in the historiography of the British case before 1939 is that the search for antecedents to the post-1945 welfare state has led to an over-concentration on the work of the state. This has had the effect of downplaying the extent and influence of voluntary or quasi-voluntary groups in shaping and implementing policy. State legislation on the issue of maternal and child welfare was minimal before 1914²⁵. Thereafter, much legislation, including the Maternal and Child Welfare Act of 1918, which allowed local authorities to develop such services as maternity hospitals, crèches and welfare clinics, was largely enabling and permissive. Additionally, after 1919, the government provided the same levels of support and subsidies for voluntary agencies undertaking work comparable to that of local authorities. This suggests that, even between the wars, the voluntarist sector was still seen as playing a major role as a fairly autonomous adjunct to the state²⁶.

Thane has argued that although there were growing calls for the involvement of the state in welfare provision after 1870, the big measures enacted before 1939, including the 1911 National Insurance Act, were aimed at men in secure, urban employment²⁷. Women, children, and the unemployed impoverished 'residuum' gained little in state assistance²⁸. However, Wilson's comments on the social control aspects of welfare developments have over-estimated and over simplified the role of the state,

²⁴ E Peretz, *Maternal and Child Welfare in England and Wales Between the Wars: A Comparative Regional Study*, unpub PhD, University of Middlesex, 1992.

²⁵ This was perhaps the fault of the Treasury as much as of the LGB; R MacLeod, 'The Frustration of State Medicine, 1880-1899', *Medical History*, 11, 1967, 15-40.

²⁶ P Thane, 'Visions of Gender in the British Welfare State', in Bock and Thane, *Maternity and Gender Policies*, p.103.

²⁷ Jane Lewis has drawn attention to the importance of gender in understanding the impact of maternalism and welfare policies on families, and on the lack of attention given to the problems of income distribution, including a family wage, *within* families. For example, the controversy surrounding the payment of maternity benefit to husbands under the 1911 National Insurance Act; pressure from the Women's Co-operative Guild in particular resulted in the payment of the benefit directly to wives: J Lewis, 'Gender, the Family, and Women's Agency in the Building of "Welfare States": the British Case', *Social History*, 19, 1994, 37-55; see also B Harris, 'Responding to Adversity: Government - Charity Relations and the Relief of Unemployment in Inter-War Britain', *Contemporary Record*, 9, 1995, 529-561.

²⁸ P Thane, *Foundations of the Welfare State*, London, 1982, p.122.

and the corresponding powerlessness of women. Her claims for the 'state organisation of domestic life' perhaps represent what was for some an ideal, but was never a reality²⁹.

Britain's failure to produce strong state action in the area of maternal and child welfare before 1939 was partly due to the fragmented nature of the agencies involved. Apart from local doctors, midwives and voluntary groups, there was the developing local government health sector, including Medical Officers of Health (MO'sH) and health visitors. Equally important during most of the period was the Poor Law, still the chief provider of health services, including hospital childbirth. None of these agencies worked together very effectively, despite their all being under the control of the Local Government Board (LGB). In practice, the conservatism of the LGB resisted the endorsement of large scale preventative care; a failure which contributed to calls for the creation of a Ministry of Health³⁰. Co-operation appears to have developed much more effectively in the inter-war years, and although debate still split along party lines, much local action was relatively consensual.

Women undertook voluntary and local government or Poor Law work for many reasons, including social or religious duty, and the urge to something challenging and acceptable to women of their class³¹. The development of individual or family based casework was an area developed primarily by women and later taken up by central or professional agencies, including Women Sanitary Inspectors (WSI's). Local studies can consider the role and influence of women, and their success or failure in moving into welfare as it became an increasingly 'professional' service³².

Finally, there is the issue of women as recipients of all this effort. Under represented in the historiography, because of their under representation in contemporary literature, except in so far as they were the targets for mortality statistics and moral homilies, their views and the use they made of the services is hard to gauge. The 'healthy/ hungry' debate between Winter, Webster and others over the effect of economic upheaval on health gives an important insight into the lives of women in the early twentieth

²⁹ E Wilson, *Women and the Welfare State*, London, 1977, p.9.

³⁰ F Honigsbaum, *The Struggle for the Ministry of Health, 1914-1919*, London, 1970; J Brand, *Doctors and the State: The British Medical Profession and Government Action in Public Health, 1870-1912*, Baltimore, 1965.

³¹ M Vicinus, *Independent Women: Work and Community for Single Women, 1850-1920*, London, 1985; J Lewis, *Women and Social Action in Victorian and Edwardian England*, Aldershot, 1991.

³² For role of women in central government administration see: M Zimmeck, 'The New Woman in the Machinery of Government; A Spanner in the Works?' in R MacLeod, ed., *Government and Expertise: Specialists, Administrators and Professionals, 1860-1919*, Cambridge, 1988, 185-202.

century. Writing on the impact of the 1914–18 War, Winter has argued that the difficult situation did not have a negative effect on health, but in actual fact helped to improve it. This was achieved through the developing commitment of central government to targeted welfare programmes, particularly for maternal and child welfare services; 'In the war period itself, the most important cause of the decline of early infant mortality appears to have been the growth of State support for infant welfare.'³³ However, as he then admits, only 60,000 of the 700,000 babies born in each war year were effected by these measures. Winter has also suggested that high female employment, and the absence of the main consumer of family food, the father, allowed for improved levels of nutrition, and therefore health, for mothers and children.

This debate also considered the effect of economic dislocation of the 1920s and 1930s. Winter has made the same case for an optimistic view of health, despite high unemployment and poverty. His conclusion is that:

Because of public provision, medical intervention, and long-term improvements in working-class nutrition, the 1930's must be seen, therefore, despite the stubborn survival of pockets of terrible deprivation, as a period of major improvement of the health of mothers and infants in Britain.³⁴

This view has been challenged by Webster and by Mitchell, who have both argued that the health of mothers and children was adversely effected by poor standards of living and nutrition in the 1930s. Webster has suggested that in most areas welfare measures would have had only a modest impact on health, as they were not implemented until the late 1930s when unemployment was falling³⁵. He has also claimed that the relief available through the Public Assistance Committees, and other bodies, was not sufficient to provide adequate minimum levels of nutrition, at least not for the whole family. Mothers in particular were under nourished; one report on the depressed area of South Wales concluded that:

All observers agree that any unfavourable manifestation of the present economic conditions is to be found primarily in the women. Their work is not lessened, but continues under anxiety and difficulty, they may be subject to the stress of child-bearing and lactation, and

³³ JM Winter, 'The Impact of the First World War on Civilian Health in Britain', *Economic History Review*, 30, 1977, 487–507, p.497.

³⁴ Winter, 'Infant Mortality, Maternal Mortality, and Public Health, p.462.

³⁵ C Webster, 'Health, Welfare, and Unemployment During the Depression', *Past and Present*, 109, 1985, 204–30, p.213.

where denial is called for it is usually the woman who denies herself for the sake of husband and children.³⁶

Mitchell has further commented that it is misleading to sideline those in the worst affected areas as not representative of the whole; women and children in deprived areas were experiencing real deprivation, and in some cases, malnutrition³⁷. Webster has also suggested that official figures of the problem were very misleading, with researchers not prepared to take the optimistic line being marginalised³⁸. The impact of this is hard to gauge, since it is difficult to relate crude figures of unemployment and numbers on relief to infant or maternal mortality; the effect on morbidity, although equally important, is almost impossible to judge. The 'healthy/hungry' debate has offered two quite polarised views, although there has been considerable consensus over the fact that people in particular areas certainly did suffer a reverse in health, probably due to adverse economic conditions. The present study will try to demonstrate how the situation affected women in Sheffield, and the attempts made to tackle it.

One of the major challenges in studying maternity in the late nineteenth and early twentieth centuries is to get beyond the generalisations and statistics offered by Census material or MOH reports. Demographic studies can gloss over the role of individual decision making, allowing completed family size, for example, to seem pre-determined³⁹. However, the individuals and families behind the 'fertility transition', infant mortality rates (IMR), and maternal mortality rates (MMR), made choices according to criteria which we understand imperfectly from this distance⁴⁰. Seccombe has suggested that evolving power structures within families gave women more say in fertility decisions⁴¹. This 'informal feminism' may also have been informed by the growing literacy of women, allowing for greater educational equality in

³⁶ J Pearse, TW Wade, JV Evans, and JE Underwood, 'Inquiry into the Present Conditions as regards the Effects of Continued Unemployment on Health in Certain Areas of South Wales and Monmouthshire', 23 Oct. 1936, PRO, MH 55/629, p.26; quoted in Webster, 'Health, Welfare, and Unemployment During the Depression', p.220.

³⁷ M Mitchell, 'The Effects of Unemployment on the Social Condition of Women and Children in the 1930's', *History Workshop Journal*, 19, 1985, 105-27, p.119.

³⁸ C Webster, 'Healthy or Hungry Thirties?', *History Workshop Journal*, 13, 1982, 110-129.; for example the Pilgrims Trust.

³⁹ A Mackinnon, 'Were Women Present at the Demographic Transition? Questions from a Feminist Historian to Historical Demographers', *Gender and History*, 7, 1995, 222-240.

⁴⁰ JR Gillis, LA Tilly, D Levine, *The European Experience of Declining Fertility, 1850-1970: The Quiet Revolution*, Oxford, 1992; D Gittins, *Fair Sex: Family Size and Structure, 1900-1939*, London, 1982.

⁴¹ W Seccombe, 'Men's "Marital Rights" and Women's "Wifely Duties": Changing Conjugal Relations in the Fertility Decline', in Gillis, Tilly and Levine, *The European Experience of Declining Fertility*, 66-84.

marriage and raising the status and power of women in the domestic setting⁴². However, Szreter has argued that areas with low rates of female employment exhibited low indications of female power⁴³. Sheffield bears out this idea, with high birth-rates to a relatively late date, followed by high rates of abortion; another indicator of a lack of female power in the domestic setting. Efforts to assess the position of women are necessarily tangential, such as the examination of attendance figures at baby clinics. Clinics were popular with women despite often being over-crowded and inefficient. Women actively sought 'high technology' hospital births, and the development of such services in Sheffield appears to have been very much a demand-led process. In this context it is significant that among working class women in Sheffield there was no traditional women led culture of pregnancy and birth. There was a culture of ignorance, and a desire for information as demonstrated by attendance at clinics. This study will consider all of these issues thematically, as they are central to every aspect of maternal and child welfare.

1.2: The Development of Infant Welfare:

Across Europe and North America, public and official concern for infant welfare began to develop after c.1870⁴⁴. This concern had many regional causes, but was basically informed by stubbornly high rates of infant mortality in the face of falling general death rates. Additionally, there were concerns, initially in France, but later in Britain, Germany, USA, and Australia, about the falling birth-rate, particularly among the middle classes. There were worries about the effect which this might have on countries and empires, and these were fuelled by contemporary concerns about the possible reduction in the quality of babies, as well as their quantity.

These concerns led to attempts to alleviate infant mortality, and in the inter-war years, maternal mortality. Again, between different countries, and even within regions of the same country, the mix of local, national, and voluntary action varied. Nevertheless, whoever the agents of change were, the solutions were often quite similar. In fact, there appears to have been quite a high level of international discussion of the issues, and the solutions

⁴² For literacy graphs see RI Woods, 'Approaches to the Fertility Transition in Victorian England', *Population Studies*, 41, 1987, 283-311, p.311, p.296; RI Woods, PA Watterson, and JH Woodward, 'The Causes of Rapid Infant Mortality Decline in England and Wales, 1861-1921', (2 parts), *Population Studies*, 42, 1988, 343-366 (part 1), *Population Studies*, 43, 1989, 113-132 (part 2), p.128.

⁴³ S Szreter, *Fertility, Class and Gender in Britain, 1860-1940*, Cambridge, 1996, p.426-8.

⁴⁴ For general surveys see: D Dwork, *War is Good for Babies and Other Young Children: A History of the Infant and Child Welfare Movement in England 1898-1918*, London, 1987; H Hendrick, *Child Welfare in England, 1872-1989*, London, 1994.

being canvassed were often international in character. This included the importation of the concept of *goutte de lait* (milk depots which supplied 'pure' milk for infant feeding) into Britain at the end of the nineteenth century, and the first 'school for mothers' opened in St Pancras in 1907, which took its inspiration from work done in Belgium⁴⁵. Indeed, it could be argued that many of the schemes implemented at a local level failed because they took their inspiration from solutions relevant to other places, and did not adapt sufficiently to meet local needs and conditions. It is likely that this was true of the milk depots set up in Sheffield to provide dried milk for infant feeding in an attempt to combat infant deaths from diarrhoeal illnesses. Although Buchanan and Beaver have drawn attention to the importance of an impure milk supply and inadequate domestic storage in contributing to these high rates, artificial feeding occurred at such low levels in Sheffield that the provision of milk was relevant only to a tiny segment of the population, and could not have significantly affected mortality rates⁴⁶.

Infant mortality and infant welfare have been studied in considerable detail by historians attempting to explain changes in mortality as they have traditionally been regarded as sensitive indicators of the overall health of a community⁴⁷. However, although absolute infant mortality rates dropped dramatically after 1900, relative differences have largely remained in place. Thus, babies born to lower income groups are still far more likely to die prematurely than those higher up the social scale⁴⁸. Recent literature shows a growing recognition that factors such as class, race, and culture had a major impact on infant mortality, together with the social position and role of the family⁴⁹. There has, accordingly, been a move towards detailed analysis of varying factors in different areas⁵⁰.

⁴⁵ C Dyhouse, 'Working Mothers and Infant Mortality in England, 1895-1914', *Journal Social History*, 12, 1978, p.249.

⁴⁶ MW Beaver, 'Population, Infant Mortality, and Milk,' *Population Studies*, 27, 1973, 243-254; I Buchanan, 'Infant Feeding, Sanitation and Diarrhoea in a Colliery Community, 1880-1911', in DJ Oddy and DS Miller, eds, *Diet and Health in Modern Britain*, London, 1985, 148-177. However, depots did develop into successful welfare clinics.

⁴⁷ D Armstrong, 'The Invention of Infant Mortality', *Sociology of Health and Illness*, 1986, 211-232.

⁴⁸ A Antonovsky and J Bernstein, 'Social Class and Infant Mortality', *Social Science and Medicine*, 11, 1977, 453-470; P Townsend, N Davidson and M Whitehead, *Inequalities in Health: The Black Report and the Health Divide*, Harmondsworth, 1992.

⁴⁹ MR Haines, 'Socio-economic Differentials in Infant and Child Mortality During Mortality Decline: England and Wales, 1890-1911', *Population Studies*, 49, 1995, 297-315; S Szreter, *Fertility, Class and Gender in Britain, 1860-1940*, Cambridge, 1996.

⁵⁰ KA Lynch and JB Greenhouse, 'Risk Factors for infant Mortality in Nineteenth Century Sweden', *Population Studies*, 48, 1994, 117-133; A Hardy, *The Epidemic Streets: Infectious Disease and the Rise of Preventative Medicine, 1856-1900*, Oxford, 1993; J P Vögele, 'Urban Infant Mortality in Imperial Germany', *Social History Medicine*, 7, 1994, 401-

Much work on infant mortality has also been done by demographers, searching for explanations of fertility decline in which the birth rate (expressed as births per thousand population) dropped from 36.3‰ in 1876, to 25.8‰ in 1909⁵¹. A review essay by Woods drew together the qualitative work of historians and the quantitative theoretical models of demographers in an attempt to elucidate the 'fertility transition' in late Victorian Britain. His conclusion was that the change was not mono-causal, and that 'the search for universal demographic variables will be a vain one'.⁵² There appears to be no simple link, in either direction, between falling birth-rates and falling IMR.

Explanations of, and solutions for, infant mortality have tended to fall into two main groups; medical and social. The former encompassed infant feeding, education of mothers, hospitalisation of childbirth, and midwifery training and registration. Relevant social factors included housing, poverty, and employment. Contemporaries found it far less problematic to address medical issues, particularly insofar as they related to the individual, rather than wider questions of poverty. However, there were obvious overlaps, with, for example, the method of infant feeding preferred by mothers being a medical issue but also a social construct. Concepts of individual autonomy and responsibility were partly behind the concentration on medical factors, together with doubts over the acceptability of macro solutions to issues such as housing, which would involve unprecedented action by 'the state'⁵³.

On a national level, attempts have also been made to explain why the British IMR tended to be lower than that of most other European countries throughout the nineteenth century⁵⁴. Woods, Watterson and Woodward have suggested that this was due to high levels of urbanisation in Britain and also to high levels of breast feeding⁵⁵. High levels of prolonged lactation would have led to a healthier infant since its food supply was sterile and nutritionally

426; N Williams, *Infant and Child Mortality in Urban Areas of Nineteenth Century England and Wales: A Record Linkage Study*, unpub. PhD thesis, University of Liverpool, 1989.

⁵¹ FB Smith, *The Peoples Health 1830-1910*, London, 1979, p.118. The equivalent figures for Sheffield were a birth rate of 41.6‰ in 1874, reducing to 27.3‰ in 1914, and 17.7‰ by 1925 (source: MOH Reports for Sheffield).

⁵² RI Woods, 'Approaches to the Fertility Transition in Victorian England', *Population Studies*, 41, 1987, 283-311, p.311.

⁵³ J Lewis, 'Family Provision of Health and Welfare in the Mixed Economy of Care in the Late Nineteenth and Twentieth Centuries', *Social History Medicine*, 8, 1995, 1-16.

⁵⁴ N Williams and G Mooney, 'Infant Mortality in an "Age of Great Cities": London and the English Provincial Cities Compared, c.1840-1910', *Continuity and Change*, 9, 1994, 185-212, p.195-6.

⁵⁵ Fildes has backed up this assumption in her work on London and other cities, including Liverpool and Newcastle-upon-Tyne, where over 90% of infants were wholly or partially breastfed in their first month. At 6 months the figure was still as high as 70%; V Fildes, 'Breast-feeding in London, 1905-19', *Journal Biosocial Science*, 24, 1992, 53-70, p.58.

optimal. Demand feeding and late weaning would have also suppressed female fertility, allowing for the spacing of children, and the probable improved health of mother and subsequent infant. Urban areas of Britain, including Sheffield, do appear to have exhibited these high levels of breast feeding which pre-supposed a reasonable level of nutritional intake and rest for the mother, in order to optimise her milk supply⁵⁶. It is possible that attempts by health visitors to restrict breast feeding to nine months, if successful, would have had the effect of increasing fertility, as would later attempts to introduce feeding by the clock. Lactation as contraception was likely only to be effective if feeding was occurring on demand for a prolonged period. However, as feeding patterns do not appear to have been changing, they can have had little effect in actually reducing fertility or infant mortality.

It has been suggested that the IMR rose in some areas, particularly urban ones, in the late nineteenth century, due to a run of hot summers which exacerbated the diarrhoeal death rate⁵⁷. MOH Reports for Sheffield were not unusual in carefully detailing meteorological conditions on a month by month basis. However, some urban areas saw rises, whilst in others the trend was flat, or even falling, so local conditions must have had a decisive effect, apart from the influence of weather⁵⁸. Contemporary observers such as Newsholme, MOH for Brighton and later for the LGB, certainly believed this. Woods, Watterson and Woodward have argued that infant mortality was falling from c. 1890, once the errant, but large, component of diarrhoeal deaths is removed.

As well as considering the progress of infant mortality in nineteenth and twentieth century Britain, from a peak of 163‰ in 1899 to the decline of the 1910s (115‰ in 1910), recent studies have attempted to explain what relation this had, if any, to the development of welfare policies. The debate has focused on environmental versus nutritional reasons for the decline. Watterson, in her analysis of 1911 Census material and LGB sanitary surveys, has suggested that improvements in domestic hygiene and sanitation played a crucial role⁵⁹. Hardy, in her work on the decline of major diseases in nineteenth century London, has also argued for the importance of the

⁵⁶ Woods, Watterson, and Woodward, 'The Causes of Rapid Infant Mortality Decline in England and Wales, 1861-1921', (part 2); p.117

⁵⁷ RI Woods, PA Watterson, and JH Woodward, 'The Causes of Rapid Infant Mortality Decline in England and Wales, 1861-1921', (2 parts), *Population Studies*, 42, 1988, 343-366 (part 1), *Population Studies*, 43, 1989, 113-132 (part 2).

⁵⁸ N Williams, *Infant and Child Mortality in Urban Areas of Nineteenth Century England and Wales: A Record Linkage Study*, unpub. PhD thesis, University of Liverpool, 1989.

⁵⁹ P Watterson, 'Environmental Factors in Infant and Early Childhood Mortality Decline in England and Wales, 1895-1910', *Social History Medicine*, 35, 1984, 37-40.

introduction of water closets in houses, and the development of domestic plumbing, together with the growing popularity of ideas about personal cleanliness⁶⁰. This point has also been made, with relation to the USA, by Tomes, who has argued that the germ theory was easily assimilated into earlier ideas of impure air and sanitation. The advice initially offered through advice manuals was aimed at the middle classes, and it is difficult to assess how relevant much of it was to the daily lives of the working classes⁶¹. However, Tomes has argued that:

Some of the most important regulatory goals of the late nineteenth century public health movement can be seen, then, as the natural extension of voluntary domestic reform.⁶²

This applied not only to a belief in the need for better sewage and water carriage systems, or improved paving, but also that the working class could be taught to apply sanitary principles for their own good and that of the community. In Sheffield, for example, the initial brief of the WSI's appointed in 1899 was to:

...visit from house to house in the poorer districts of the city, and ascertain as to the general conditions of the rooms and bedrooms; to lend where necessary brushes for lime washing; to give instructions as to ventilating and cleansing of rooms and bedrooms; to see that bedclothes and clothing are kept reasonably clean.⁶³

Some writers have suggested that poorer households only developed these ideas in response to the exhortation and example of their social betters⁶⁴. However, it is likely that such changes came as much from within the class, particularly from women⁶⁵.

⁶⁰ A Hardy, *The Epidemic Streets: Infectious Disease and the Rise of Preventative Medicine, 1856-1900*, Oxford, 1993; see also S Szreter, 'The Importance of Social Intervention in Britain's Mortality Decline c. 1850-1914: a Reinterpretation of the Role of Public Health' *Social History Medicine*, 1, 1988, 1-37.

⁶¹ RD Apple, 'Constructing Mothers: Scientific Motherhood in the Nineteenth and Twentieth Centuries', *Social History Medicine*, 8, 1995, 161-178; apart from advice manuals, advertising also used the language of science to sell its baby products, particularly artificial baby foods.

⁶² N Tomes, 'The Private Side of Public Health: Sanitary Science and Domestic Hygiene and the Germ 1870-1900', *Bulletin History Medicine*, 64, 1990, 509-39, p.536.

⁶³ *Sheffield City Council Health Cttee*, minutes, 13/04/1899.

⁶⁴ A Davin, 'Imperialism and Motherhood' *History Workshop Journal*, 5, 1978, 9-65.

⁶⁵ J Bourke, *Working Class Cultures in Britain 1890-1960: Gender, Class, and Ethnicity*, London, 1994, p.68, on the popularity among girls of domestic education; J Bourke, 'Housewifery in Working Class England, 1860-1914', *Past and Present*, 143, 1994, 167-97; E Roberts, *A Woman's place: An Oral History of Working Class Women 1890-1940*, London, 1984, p.168; BV Heagerty, *Gender and Professionalisation: the Struggle for British Midwifery, 1900-36*, unpub PhD thesis, Michigan State University, 1990, p.68, found that

Contemporary commentators noted, and recent research has picked up on, correlations between methods of urban sewage disposal and infant mortality. Williams has explored the connection between towns such as Sheffield which had high IMR's and a privy midden system, with sewage and other refuse being stored in communal, and infrequently emptied, ashpits⁶⁶. The positive contribution made by breast feeding to the health of infants was also understood. More controversial to modern thinking was the stress laid on the detrimental effect of maternal employment and the 'ignorance' of mothers⁶⁷. However tangential such ideas may have been to the alleviation of IMR, they are important to historians because contemporary commentators, including Newman and many MO'sH, thought that they were and acted accordingly. In fact, Garrett and Reid have postulated a reverse causality for married women's work and infant mortality, with high levels of infant mortality freeing women to work, rather than their work being the *cause* of the high rates. However, this has been challenged by Graham, who suggested that high employment rates for married women did correlate with high IMR, but that women who lost infants would not go out to work in areas where it was unacceptable, whatever their losses. In contrast, women whose work was necessary to the family would continue to work, and attempt to reduce their fertility accordingly, although he does not suggest how the latter was achieved⁶⁸. Both Garrett and Reid, working from the 1911 Census, and Williams, working from earlier data on Sheffield, have concluded that:

...at the individual level it was where one lived that most strongly influenced the survival chances of one's child, rather than the family's position in the social hierarchy.⁶⁹

For an area such as Sheffield, once the outline graph of infant mortality has been drawn, it is possible to consider the solutions canvassed and the

midwives standing in the community depended on their cleanliness, and that they deeply resented being accused of being 'dirty' by midwifery supervisors.

⁶⁶ Williams, *Infant and Child Mortality in Urban Areas of Nineteenth Century England and Wales*.

⁶⁷ Graham has supported the link between married women's employment and high infant mortality for the 1911 census, although suggested that it was the type of work undertaken, rather than the fact of it which was dangerous. D Graham, 'Female Employment and Infant Mortality: Some Evidence from British Towns, 1911, 1931, and 1951', *Continuity and Change*, 9, 1994, 313-345.

⁶⁸ Graham, 'Female Employment and Infant Mortality', p.330.

⁶⁹ E Garrett and A Reid, 'Satanic Mills, Pleasant Lands: Spatial Variation in Women's Work, Fertility and Infant Mortality as Viewed from the 1911 Census', *Historical Research*, 67, 1994, 156-177; N Williams, 'Death in its Season: Class, Environment and the Mortality of Infants in Nineteenth Century Sheffield', *Social History Medicine*, 5, 1992, 71-94.

attempts by interested agencies to address the problem, to assess how relevant they were to the needs of the City and its infants.

Generally, women in Sheffield took up infant welfare services enthusiastically, suggesting a demand for such provision. Apart from limited attempts to educate 'ignorant' mothers, local policies were directed towards practical provision and do not appear to have been regarded as proscriptive or stigmatising. Even in a local study, it has proved impossible conclusively to point to one area of action as being responsible for declining IMR. However, the services created should be considered not only in terms of outcome but also of the perceived result, and the effect that this had on mothers and on the development of the agencies themselves.

1.3: Childbirth:

Before the inter-war period in Britain, concepts of maternal welfare revolved primarily around the act of childbirth; particularly the role of midwives, and the medical and social status of childbirth. Maternal mortality was not considered to be a major problem given that it was falling in line with infant mortality. Ante-natal care developed as a response to concern about infant, rather than maternal welfare. Post-natal care was certainly concerned primarily with the welfare of the baby. Although mothers received free medical care for one year after the birth, this was primarily in recognition of the need to keep mother healthy and preferably breast-feeding, and therefore to encourage the survival of the infant⁷⁰.

The development of midwifery training in the late nineteenth century, and the gradual move towards the hospitalisation of childbirth, have been viewed as a power struggle between men and women, professionals and amateurs. There has been little focus on the views of women themselves, who have been regarded as passive and deferential recipients of this care.

Much of the debate around nineteenth century midwifery has been informed by the writings of doctors, particularly those working in the emerging field of general practice, in medical journals. They were by no means unbiased, with *The Lancet* in particular being the voice of the 'general practitioner'.⁷¹ Doctors recognised the potential of midwifery work to themselves in establishing practices, and also as a means of gaining a foothold in an overcrowded profession. One doctor remarked that, 'The

⁷⁰ After the 1911 National Insurance Act.

⁷¹ For the emergence of the general practitioner see I Loudon, *Medical Care and the General Practitioner, 1730-1850*, Oxford, 1986; A Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911*, Cambridge, 1984.

successful practise of midwifery at the outset of life as surely establishes a professional man's reputation as the contrary retards his progress.' ⁷² The foundation of specialist hospitals covering 'women's diseases' was used by doctors as a way of gaining recognition and status given the limited numbers of posts in general hospitals. By the mid-nineteenth century, the creation of a women's hospital, children's hospital, or eye hospital, was a way for an ambitious doctor to move up the social and professional scale, when sinecures in general hospitals were hard to come by⁷³. Dr Aveling, a GP and the founder of the Sheffield Hospital for Women used his work in Sheffield as a stepping stone to a lucrative London practice.

Midwives were often seen as rivals, and their inferiority of training and cognition was stressed. Aveling wrote of the 'ignorance and incompetence' of midwives throughout history⁷⁴. This was despite the fact that until 1886 doctors themselves had no compulsory midwifery element in their training, and until the nineteenth century midwives were generally literate and respected members of their communities⁷⁵. Debate centred around the need to instruct midwives and ensure that if they were to survive, they did so in a role subordinate to the doctor or hospital⁷⁶. When midwives finally gained legal recognition in 1902, their role was enshrined as a subordinate one, with both their professional and private lives open to scrutiny and judgement, and with no representation on the Central Midwifery Board. Donnison has argued, however, that without the Act midwifery would not have survived at all, and would have become virtually outlawed, through the influence of doctors as occurred in the USA⁷⁷.

⁷² J Toogood, 'On the Practise of Midwifery with Remarks', *Provincial Medical and Surgical Journal*, 7, 1844, 103-108, quoted in I Loudon, *Death in Childbirth: An International Study of Maternity Care and Maternal Mortality, 1800-1950*, Oxford, 1992.

⁷³ L Granshaw, ' "Fame and Fortune by Means of Bricks and Mortar": The Medical Profession and Specialist Hospitals in Britain, 1800-1948', in Granshaw and Porter, *The Hospital in History*, 199-220; AM Kass, 'The Obstetrical Casebook of Walter Channing, 1811-1822', *Bulletin History Medicine*, 67, 1993, 494-523; O Moscucci, *The Science of Woman. Gynaecology and Gender in England, 1800-1929*, Cambridge, 1990; JV Pickstone, *Medicine and Industrial Society: A History of Hospital Development in Manchester and It's Region, 1752-1946*, Manchester, 1985.

⁷⁴ JH Aveling, *English Midwives: Their History and Prospects*, orig. pub. 1872, reprinted London, 1967.

⁷⁵ D Harley, 'Provincial Midwives in England: Lancashire and Cheshire, 1660-1760', in H Marland, ed., *The Art of Midwifery: Early Modern Midwives in Europe*, London, 1993, 27-48, p.32-34.

⁷⁶ J Donnison, *Midwives and Medical Men: A History of The Struggle for the Control of Childbirth*, London, 2nd edit., 1988, p.125. There were several unsuccessful bills before 1902 Act was passed.

⁷⁷ JW Leavitt, *Brought to Bed: Childbearing in America, 1750-1950*, Oxford, 1986; RW Wertz and DC Wertz, *Lying-in: A History of Childbirth in America*, Yale, 2nd edit., 1989.

Research into midwifery and childbirth has probably been most extensive in Britain and the USA, although research is beginning to focus on other countries and their differing experiences⁷⁸. The Netherlands institutionalised midwifery training early in the nineteenth century, with local authorities sponsoring some midwives through their training, in order to ensure an adequate supply for their area⁷⁹. There was no tradition of institutional deliveries, or even of out-patient deliveries. Van Leiburg and Marland have suggested that the trained midwifery base in the Netherlands drew its practitioners from the lower middle class or upper working class. Presumably the difficult to research body of untrained, unlicensed, part-time midwives came from a lower group⁸⁰. For the USA, Ladd-Taylor has detailed the midwifery training required after the passing of the 1921 Sheppard-Towner Maternity and Infancy Protection Act, although she has argued that professionalisation did not reach into the remote south. The Act, although partly intended to safeguard midwives, helped to reduce their numbers, and increased the medicalisation of childbirth by demanding certain levels of education and by outlawing ritual⁸¹. The 1902 and 1936 Midwives Acts did the same in England and Wales, by laying down training schedules, together with a strict moral code, and, after the 1936 introduction of a salaried midwifery service, allowing for the sacking of those who did not conform in some way.

For all areas, recent analysis, particularly with a feminist viewpoint, has emphasised the continuity of the role of the female midwife, rather than the 'new' disciplines of obstetrics and gynaecology. The role of the midwife has been placed in a long term context of healing and nurture, and it has been suggested that most midwives were skilled and effective. It is also argued that the culture of birth as a female ritual was a very long standing one and survived in the hospital era with women preferring the service of untrained

⁷⁸ Research has tended to focus on the nineteenth and twentieth century 'decline' of midwifery; an important recent counterpoint to this has been H Marland, ed., *The Art of Midwifery: Early Modern Midwives in Europe*, London, 1993.

⁷⁹ Harley has argued that the reason for the decline of the status of the English midwife in the late eighteenth century, was that the system of ecclesiastic licensing fell into disuse. He has suggested that if the State had taken over licensing, as occurred in the Netherlands, the status and respectability of midwifery would have remained; D Harley, 'Provincial Midwives in England: Lancashire and Cheshire, 1660-1760', in H Marland, ed., *The Art of Midwifery: Early Modern Midwives in Europe*, London, 1993, 27-48, p.42.

⁸⁰ MJ Van Lieburg and H Marland, 'Midwifery Education, Regulation, and Practice in the Netherlands During the Nineteenth Century', *Medical History*, 33, 1989, 296-317; see also: H Marland, 'Questions of Competence: The Midwife Debate in the Netherlands in the Early Twentieth Century', *Medical History*, 39, 1995, 317-337.

⁸¹ M Ladd-Taylor, ' "Grannies" and "Spinsters": Midwife Education Under the Sheppard-Towner Act', *Journal Social History*, 22, 1988, 255-275.

local 'handywomen' rather than professionals of either sex⁸². There has been the tendency to use a quite overt 'conspiracy theory' to explain why women did, however, use male doctors, and did increasingly give birth in a hospital setting. Their role is seen as passive whilst the male system took over, and literally forced them into regimented hospital regimes characterised by high levels of drug administration and intervention⁸³. One historian has commented that, 'It was the desire to establish male control, rather than therapeutic advances in medicine, that provided the impetus for the creation of maternity hospitals.'⁸⁴

Obviously this picture is too simplistic both in terms of the attitudes and qualities of midwives and of women themselves. Leavitt and Walton have suggested that fear of pain and debility, if not death, were important in shaping demands by women for different types of care⁸⁵. Progression from 'social' to 'medical' childbirth was not linear; doctors and midwives often worked in tandem, and used custom and ritual without a sense of opposition⁸⁶. Dye has commented that 'Poor and working class women were central to the transformation of birth from a social to a medical phenomenon.'⁸⁷ This seems to accord with Leavitt's view that, potentially, the poorest got some of the most up to date treatment, but perhaps found it hard to make their views known to those treating them because of their low status. Evidence suggests that many women did want more intervention in their births, particularly in the form of analgesics. JY Simpson, an early advocate of analgesia in birth, argued that

⁸² E Roberts, *A Woman's place: An Oral History of Working Class Women 1890-1940*, London, 1984; Donnison, *Midwives and Medical Men*, p.147.

⁸³ Shorter sees this as a positive development in freeing women from the tyranny of their bodies, although this was replaced, by the 1940's, with the over much medical concern for the foetus, relegating women to the status of vessels; E Shorter, *A History of Women's Bodies*, London, 1983. See also: J Mitchell and A Oakley, *The Rights and Wrongs of Women*, Harmondsworth, 1976; A Oakley, *Women Confined: Towards a Sociology of Childbirth*, Oxford, 1980; M Tew, *Safer Childbirth? A Critical History of Maternity Care*, 2nd edition, London, 1995. For USA: B Ehrenreich and D English, *Witches, Midwives, and Nurses: A History of Women Healers*, New York, 1976; B Ehrenreich and D English, *For Her Own Good: 150 Years of the Experts Advice to Women*, London, 1979.

⁸⁴ MC Versluysen, 'Midwives, Medical Men and "Poor Women Labouring of Child": Lying-in Hospitals in Eighteenth Century London', in H Roberts, ed. *Women, Health and Reproduction*, London, 1981, 18-49.

⁸⁵ JW Leavitt and W Walton, ' "Down to Death's Door": Women's Perceptions of Childbirth in America', in JW Leavitt, ed., *Women and Health in America*, Wisconsin, 1984, 155-165.

⁸⁶ SM Stowe, 'Obstetrics and the work of Doctoring in the Mid-Nineteenth Century American South', *Bulletin History Medicine*, 64, 1990, 540-566; M Ladd-Taylor, ' "Grannies" and "Spinsters": Midwife Education Under the Sheppard-Towner Act', *Journal Social History*, 22, 1988, 255-275.

⁸⁷ NS Dye, 'Modern Obstetrics and Working Class Women: the New York Midwifery Dispensary, 1890-1920', *Journal Social History*, 20, 1986-7, 549-64, p.550.

'Obstetricians may oppose it [analgesia] but I believe our patients themselves will force the use of it.'⁸⁸

It is difficult to be certain as to the role of professionals, including public health officials, in this; whether they succeeded in making women 'aware' of the inadequacy of their home conditions. It was certainly a major strand of the inter-war debate, that women were terrified of childbirth because too much publicity had been given to maternal mortality, and that this had a detrimental effect on numbers of home births. Loudon has argued that by the late nineteenth century the ability to engage a doctor for the delivery, rather than any type of midwife, was important for gauging relative social positions within the working community. Respondents to the Co-operative Guild survey on maternity relate the difficulties of saving for the doctors fee, and the majority (who were wives of skilled workers) seem to have engaged doctors, not midwives⁸⁹.

In her study of New York, Dye has argued that there was a struggle for power between doctors and patients as much as between doctors and midwives⁹⁰. Patients attempted to assert control by engaging doctors and midwives, by resisting certain procedures (e.g., internal examinations), and by demanding others (e.g., analgesics). At the same time, doctors tried to enhance their authority by refusing to work with midwives, demanding the right to define active labour regardless of how the patient saw her progress, and by insisting on frequent internals. Dye has concluded that the doctors were successful in medicalising childbirth before the rise of the hospital as the place of delivery. Borst has agreed with this view to a certain extent in her study of obstetric practice in Wisconsin. She has noted the take over of normal births by GP doctors, but has found that they continued to operate in local communities along ethnic lines, and that their work combined elements of 'old' and 'new' craft. Women accepted doctors' views and expertise because they believed a safer and more scientific approach to birth was being offered and because doctors' were respected members of the wider community in a way that midwives could not match⁹¹. The choice was perhaps spurious because, as Borst has discovered, medical education was so sparse that doctors were

⁸⁸ Quoted in CDH Pitcock and RB Clark, 'From Fanny to Fernand: the Development of Consumerism in Pain Control During the Birth Process', *American Journal Obstetrics and Gynaecology*, 167, 1992, 581-587. See also: JW Leavitt, 'Birthing and Anesthesia: the Debate over Twilight Sleep', in JW Leavitt ed. *Women and Health in America: Historical Readings*, Wisconsin, 1984, 175-184.

⁸⁹ ML Davies, ed., *Maternity: Letters from Working Women*, 1915, reprinted London, 1978.

⁹⁰ Dye, 'Modern Obstetrics and Working Class Women, 549-64.

⁹¹ CG Borst, *Catching Babies: The Professionalisation of Childbirth, 1870-1920*, London, 1995, p.126-144.

unlikely to be better informed about birth than midwives. Yet however mistaken their choice might appear to have been, women were nevertheless making their own decisions about the type of care they wanted, and the treatment they expected. Leavitt and Loudon have argued that women remained in control of their childbirth experience, regardless of the type of birth attendant, until removed from their homes and friends⁹².

However, it is possible that a lot of the move to hospitals was initiated by women themselves, in response to beliefs about safety, efficacy, and the belief that hospital could provide rest⁹³. There is evidence that women were afraid of the possibility of death and disability in childbirth, and believed, perhaps due to the propaganda of obstetricians and hospitals, that hospitals were the safest place to give birth. This belief appears to have originated before the inter-war scares about maternal mortality (expressed as mortality per thousand births; the maternal mortality rate [MMR]), however, with demand at the Jessop Hospital in Sheffield, for example, outpacing the supply of beds and staff before the First World War. As Marks has argued, this perhaps had more to do with local conditions, including the reputation of hospitals, than national debate⁹⁴. The promise of 'scientific', and therefore implicitly safe, birth which has been exposed by Tew as at best ineffective, was probably not the only criteria by which women chose hospital birth⁹⁵. There were positive reasons for women to go into hospital, including the provision of analgesia, the chance of a rest, and the fact that hospitals were cheaper than engaging a certified midwife or doctor for home delivery⁹⁶. Work on Sheffield, and corroborative evidence from other sources, demonstrates that women were quite positive about advice and help. It also shows that by 1940 only 1/3 of births were institutional, with doctors and midwives sharing the remainder; the take over was far from total at this point.

⁹² Leavitt, *Brought to Bed*; I Loudon, *Death in Childbirth: An International Study of Maternity Care and Maternal Mortality, 1800-1950*, Oxford, 1992.

⁹³ LV Marks, *Model Mothers: Jewish Mothers and Maternity Provision in East London, 1870-1939*, Oxford, 1994; LV Marks, ' "They're Magicians". Midwives, Doctors and Hospitals: Women's Experience of Childbirth in East London and Woolwich in the Inter-War Years', *Oral History*, 23, 1995, 46-53.

⁹⁴ Marks, ' "They're Magicians". Midwives, Doctors and Hospitals', 46-53.

⁹⁵ M Tew, *Safer Childbirth? A Critical History of Maternity Care*, 2nd edition, London, 1995.

⁹⁶ N Leap and B Hunter, *The Midwife's Tale: An Oral History From Handywoman to Professional Midwife*, London, 1993, p.113; J Sawicki, *Disciplining Foucault: Feminism, Power and the Body*, London, 1991; provides a foucauldian counterpoint to the feminist critique which emphasised technology and male power. Sawicki suggests that power is not monolithic; women can help to shape the dominant discourse [p.80]. She also comments that technology is not uniformly negative for women; i.e. birth control, analgesics in birth [p.89].

This study will consider the development of the role of the midwife as an example of a female provider of care, and will look at how state regulation and supervision shaped the character and professional identity of the midwife. Obviously, midwives were not all ignorant Sarah Gamp figures, as happy laying-out the dead as helping at a lying-in, and dispensing abortifacients on demand. Nor were they all paragons of traditional healing. The truth lay somewhere in between, with midwives not a homogeneous group. Before the 1936 Midwives Act, which required local authorities to ensure provision of a salaried midwifery service, and pension off any independent midwives no longer required, most midwives were independent and usually part time, and their expertise and training varied considerably. Analysis of midwives in Sheffield will try to demonstrate the variety of types of practice in one area, although the further one gets from the trained professional, the thinner the evidence becomes.

By the early twentieth century, one of the reasons for the growing interest in questions of childbirth management, was the high rate of MMR compared to other adult death rates in most western countries; there is evidence to suggest that the MMR in Britain was actually rising during the first quarter of the twentieth century⁹⁷. It was not until the mid-1930s that the MMR began its sudden and steep decline after the introduction of sulphonamides which dramatically reduced death rates from fever. Earlier efforts, including antiseptic, and aseptic regimes, midwifery regulation, and ante-natal care, had no downward effect on the MMR.

This study will trace the development of maternal mortality as an issue of concern. Generally the attempts made to tackle it at the local level took the model of solutions to infant mortality, which were perceived to have been successful, as their guide. These therefore included ante-natal clinics, close supervision by the WSI's, and attempts at the provision of nutrition, although this was a far more contentious issue with expectant mothers than it had been with infants. Many contemporaries suggested that maternal mortality was more prevalent among better-off women as they engaged inexperienced doctors who practised dangerous intervention. However, the evidence for Sheffield suggests that the problem was largely confined to working class areas, and that remedial policies were aimed at this group. There is less completed work on maternal mortality than on infant mortality, and this local

⁹⁷ Shorter argued that rising abortion rates and related deaths obscured falls in MMR at full term; but evidence from Loudon and Fox supports the view of, at best static full-term MMR; I Loudon, *Death in Childbirth*; Shorter, *History of Women's Bodies*, E Fox, 'Powers of Life and Death: Aspects of Maternal Welfare in England and Wales Between the Wars', *Medical History*, 35, 1991, 328-352.

study should therefore help to illuminate the complexities of the general issues as well as focusing on the particular situation on Sheffield. It will suggest that Sheffield was unusual in that its high MMR was characterised by high rates of sepsis rather than the 'accidents of childbirth' prevalent in other areas, and this was caused by the extensive resort to illegal abortion in Sheffield. This frequently resulted in septic deaths which impacted on MMR.

1.4: Preventing Conception:

...there is doubt about the means used to control marital fertility, and the motivation which changed the behaviour of individuals.⁹⁸

The mechanics of family limitation tend to be hidden from history. The nature of the subject means that it is difficult to gain information about practises and prevalence, and the beliefs and ideas associated with preventing conception. The written evidence is patchy, and where it does exist, tends to come from the side of the 'expert' such as the doctor, clergyman or lawyer; there is very little on what the women who bore children felt and practised. Researchers have attempted to circumvent this difficulty through the use of oral history, but even then there is the possibility of only atypical respondents wishing to discuss the issue, and then perhaps altering their recollections to make them more 'acceptable', by underplaying their knowledge⁹⁹.

Much of the work on birth control and abortion has stemmed from interest in explaining the mechanics of the late nineteenth century fertility decline in Britain and other countries. Debate has centred round the question of the diffusion of contraceptive knowledge and use down the classes, with the middle and upper classes apparently being the first to show smaller family sizes, and occupational groups like miners or agricultural workers being among the last¹⁰⁰. There has also been interest in whether the available range and social acceptability of contraception increased at this period, allowing greater numbers to have access with less stigma attached.

Both of these directions probably oversimplify the situation. Working class sexuality and practise had its own dynamic, and although increased discussion of birth control informed this, it was not wholly dependant on

⁹⁸ R I Woods, 'Debate: Working Class Fertility Decline in Britain', *Past and Present*, 134, 1992, p.200.

⁹⁹ E Roberts, *A Woman's Place: An Oral History of Working Class Women, 1890-1940*, London, 1984, p.100.

¹⁰⁰ R Woods, 'Debate: Working Class Fertility Decline in Britain', *Past and Present*, 134, 1992, 200-211.

absorbing the ideas of the middle classes in the interests of social betterment. Angus McLaren has commented that:

The fact that working class families remained larger than those of the middle class did not mean that the worker was 'ignorant' of the means of family restriction. What it showed was that the two classes had different needs and aims.¹⁰¹

Additionally, although recent work does show that there were at least refinements of old contraceptive techniques, such as the improvement of condom manufacture, for the majority of people information and access remained as difficult as it had done throughout the nineteenth century¹⁰². Advances in contraceptive availability, such as the cap, did not in fact appear until after the First World War when the fertility decline was at least one generation old. Szreter has argued that before this time, non-mechanical methods including abstinence and reduced coital frequency probably had the most significant impact on fertility¹⁰³. It is likely that provision of condoms, for use as a prophylactic in the war, had broken down many male fears about contraception, although between the wars it was the dispensation of the cap in birth control clinics that was intended to give women autonomy and safety¹⁰⁴. The development of the availability of mechanical forms of contraception for all classes occurred during the inter war years following the opening of the first Marie Stopes birth control clinic in 1921. Cohen has suggested that the use of working class midwives to examine women did break down some of the stigma involved in attendance. However, she has commented that the impracticalities of keeping, cleaning and inserting caps in a crowded home meant that, although theoretically autonomous, in practice women needed the tacit consent of their husbands. Cohen has also pointed out the contradictions inherent in the use of the cap; whilst officially empowering women, it could work against them by denying their right to refuse sex¹⁰⁵.

¹⁰¹ A McLaren, 'Women's Work and Regulation of Family Size: the Question of Abortion in the Nineteenth Century', *History Workshop Journal*, 4, 1977, 70-81; see also D Gittins, *Fair Sex: Family Size and Structure, 1900-1939*, London, 1982, preface.

¹⁰² R Porter and L Hall, *The Facts of Life: the Creation of Sexual Knowledge in Britain, 1650-1950*, New Haven and London, 1995, p.259; S Humphries, *A Secret World of Sex: Forbidden Fruit The British Experience 1900-1950*, London, 1988, p.35-62.

¹⁰³ S Szreter, *Fertility, Class and Gender in Britain, 1860-1940*, Cambridge, 1996, p. 413.

¹⁰⁴ Mechanical forms of contraceptive were expensive: condoms were about 3/- per dozen in the late nineteenth century, when one third of families were living on incomes of below 21/- a week; P. Knight, 'Women and Abortion in Victorian and Edwardian England', *History Workshop Journal*, 4, 1977, 57-68.

¹⁰⁵ DA Cohen, 'Private Lives in Public Spheres: Marie Stopes, the Mothers Clinics and the Practice of Contraception', *History Workshop Journal*, 35, 1993, 95-116; see also A McLaren, *Birth Control in Nineteenth Century England*, London, 1978, p.202.

Chapter 6 demonstrates that in the area of birth control there was probably less class consensus than with any of the other welfare developments. A voluntary birth control clinic set up in Sheffield in 1933 was supported by the Council, but was not taken up with enthusiasm by working class women. The numbers of women using it remained negligible up to 1940. The most popular methods probably remained a mixture of the sheath, withdrawal, abstinence, and abortion, although given the nature of the subject, it is impossible to be certain of this.

It can be shown, however, that the birth rate in Sheffield did fall dramatically, if late, with major declines not occurring until after the First World War. It is likely that the reasons for this were partly economic, and that the instrument of control was abortion. Although the spread of contraceptive techniques is uncertain, one area which was felt by contemporaries to have been of major concern was abortion. This area of birth control illustrated the size of the gap between working class and middle class ideas and practices. Although legally proscribed since 1803, folk wisdom still held that before 'quickenings', attempts at termination were acceptable, although this had to be done by the woman concerned¹⁰⁶. Accepting outside mechanical help, in any case always a last resort, tended to be seen in an unfavourable light¹⁰⁷.

The means of procuring abortions, effective or not, were developing, in the nineteenth century, with the increased availability of douches and syringes in addition to 'patent' remedies. Brown has suggested that although the sale of 'female pills' had begun in the eighteenth century, it was only towards the end of the nineteenth century that links were made between these and women's attempts at self-abortion¹⁰⁸. This concern might have been informed by growing fears over the use of abortion by 'genteel' women; perhaps linked with worries about racial decline and the rise of emancipated women. Middle and upper class women would not have been strangers to abortion, and would perhaps have found help from doctors easier to obtain than their working class counterparts. However, their use of 'quack' remedies, and their susceptibility to blackmail, shows that they too were vulnerable to pressures from family and society¹⁰⁹. It is likely that if working class families could not afford condoms, then the patent pills would also be beyond reach. This study will look at the

¹⁰⁶ W Seccombe, 'Starting to Stop: Working Class Fertility Decline in Britain', *Past and Present*, 126, 1990, 155-188, p.155. For a detailed account of the changing legal status of abortion, see: B Brookes, *Abortion in England, 1900-67*, London, 1988.

¹⁰⁷ E Roberts, *A Woman's Place: An Oral History of Working Class Women, 1890-1940*, London, 1984, p.100.

¹⁰⁸ PS Brown, 'Female Pills and the Reputation of Iron as An Abortifacient', *Medical History*, 21, 1977, 291-304.

¹⁰⁹ *The Lancet*, 1898, ii, p.1570.

use of diachylon pills for abortion in the Sheffield area, including how knowledge of their use was spread and the attitude taken by the local medical profession.

When considering concern about abortion, it should be remembered that the actual abortion rate was presumably far lower than the attempts to obtain abortion. Most oral compounds would probably have little effect, and surgical intervention was a route taken by only the most desperate¹¹⁰. Additionally, only those abortions which reached the attention of doctors could really be counted; it is impossible to estimate the number of successful abortions which never required attention.

Sauer has suggested that abortion was attempted by those in extreme poverty and unmarried women attempting to retain social status; this group might include middle class women or servants. However, in pre-war Germany concern centred around the fact that the chief users of abortion were married women attempting to control the size of their families; it is likely that the same situation prevailed in Britain¹¹¹. Several writers have stressed that abortion might have been a preferred option for many because action only need be taken in the actual event of a pregnancy, which was cheaper than continual use of aids¹¹². It also allowed decisions about the economic or practical implications of another child to be postponed almost until the last minute. McLaren has suggested that in middle class families, the male as breadwinner made the choices about limitation and used 'male' methods such as the condom or withdrawal. In working class households the decision rested with the female who was more likely than her middle class counterpart to have community or workplace access to information. His contention was that '...in contrast to the male middle class contraceptive approach fertility control there was also a working class female model of control through abortion.'¹¹³ In opposition to this, Szreter has argued that abortion was in fact most prevalent in patriarchal communities where women had least access to domestic power, and workplace information networks¹¹⁴. The experience of Sheffield, which experienced very high rates of illegal abortion in the inter-war years supports

¹¹⁰ Brown, 'Female Pills'; J Woycke, *Birth Control in Germany, 1871-1933*, London, 1988; R Sauer, 'Infanticide and Abortion in Nineteenth Century Britain', *Population Studies*, 32, 1978, 81-94.

¹¹¹ C Osborne, 'Abortion in Weimar Germany: the Debate Amongst the Medical Profession', *Continuity and Change*, 5, 1990, 199-222.

¹¹² McLaren, 'Women's Work'; P Knight, 'Women and Abortion in Victorian and Edwardian England', *History Workshop Journal*, 4, 1977, 57-68.

¹¹³ McLaren, 'Women's Work', p.78.

¹¹⁴ S Szreter, *Fertility, Class and Gender in Britain, 1860-1940*, Cambridge, 1996, p.426-8.

this view, although women did have some access to networks which allowed dissemination of information about, for example, abortifacients.

Both Woods and Seccombe have emphasised the importance of women's influence in changing the behaviour of their husbands in order to stop or space their families. The question of women's empowerment within the marriage, allowing her to enforce withdrawal or reduced coital frequency, needs further study. Seccombe has suggested that the medicalisation of childbirth, with the advent of the WSI's in particular, helped women to see childbirth as a pathological event, and legitimised their fears of repeated pregnancies. 'Doctors orders' also helped to convince reluctant husbands¹¹⁵. After all, women had more to lose on a personal level than men through repeated child bearing, and through their control of the family exchequer, might also be more aware of the practical implications. Both Hall and Giles have drawn attention to the inter-war model of a 'strong' mother, with domestic power, in contrast to her weak husband emasculated by war or unemployment¹¹⁶. This view does not appear to have been current in Sheffield. Gittins has found that women attending birth control clinics in Manchester and Salford did so as a last resort after bearing several children; there was little evidence of planning before the family was started, implying a 'wait and see' attitude. Seccombe has agreed, arguing that contraception was not important until the family was complete, suggesting that 'stopping', once a certain family size had been achieved, was more important than 'spacing' an undecided total¹¹⁷. Woods has argued that although the growing dissemination of birth control literature may not have been important for the practical advice which it offered, it did help to encourage a climate in which such things could be discussed, and to allow for the possibility of choice¹¹⁸.

It was argued, at this time, locally and nationally, that Sheffield had one of the highest illegal abortion rates in the country during the 1920s and 1930s. This study will consider estimates of the amount of abortion occurring, and the effect this was believed to have on MMR. It is really possible only to suggest reasons for the high rate, as the qualitative evidence is so thin. It is likely that economic concerns, and changing expectations about lifestyle and quality, had an effect on behaviour. Failure of other birth control methods to secure

¹¹⁵ W Seccombe, 'Starting to Stop: Working Class Fertility Decline in Britain', *Past and Present*, 126, 1990, 155–188, p.181–2.

¹¹⁶ J Giles, *Women, Identity and Private Life in Britain, 1900–1950*, London, 1995, p.55; LA Hall, 'Impotent Ghosts from No Man's Land, Flappers Boyfriends, or Crypto-patriarchs? Men, Sex, and Social Change in 1920's Britain', *Social History*, 21, 1996, 54–70.

¹¹⁷ W Seccombe, 'Starting to Stop', 155–188.

¹¹⁸ RI Woods, 'Debate: Working Class Fertility Decline in Britain', *Past and Present*, 134, 1992, 200–211.

the desired outcome might also have been significant. Contemporaries speculated that women were turning to more dangerous forms of abortion, such as those by instruments, due to the outlawing of popular methods such as the oral use of diachlyon. Chapter 6 will look at possible changes in the type of abortion favoured, and how these might have affected perceptions of the problem of abortion and of mortality rates.

1.5: Conclusion:

Through the organising force of women's reproductive lives, this study of Sheffield will attempt to illustrate and modify some of the ideas put forward by other researchers. It will also try to synthesise areas not normally tackled together, to provide a more complete picture of the situation in one city and to guard against the artificial compartmentalisation of topics which were intermingled in the lives of individuals.

This study will question some of the assumptions about the passive nature of women's responses to the development of policies which affected them, and will argue that women were influential in the provision of some services, and in the rejection of others. Working class women were not passively accepting of services and ideologies forced on them by middle class volunteers or an ideologically committed state. Working class sexuality and fertility did have its own dynamic, as demonstrated over issues of birth control and abortion. However, there was no obvious culture of support and information within the female working class community over issues of maternity; this may have been due to the nature of Sheffield society. Support by women for the provision of advice and assistance at clinic and through home visiting, and in particular the demand for managed hospital deliveries rather than home births, suggests that women were actively seeking models and advice outside their communities. How far provision of services matched needs or expectations is difficult to judge; in the case of many clinic services it probably fell short both in terms of accessibility and quality. This was due primarily not to clashes of ideologies between clients and providers, but to financial constraints.

This pragmatism and consensus is significant in considering the development of policies. The language of ideas about eugenics, national deterioration and the role of state medicine do appear to have played a part in determining the tone of debates about mortality, morbidity and welfare among mothers and infants. However locally, where it appears that most of the practical initiative was taken, there was a belief that improved health and

welfare could be secured and that the limits of action were determined by resources rather than ideology.

A local study of one area cannot be taken as being representative of the country as a whole. In some respects, such as provision of infant welfare, Sheffield was typical, and in other areas, such as its very high abortion rates, it was perhaps not. However, it does highlight certain general features including the influence of women, and of pragmatic policy making, and the multi-causality of issues of mortality, relating to national and local conditions.

Given the limitations of the evidence, there are some areas which it has not been possible to tackle as comprehensively as would be wished. Apart from the inherently inaccessible areas of individual and family decision making, particularly with regard to fertility, there are specific problems connected with Sheffield. The first is the total lack of Poor Law records relating to the period; these were all destroyed before 1939 and do leave a considerable gap in the discussion of provision of, for example, institutional childbirth. The other significant institution from which records have been lost is the Jessop Hospital for Women. Although the Minute Books of the Weekly Board and other committees are extant, all patient registers and casenotes for the period 1864–1940 have been lost. These losses highlight a potential difficulty with this type of research. Where they have been preserved, hospital archives have often been stored in inadequate conditions in hospitals, with heavily restricted access, resulting in the loss of historically significant material¹¹⁹. Despite these restrictions, the evidence which has remained is of sufficient depth and variety to allow maternal and infant welfare in Sheffield to be studied effectively and for conclusions to be reached.

¹¹⁹ E Higgs and J Melling, 'Chasing the Ambulance. The Emerging Crisis in the Preservation of Modern Health Records', *Social History Medicine*, 10, 1997, 127–136.

2: Informing Ideologies? Eugenics and State Medicine.

2.1: Introduction:

This chapter will deal briefly with the national background to the concern over maternal and infant welfare which manifested itself in various remedial programmes in Sheffield and other places from around the turn of the century.

It will concentrate on two of the main themes running through these debates; the influence of eugenics and ideas of racial decline; and the role of 'state medicine' in securing health and welfare. Specific contemporary debates over issues such as maternal mortality or abortion, for example, will be considered in the chapters dealing with these issues. However, although, the general themes of eugenics and state medicine, did not appear to have had a significant impact on the direction and character of the debate at the local level, they underlay a wide range of debates and influenced attitudes and language if not outcome.

2.2: Eugenics and Social Darwinism:

There was concern in certain quarters about the quality, if not the quantity of the British population, even before the shock to the national psyche inflicted by the Boer War. Writers such as Henry Mayhew, and statisticians like William Farr, were concerned about the lifestyles and breeding rates of the lower classes from the 1850s.

'Eugenics' itself developed out of the popularising theories of evolution and the 'survival of the fittest' propounded in mid-century by Charles Darwin. Darwin's cousin, Francis Galton, who coined the term 'eugenic' in 1883, helped to develop a social theory of heredity¹. Humans could be divided into the 'fit' and the 'unfit'; categories which roughly corresponded to class. The professional middle classes, who were the main supporters of eugenics or 'social Darwinism', believed that they were the guardians of the racial health of the nation. They were in favour of a meritocracy both mental and physical, which in practice meant the middle classes themselves. The working classes living in slum conditions were seen as obviously degenerate, as were the inbreeding, disease ridden aristocracy². Even capitalists were seen as

¹ LA Farrell, 'The history of eugenics: A bibliographical review', *Annals Science*, 36, 1979, 111-123, p.111.

² Greg, a Manchester economist, wrote that: 'Not only does civilisation, as it exists among us, enable rank and wealth, however diseased, enfeebled, or unintelligent, to become the continuors of the species in preference to larger brains, stronger frames and sounder constitutions: but that very rank of wealth, thus inherited without effort and in absolute security, tend to produce enervated and unintelligent offspring'; WR Greg, 'On the failure of

contributing to 'race suicide' by employing, and therefore encouraging, cheap 'unfit' labour for short term gain.

Although proponents such as Francis Galton and Karl Pearson saw eugenics as a science (i.e. biometrics), it was influential primarily in terms of social debate and policy between c.1880 and 1914. In fact, supporters of eugenics saw it as more than a science. One supporter, Schuster wrote that eugenics was concerned with; '...those agencies under social control which may improve or impair the racial qualities of future generations, either physically or mentally.'³

Social Darwinism fed successfully on wider fears about the falling birth rate, high infant mortality, and the increasing visibility of the 'residuum'; the very poor concentrated largely in urban centres. Freeden has suggested that by the time of the Boer War many liberal theorists had largely moved away from social Darwinism as a guiding principle.⁴ It was seen by writers such as Hobhouse as a conservative tool; using science to justify the omnipresence of poverty and giving the middle classes a racial rationale for their social position. Rather, Hobhouse suggested that social reform was a natural part of mans' evolution, and that as a higher animal, he should co-operate, and help the weaker in his society. He opposed those such as Leslie Stephens, who commented that charity appeared to be a moral act, but was in fact immoral because '...all charity which fosters a degraded class is...immoral'.⁵ 'Classical' liberals such as Stephens and Herbert Spencer used social Darwinism to argue that social evolution could only occur in an open (i.e., democratic, laissez-faire) society. Anything which tended towards greater state intervention (as suggested by 'new' liberals, and radical eugenists) weakened this natural action. Spencer, for example, believed suffering could be alleviated by the state, but only at the cost of social progress. He even argued that greater state involvement in areas such as social welfare was tantamount to state slavery, as the levying of higher taxes and great volumes of legislation inhibited the freedom of the individual.⁶ Spencer saw evolution as the 'invisible hand ' which gave society structure and direction. The state, by aiding the 'unfit' through social reform, could undermine this.

natural selection in the case of man.', *Fraser's Magazine*, 78, 1868, 361, cited in G Jones, *Social Darwinism and English Thought: The Interaction Between Biological and Social Theory*, Brighton, 1980

³ E Schuster, *Eugenics: a Science and an Ideal.*; cited in LA Farrell, 'The History of Eugenics: A Bibliographical Review', *Annals Science*, 36, 1979, 111-123, p.112.

⁴ M Freeden, *The New Liberalism*, Oxford, 1978, p.1.

⁵ Quoted in: G Jones, *Social Darwinism and English Thought*, p.75.

⁶ H Spencer, *The Man Versus the State*. Edited and with an introduction by D Macrae, London, 1969, p.101.

This doctrine was in turn rejected by writers such as Geddes and Ruskin, who objected to political economy based on calculations of personal advantage.⁷ They preferred to see society as an organically linked structure, which functioned symbiotically. Hobhouse, and other supporters of 'new liberalism' argued that only if all classes were given the same quality of environment and equal opportunity in life would it be possible to judge if certain types of people were 'inferior'.⁸ Liberals such as Lloyd George and Churchill increasingly saw the way forward as being through social reform, which would at least give some support to the poorest in society. These ideas came to prominence after the Liberal victory in the general election of 1906. However, they still embodied the basic Poor Law tenets of a difference between the 'deserving' and 'undeserving' poor. The former, who included pensioners, and those subject to cyclical unemployment were entitled to state help, which for pensioners was non contributory. The 'undeserving' corresponded largely to the 'unfit' of eugenic thought; the drunken and work-shy, and of course, unmarried mothers⁹.

Eugenics was far from being only an academic theory; it had populist appeal, although numbers in the organised eugenics movement always remained relatively small. In 1901, Arnold White, a radical writer on imperial matters, wrote of the physical condition of army recruits. He claimed that in 1899 $\frac{3}{5}$ of men volunteering for service in Manchester were rejected as being unfit.¹⁰ Rowntree also discovered in his work on York that of 33,600 volunteers in York, Sheffield and Leeds between 1897 and 1900, the army rejected 26½% as unfit, and accepted a further 29% as 'specials'.¹¹ It was Major General Sir John Maurice who perhaps had the biggest impact, however, in his article in the *Contemporary Review*

...taking into account those whom the officers did not think it worthwhile to bring before the Doctors, those whom the Doctors reject, and those who are rejected after trial in the Army, ...to put it in its simplest terms, out of every five men who are willing to enlist only two are fit to become efficient soldiers.¹²

⁷ G Jones, *Social Darwinism and English Thought*, p.58.

⁸ M Freeden, *The New Liberalism*, Oxford, 1978, p.17.

⁹ Churchill was a supporter of the eugenic segregation of the feeble-minded; P Addison, *Churchill on the Home Front, 1900-1955*, London, 1992.

¹⁰ A White, *Efficiency and Empire*, London, 1901, p.101-102.

¹¹ BS Rowntree, *Poverty: A Study of Town Life*, London, 1901, p.216-221.

¹² JF Maurice, 'Where to Get Men', *Contemporary Review*, 81, 1902, 79-86, p.79.

Figures such as these profoundly shocked their middle class readers who had perhaps rejected the more sensationalist writings of White. Maurice further argued that:

...if the great body of the nation itself is decaying in health and physical vigour, no increased inducements to enlist, whether in the form of compulsion, of higher pay, or other advantages, can adequately compensate the evil.¹³

Haunted by the growing economic power and prestige of Germany, and fearful of Britain losing her 'place in the sun', theorists and policy makers sought ways to arrest the perceived physical and moral decline of the population. One of the informing concerns was the decline in the birth-rate among the middle classes. Completed family size had dropped dramatically by the end of the century, yet the working classes were felt to be increasing at an undiminished rate. Stedman Jones has highlighted the fears of the middle classes that cities, in particular, would be swamped by the 'unfit'.¹⁴ Studies such as those of Mayhew, and later of Simms, and Mearns in his pamphlet 'The Bitter Cry of Outcast London' (1883), give the impression that venturing into the poorest districts was like exploring a foreign country; darkest London as much as darkest Africa.¹⁵ Wohl has argued that from the 1840s, the most accurate and effective writings on the urban slums were penned by medical men, and in particular, Medical Officers of Health (MO'sH) such as John Simon (MOH in the City of London 1848–1855). These had a very limited readership.¹⁶ *The Lancet* complained in 1883 that reformers such as Farr, Chadwick and Simon had 'preached almost to deaf ears' and had 'till very lately scarcely ruffled the conscience of political men.'¹⁷

Social Darwinism was a theory espoused by 'old' and 'new' liberals alike, as well as conservatives and some socialists. By 1900, however, it had taken on an extreme tinge, and writers such as Saleeby and Whetham were able to demand a 'rightly-directed selective birth rate...' to counteract fears of 'race suicide'.¹⁸ Whetham had warned that:

¹³ Maurice, 'Where to Get Men', p.82.

¹⁴ GS Jones, *Outcast London: A Study in the Relationship Between Classes in Victorian Society*, 2nd Edition, London, 1984.

¹⁵ GR Simms, *How the Poor Live and Horrible London*, London, 1889.

¹⁶ A Mearns, *The Bitter Cry of Outcast London*, Edited and with an introduction by AS Wohl, Leicester, 1970.

¹⁷ Quoted in: AS Wohl, 'The Bitter Cry of Outcast London', *International Review Social History*, 13, 1968, 189–245, p.18.

¹⁸ CD Whetham, *The Family and the Nation: A Study in Natural Inheritance and Social Responsibility*, London, 1909, p.178; CW Saleeby, *Parenthood and Race Culture: An Outline of Eugenics*, New York, 1909, p.201.

As long as the feeble-minded and the habitual criminal are allowed to multiply at will, so long will a section of the community remain parasitic upon the rest; an expense to, and a drag upon, their more efficient fellows.¹⁹

Whetham's remedies included segregating the feeble minded, habitual criminals, and the 'hopeless pauper' with the belief that these types could be weeded out of the race if not allowed to breed. Not all of his suggestions were so apocalyptic, however. Whetham also supported the idea of private endowments for young healthy wives likely to produce good stock. He also called for women to have '...a considerable period of absence from work before and after each birth...'²⁰ This would allow them to rest and produce healthier children, although he said nothing about how to alleviate the poverty that the even temporary lack of a necessary wage might bring.

Saleeby, although also a self proclaimed eugenicist, was far more environmental in his approach. He, like Whetham, advocated the segregation of the insane, alcoholic and diseased, but he also believed that children once conceived were sacred. He asserted that '...most the babies born in the slums are splendid little specimens of humanity...', and that most infants were killed by their environment, not hereditary defects. He was quick to stress that he '...strenuously repudiated any suggestion that the eugenic end is legitimately or effectively to be served by permitting the infant mortality to continue.'²¹

Eugenics was seen as radical, in both being able to discuss wholesale state intervention, even if only for the segregation of the 'unfit', and in publicly addressing questions of sex. However, wider Social Darwinist theories were very much in the earlier Victorian social tradition for two reasons. They continued to emphasise the difference between the 'deserving' ('fit') poor, and the 'undeserving' ('unfit') poor. Thus, the latter could be dealt with only through forcible segregation and possible sterilisation; whereas the former could be helped to higher things, primarily through education, and possibly some public health measures (i.e., improved housing). The second point was that although eugenicists increasingly called for state intervention, particularly as regards the problem of how to deal with the 'unfit', there was still a belief that many of the problems of poverty and ill-health were self-inflicted. Thus, there was a continued belief in the responsibility of the individual for his/her own actions. Indeed this caused splits in the movement because the more

¹⁹ CD Whetham, *The Family and the Nation*, p.177.

²⁰ CD Whetham, *The Family and the Nation*, p.201.

²¹ CW Saleeby, *Parenthood and Race Culture*, p.25.

radical eugenicists such as Galton seemed to suggest that if all traits were hereditary, then there was no room for free will, or individual morality. He was criticised by Stephens on this point.²²

The importance of debate on a political level was highlighted in 1904 with the creation and report of the Inter-departmental Committee on Physical Deterioration. This took as its term of reference the need '...to indicate generally the causes of such physical deterioration as does exist in certain classes...'²³. In its conclusion, the Committee suggested that: 'There is no lack of evidence of increasing carelessness and deficient sense of responsibility among the younger women of the present day...'²⁴. The findings of the Committee did not support the thesis that the calibre of the British race was in irrevocable decline. Instead it saw the problem of high infant mortality, for example, as caused by ignorant women who were, however, probably amenable to education. The main recommendation of the Committee was centred around '...some great scheme of social education'; aimed mainly at women²⁵. Its views demonstrated the influence of the pragmatists, in particular MO'sH who had local influence and generally took a social and environmental focus rather than one based on deterioration and heredity. Arthur Newsholme, MOH for Brighton, and later at the LGB commented:

That maternal ignorance is a chief factor in the causation of excessive child mortality is, I have said elsewhere, "comfortable doctrine for the well-to-do person to adopt." It embodies an important aspect of truth, but it is mischievous when it leads to the notion that what is chiefly required is the distribution of leaflets of advice, or the giving of theoretical instruction in personal hygiene.²⁶

Newsholme's contention was that clean and effective milk and water supplies, and the provision of comprehensive medical and support services, were of greater importance than education. He was of the opinion that the ignorance of all classes of mother was roughly equal but that: '...the *ignorance* of the working class mother is more dangerous because it is *associated with relative social helplessness*.'²⁷ These comments, although retrospective, do perhaps highlight the differences between the observers and theorists, and those such as Newsholme who were involved in creating, implementing and

²² G Jones, *Social Darwinism and English Thought*, p.109.

²³ *Report of the Inter-Departmental Committee on Physical Deterioration*, London, 1904, p.v.

²⁴ *Inter-Departmental Committee on Physical Deterioration*, p.55.

²⁵ *Inter-Departmental Committee on Physical Deterioration*, p.57

²⁶ A Newsholme, *Fifty Years in Public Health*, London, 1935. p.372.

²⁷ Newsholme, *Fifty Years in Public Health*, p.374.

observing policy on the ground. Newsholme admitted that his views on poverty developed considerably over time and that he moved away from a personal failings model to one which saw society as having to accept a larger degree of responsibility and care. He suggested that many MO'sH were swayed by biometrics and by the glib statements based on impenetrable, and in Newsholme's opinion, flawed, statistics²⁸. However, most MO'sH and co-workers believed that progress was possible and desirable. One contributor to the Journal of the Royal Sanitary Institute commented:

While it is urgently necessary that the question of better housing, better milk supply, the economic position of mothers, and the education of mothers still receive immediate attention, it is also necessary to realise that while criminals, inebriates and the feeble-minded continue to propagate, successful efforts in lowering the death rate among children of such parents must lead to racial degeneracy.²⁹

This perspective was by no means common for MO'sH, at least not in a form as openly expressed as this, but certainly underlay many of their pronouncements. The language and organisation of ideas of such people which demonstrated their belief in the basic inferiority of the working classes, were partly paternalistic, but were probably informed, even unconsciously, by eugenic views. On issues such as illegitimacy and alcohol, these tended to fuse with mainstream middle class views on morality.

Recent writers have suggested that the impact of eugenic ideas on early twentieth century social legislation was minimal, but in general, it does appear that eugenics had a place in late nineteenth and early twentieth century debates about population and health.³⁰ It was both a conservative force, in providing a scientific rationale for the social *status quo*; and a radical force in advocating overt social control over those deemed 'unfit' by another section of society. Social Darwinism was a portmanteau of ideas, used by different groups in different ways, yet the interaction between eugenic ideas and questions of public health and sanitary reform were influential in the attempted development of state control over motherhood and the family. Social hygiene and education for motherhood, for example, were seen as applying only to the working classes; and taught to them by the middle classes. Assistance in the form of health visitors or milk depots included a

²⁸ A Newsholme, *The Last Thirty Years in Public Health*, London, 1936, p.66-79; p.208.

²⁹ *Journal Royal Sanitary Institute*, 2, 1908, 758-762. p.762

³⁰ E.g., D Paul, 'Eugenics and the Left', *Journal History Ideas*, 45, 1984, 561-590.

form of moral means testing³¹. Personal and domestic hygiene, the feeding and care of infants, nutrition, and the regulation of leisure activities, were all seen as legitimate areas of operation by those who were distributing the milk and maternity allowances. Acceptance of help involved at least tacit acceptance of the moral codes of the instructors.

Perhaps more significant was the effect of eugenics on the organising structure and language of ideas. However, this thesis will argue that in most areas of maternal and child welfare, pragmatism, informed by what was practically and economically possible was more important than ideology, and this can be demonstrated in the arguments and developments around state medicine.

2.3: State Medicine:

One of the problems with the history of organised health care in Britain before the creation of the National Health Service (NHS) in 1948 is the temptation to see all earlier developments as feeding organically into the implementation of the post-1945 system³². Thus the continued importance of the voluntary sector in providing services in the inter-war years can be overlooked in the concentration on the development of state medicine. However, as Lewis and Webster have argued, the centralised form which the NHS took was by no means a foregone conclusion even ten years previously, with the dominating theme, despite the creation of a Ministry of Health in 1919, being the continued existence of a multiplicity of agencies for the delivery of health care³³. These were capable of co-operating, but were often in competition for patients and resources. Many of the arguments put forward for a system of state medicine in the first half of the twentieth century were based on pragmatic concern about the overlap of some services, the paucity of others, and the most effective use of resources³⁴. Although many in the medical profession were vehemently opposed, first to notification of disease, then to National Insurance, then to further encroachments of state on private

³¹ J Donzelot, *The Policing of Families*, London, 1979. This was in fact explicit in the case of midwives, who were heavily supervised in their personal as well as professional conduct; BV Heagerty, *Gender and Professionalisation: the Struggle for British Midwifery, 1900-36*, unpub PhD thesis, Michigan State University, 1990.

³² For example Fraser suggested that the welfare state was 'the end product of a very long historical process; D Fraser, *The Evolution of the British Welfare State: A History of Social Policy Since the Industrial Revolution*, London, 2nd edition, 1984, p.xxi.

³³ Ministry of Health Act, [9+10 Geo.5.c.21]. C Webster, *The Health Services Since the War*, Volume 1, *Problems of Health Care: The National Health Service Before 1957*, London, 1988; J Lewis, *What Price Community Medicine? The Philosophy, Practice and Politics of Public Health Since 1919*, Brighton, 1986.

³⁴ WA Brend, *Health and the State*, London, 1917, p.26-7; Lord Dawson, 'Medicine and the State', *BMJ*, i, 1920, p.743.

practice, their competing arguments also appear to have been largely pragmatic. Discussions about health care, and the relative importance of preventative and curative, medicine were the province of practical policy makers rather than theorists. Many of the developments which did occur up to 1940 were the result of piecemeal reform and development at a local and national level, rather than due to greater plans. Lewis has argued that it was precisely this *ad hoc* development of local authority health care under the auspices of MO'sH which left them unable to compete with the demands of hospital based curative services under the NHS. The fact that MO'sH and other practical workers failed to develop coherent philosophies to underpin their work left them unable to defend themselves, and led, after 1948, to the loss of many of the services that they had previously run.

Questions about the role of the state, either as a local or national entity, were bound up with practical issues concerning the importance of preventive medicine, and the development of measures such as welfare clinics and home based health visiting. It was argued that although private doctors and voluntary hospitals should provide curative based care, it was the wider community which could best provide *health* care as such. In reviewing work on maternal and child welfare up to 1936, Newsholme commented:

Through these enterprises there runs the dual theme that health is dependent very largely on security from poverty, in the sense of privation of essential needs; and that to promote this security, and therefore reduce a large proportion of total poverty, there must be developed a practical intimacy between Medicine and the State, far beyond what has hitherto existed.³⁵

To this end he had argued in 1908 for one medical service which should be free at the point of delivery, and funded by insurance, partly to remove the stigma of attention under the Poor Law, and partly to relieve problems of co-ordination, with that between the Local Authorities and the Local Government Board (LGB), and between the LGB and the Board of Education being particularly poor³⁶. In this he was supported by other MO'sH, such as Dr Scurfield, the MOH for Sheffield, who in evidence to the Royal Commission on the Poor Laws in 1907, called for the abolition of the Poor Law, and the creation of a salaried 'public medical service'.³⁷

³⁵ Newsholme, *Last Thirty Years*, preface.

³⁶ Newsholme, *Last Thirty Years*, p.88.

³⁷ *Royal Commission on the Poor Laws and the Relief of Distress*, appendix volume 4, London, 1909, qu 41884-42046.

Before 1920 state medicine developed primarily as a series of *ad hoc* locally based services. These could be traced back to the development of Sanitary Authorities and the appointment of MO'sH, particularly after 1872. Initially the concern of such departments was with broad measures of health, such as the provision of clean water, sewage and refuse services³⁸. However, although the development of a more personal approach to preventive medicine did occur, particularly with the implementation of infant welfare policies, this was foreshadowed by legislation over disease notification in the 1890s, and the development of fever hospitals. MO'sH themselves did not make a sharp distinction between collective and individually based policies; for example, efforts to reduce infant mortality included improving community sanitation as well as home visiting and efforts to improve domestic cleanliness.

This attitude that problems could be solved on a micro level equated with ideas of individual responsibility and found much favour. It was demonstrated in the individual casework of the Charity Organisation Society, the Guild of Help and many other local charities. The individual approach continued to flourish in this period, although there were increasing demands for macro-solutions³⁹. However, individually based responses remained more influential in terms of policy, if not in the levels of assistance which they provided.

As early as 1917, the British Medical Journal (*BMJ*) was worrying about the total removal from general practice of the care of expectant mothers and children in particular and deplored the appointment of 'whole time medical officials'. It commented that:

The wise advice of a doctor acquainted with the history of the family and familiar with the conditions of life in the district can do more to preserve child life than any amount of specialised advice given in centres, or the distribution of leaflets in tons.⁴⁰

This was the voice of the general practitioner (GP) and was increasingly at odds with that of the MOH. Dr Robertson, the MOH for Sheffield to 1904, and thereafter for Birmingham, commented, also in 1917, that 'Doctors should

³⁸ Many MO'sH had pioneering schemes and worked hard, despite attitude of the LGB and the Treasury; R MacLeod, 'The Frustration of State Medicine, 1880-1899', *Medical History*, 11, 1967, 15-40.

³⁹ Eg the *Minority Report on the Poor Law*.

⁴⁰ *BMJ*, i, 1917, 430-431.

accept that curative work must be subservient to the more important and difficult preventive work.⁴¹

Significantly these debates were all grounded in the implementation of practical policy around maternal and child welfare. Following the creation of the Ministry of Health, which to general relief was distinct from the Poor Law in a way that the LGB had never managed, a Committee chaired by Lord Dawson of Penn deliberated on the way forward for state medicine. He argued that measures such as the Maternal and Child Welfare Act of 1918, represented 'a State medical service by instalments, almost by stealth.'⁴² The Report came down in favour of the return of preventive medicine, as represented by such services as clinics, to the GP rather than to salaried staff. An editorial in *Public Health*, the official journal of the Society of MO'sH accused the report of being 'reactionary'.⁴³

In practice, many of the suggestions for the development of medicine were geared towards the peaceful co-existence of public and private care. In relation to services for expectant women, for example, Campbell suggested that:

A complete Maternity Service must have as its nucleus domiciliary midwifery by doctors or midwives in private practice, but this should be amplified and rounded off by facilities arranged and offered by the Local Authority and made available for all women requiring them.⁴⁴

She further insisted that 'By a complete Maternity Service I do not mean a municipal or State service'.

Despite the reluctance of central government or local authorities to formulate coherent philosophies for the policies, the *ad hoc* effect of measures such as the dismantling of the Poor Law, was to greatly increase the influence of the MOH over curative as well as preventive care. This could be seen most dramatically in the responsibility of MO'sH in the 1930s for hospital beds and midwives, in addition to welfare clinics, TB services, and infectious disease⁴⁵. Dawson's fears of a state service by stealth appeared to be continuing in the

⁴¹ J Robertson, 'The Child Welfare Campaign and the Position of the Medical Officer of Health', *Public Health*, 30, 1917, 2-5, p.5.

⁴² Dawson, 'Medicine and the State', p.743.

⁴³ *Public Health*, 33, 1920, 175-6.

⁴⁴ JM Campbell, *The Protection of Motherhood*, London, 1927, p.33.

⁴⁵ Honigsbaum has described the refusal of MO'sH to allow GP's access to beds in the Local Authority hospitals created after the break up of the Poor Law in the 1930's. MO'sH apparently did not trust GP's to work effectively, accusing them of failure to co-operate over infant welfare clinics or ante-natal care; F Honigsbaum, *The Division in British Medicine: A History of the Separation of General Practice From Hospital Care, 1911-1968*, London, 1979, p.138-9.

inter-war years with the prestigious voluntary hospitals also beginning to feel threatened by the dominance of the Local Authority. After the dismantling of the Poor Law in 1929, Local Authorities took over 50% of available beds giving them 72,500 general beds in hospitals by 1938; equivalent to those commanded by voluntary hospitals. In some areas, including Sheffield, there appears to have been a fair degree of co-operation between the institutions, but difficulties of competition and overlap remained⁴⁶.

Even the voluntary sector, still significant in size and personnel in the inter-war years, had, as Harris and Lewis have suggested, been co-opted to assist Local Authority work⁴⁷. Newsholme commented that '...while voluntary work for child welfare persists and is to be seen in all well governed sanitary areas, it is in large measure voluntary work "in a municipal setting".'⁴⁸ Yet Lewis has argued that this high point of Local Authority medicine was inevitably transitory precisely because MO'sH failed to remain pioneering in their approach to public health problems in the inter-war years⁴⁹. Although they had earlier developed many of the most radical policies, including the provision of school medical services and health centres, they failed to address issues of unemployment and nutrition in the inter-war years⁵⁰. Extra-governmental pressure groups and social scientists took the lead. This demonstrated that in fact voluntary groups had not been totally subsumed into a larger state view, and were able to retain an independent outlook. For example, Maud Pember Reeves, author of a survey on maternal nourishment conducted by the Fabian Women's Group, commented:

At this moment any weighing centre, school for mothers, or baby clinic which does exist is fighting the results of bad housing, insufficient food and miserable clothing – evils which no medical treatment can cure.⁵¹

Very few MO'sH attempted to address social issues, and those who did, such as M'Gonigle with his work on nutrition and health in Sunderland, were marginalised by Government and by other MO'sH. A reading of contributions

⁴⁶ C Webster, *The Health Services Since the War, Volume 1, Problems of Health Care: The National Health Service Before 1957*, London, 1988, p.6, p.20.

⁴⁷ B Harris, 'Responding to Adversity: Government – Charity Relations and the Relief of Unemployment in Inter-War Britain,' *Contemporary Record*, 9, 1995, 529–561; J Lewis, *What Price Community Medicine? The Philosophy, Practice and Politics of Public Health Since 1919*, Brighton, 1986.

⁴⁸ Newsholme, *Last Thirty Years*, p.189.

⁴⁹ Lewis, *What Price Community Medicine?*, p.17.

⁵⁰ Welshman has suggested that this malaise continued after 1948, with failed attempts by MO'sH to tackle the issue of 'problem families'; J Welshman, 'In Search of the "Problem Family": Public Health and Social Work in England and Wales, 1940–1970', *Social History Medicine*, 9, 1996, 447–465.

⁵¹ M Pember Reeves, *Round About a Pound a Week*, London, 1913, p.229.

to the journal *Public Health* over these years backs up Lewis' arguments and does go some way to explaining the ultimate failure, not of state medicine, but of a Local Authority, preventative based model for care.

2.4: Conclusion:

Ideological debates over eugenics were significant in setting the context of the development of practical policy but appear to have little concrete impact over the development of services. The role of the state in medicine and welfare did become increasingly significant, but primarily at the local rather than the national level. Lewis' suggestions about the *ad hoc* nature of local authority policy and practise are supported by the situation on Sheffield, with little discussion evident of underlying policy aims. The inter-war years in particular demonstrated conspicuous general levels of consensus over welfare developments and a lack of ideological debate.

**An outline plan of Sheffield,
showing areas mentioned in the text.**

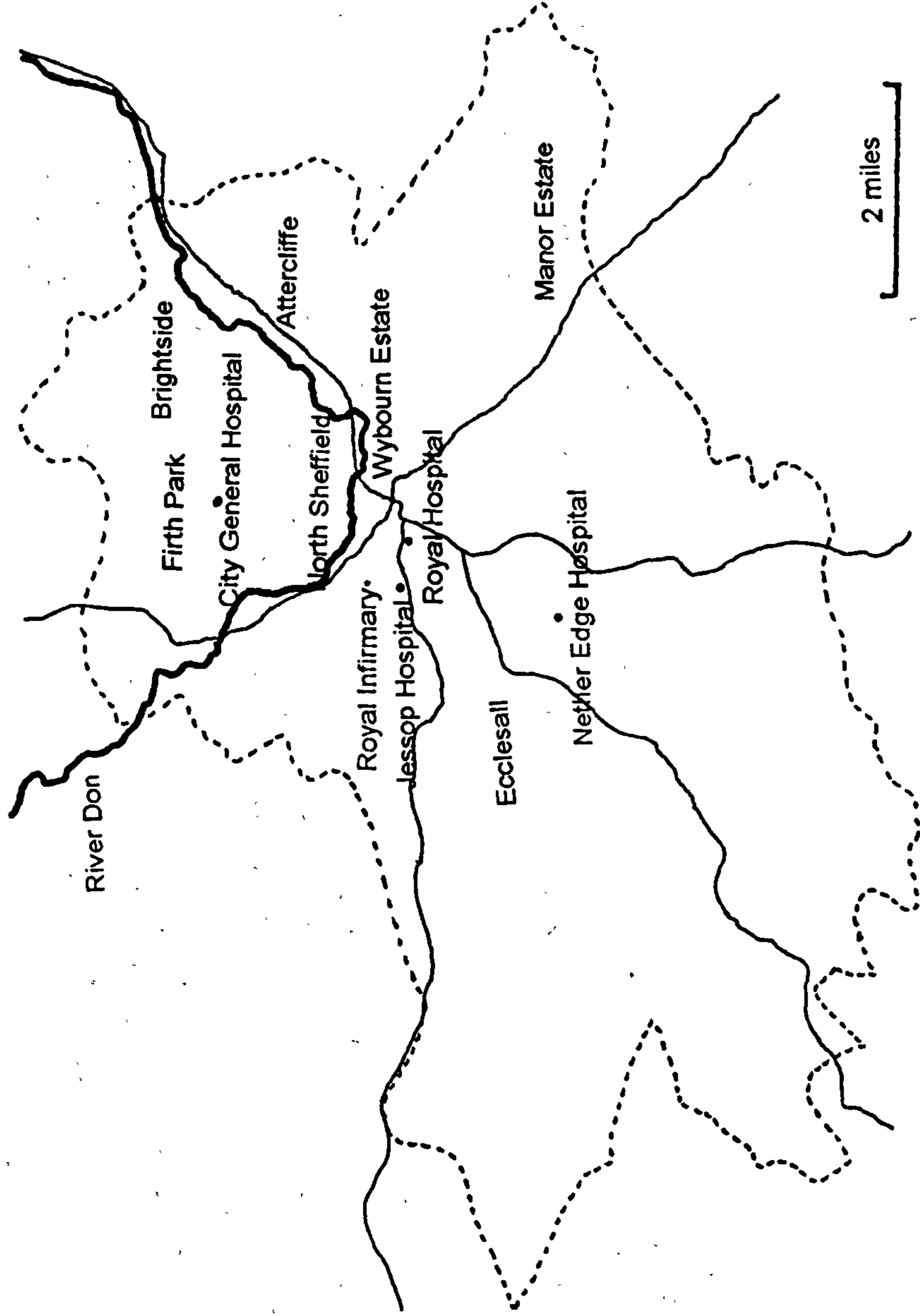


Figure 3.1

3: Society and Health in Sheffield.

3.1: Introduction:

The town of Sheffield is built chiefly of brick, and extends about a mile from north to south, and three quarters of a mile east to west: the atmosphere being so much impregnated with smoke, has given a dingy hue to the houses, which does not at all contribute to fix a favourable impression of the place on the mind of the passing tourist: the streets are sufficiently irregular and dirty; nor can Sheffield boast of its public buildings...¹

Under smoke and rain, Sheffield is suggestive of nothing so much as of the popular conception of the infernal regions. From the chimneys great volumes of smoke pour their listless way towards a forbidding sky...in the streets there is a substratum of dust and mud; in the atmosphere a choking something that appears to take a firm grip on one's throat. The aspect of the northern fringe of Sheffield on such a day is terrifying, the black heaps of refuse, the rows of cheerless looking houses, the thousand and one signs of grinding industrial life, the inky waters of river and canal, the general darkness and dirt of the whole scene serves but to create feelings of repugnance and even horror.²

Apart from the interval of years, little separated these two descriptions of nineteenth century Sheffield which, although housing a vastly expanded population, had not developed in service or stature.

Sheffield is an industrial town, situated on the south eastern fringe of the Pennine chain. The hilly aspect gave Sheffield its main initial natural advantage; fast flowing water courses which could be harnessed to provide power for mills. In its time Sheffield boasted flour mills, paper mills, and even a silk mill, but their chief local use was for the working of metal; primarily through the action of hammers and grind wheels. The area possessed other natural features which helped to make metal working, specifically that of iron and steel, its staple trade. There were local deposits of iron ore, together with abundant supplies of wood and coal to fuel the furnaces for smelting it.

By the 1870s coal remained the sole vital local element, with water power becoming redundant in the face of steam, and later electrical power, and top quality iron being imported from the continent, for working in Sheffield. The major steel works developing by this period needed space and good communications. They congregated in the only flat area of the town, to the

¹ SR Clarke, *The New Yorkshire Gazetteer or Topographical Dictionary*, 1828. Quoted in S Pybus *'Damned Bad Place Sheffield': An Anthology of Writing about Sheffield Through the Ages*, Sheffield, 1994, p.90.

² JS Fletcher, *A Picturesque History of Yorkshire*, 1899. Quoted Pybus, p.170

north east where the River Don flowed towards Rotherham and Doncaster. In contrast, the south and west of Sheffield, from where the Rivers Don, Loxley, Rivelin, Porter, and Sheaf entered, were no longer so vital. Instead of mills and industrial development, the wooded slopes of western Sheffield saw the growth of middle class suburbs, where the new steel magnates could live diametrically across the town from their plants and their employees.

Sheffield is very hilly, and although contemporaries remarked on the healthiness of the sloping suburbs, those low lying areas along the valleys appear to have experienced high morbidity and mortality rates. By the time the rivers reached the town centre, they tended to be a scene of some horror:

These rivers, that should water Sheffield so pleasantly, are polluted with dirt, dust, dung, and carrion...

Descending steep Bungay-Street, a region ominously called 'The Ponds' is found. A plank bridge over the Sheaf here shows dead dogs and cats floating on the slimy waters, and a terrible condition of the partially walled banks, through cutlets in which fluents of excremental slush ooze into the river.³

Sheffield's hilly terrain had the effect of splitting its suburbs into distinct units, each with a strong sense of local identity. The town exhibited a high degree of geographical separation on class lines by the late nineteenth century. The hilly terrain probably helped to cause this division, which as time went on became self-perpetuating. Generally speaking, the middle classes, a relatively sparse group in Sheffield, lived in the western and southern suburbs. Those engaged in the cutlery and allied trades still tended to live in the centre of the town. Workers at the big new steel plants were settling in the new housing appearing around the factories in the north east.

The physical terrain and residential divergence evident in nineteenth century Sheffield both had an effect on the health of the town, and the means by which problems were tackled.

3.2: Industrial Development:

Sheffield experienced two main periods of industrial change and population explosion. The first was at the end of the eighteenth century, the period of the classic 'industrial revolution'. Up to this time, Sheffield had been primarily an importer of steel, which was then used in its edge tool trade. The eighteenth century saw the emergence of cementation furnaces in the region, for creating blister steel from iron. When hammered, this steel was of

³ 'Condition of Our Chief Towns - Sheffield.' *The Builder*, 19,1861, 641-643.

sufficient quality for the production of cutlery and other tools. The development of crucible steel making, invented by local watchmaker Benjamin Huntsman in 1751, also helped to turn Sheffield into a major steel making, as well as steel using, town.

In the nineteenth century, Sheffield experienced a second surge in population which corresponded to the growth in its heavy trade industry. This period, from around 1850 to 1870, was perhaps the time of Sheffield's major industrial revolution, with huge steel making plants transforming the industry of the town and its labour market. Up to this point, the light finishing trades provided most of the employment in Sheffield for individual or small workshop concerns. These trades, particularly cutlery, edge tools, and medical instruments, continued, and the town's reputation for these products remained high. However, it was the growth of the heavy steel industry, initially in railways but later in armaments and ship building, that resulted in huge factories appearing in the north east of the town. The half mile wide flat stretch of land in the lower Don valley was where Charles Cammell sited his Cyclops Works in 1845; Spear and Jackson's *Ætna Works* and Firth's *Norfolk Works* soon followed. These changes led to a steep rise in population, much of it through in-migration, and associated changes in housing and civil development. In retrospect this 'golden age' of Sheffield industry seems very transient. Largely created to fuel the railway boom, the steel making plants expanded successfully into ships, guns and later, tanks. They developed armour plating and the ordinance to breach it. In the fifty years from 1870 to 1920 Sheffield prospered primarily on war, or the threat of war.

Iron and steel are the basis of armaments, and an expansion of the industries producing them has always followed the outbreak of hostilities in modern times. The great war was by no means exceptional in this respect... During its course the Sheffield armaments firms greatly increased their productive capacity, and large numbers of ordinary engineering and steel works were converted to the production of munitions.⁴

Sheffield had experienced several severe trade depressions in the years before the First World War, although unemployment always appeared to be of a temporary nature, with resulting upswings compensating for the hardships suffered. The war, however, was a time of massive employment opportunity in Sheffield, following several lean years, and fuelled by the armament boom. This period saw a huge increase in production assisted by

⁴ ADK Owen, *A Report on Unemployment in Sheffield*, prepared for the Sheffield Social Survey Committee, Sheffield, 1932.

considerable in-migration of labour, and the major movement of women into the work force. Prior to this, female employment in Sheffield had been low, representing only about 10% of the female population in 1910. Employment opportunities were centred chiefly on the traditional female occupation of service, although even this opening was smaller in Sheffield than in some other cities due to the relative paucity of the servant employing class. As far as the metal trades were concerned, most women were employed in finishing; primarily the buffing of metal articles. This work was dirty and the women thus engaged had a reputation for being somewhat 'fast'. As early as 1839, a local doctor, George Holland noted that:

...experience must furnish statistics of the inevitable results of good trade; the means which it affords for dissipation, idleness and profligacy, and the effects of these on individuals and society; the irresistible temptation which it offers to young females to discard the smooth and even tenor of domestic duties, for the licentious freedom of the shop, and its higher remuneration. The consequences flowing from this change; immorality, early marriages and their attendant evils, children and an ignorant mother.⁵

This reputation was probably due primarily to female workers being young single women, since the proportion of married women working in Sheffield was almost negligible. During the war this pattern changed, with married women in particular moving into employment. This shift was a temporary one, however, and, as Owen, a social commentator noted, Sheffield experienced a sharp depression in 1918–19 as firms shed wartime employees:

...this number included a great many women, who were gradually re-absorbed into domestic life now that the wartime demand for their services no longer existed.⁶

The production levels reached during the war were obviously exceptional, and the eventual decline of Sheffield's status could be traced back as far as 1879 when Gilchrist Thomas invented the 'basic' process, which allowed the removal of phosphorous from steel. Iron with a high phosphate content was common in Britain, but until this time it was largely useless for quality steel making, and it was for this reason that most iron ore used in Sheffield came from Sweden. After 1879 all grades of iron could be used, resulting in a partial shift of the British steel industry to Cleveland and

⁵ G Holland, *Moral Social and Intellectual Condition of the Industrious Classes of Sheffield*, part I, London, 1839, p.21.

⁶ ADK Owen, *A Report on Unemployment in Sheffield*.

Wales, and in particular allowing the huge iron reserves of the USA and Germany to be worked. This in turn led to the development of steel industries in these countries, and the consequent slump in demand for Sheffield steel⁷.

From the last quarter of the century onwards Sheffield experienced frequent trade slumps of increasing severity, which had a major impact on the town, since they intensified demands for social welfare measures from local government. Not only did charities seem less and less capable of meeting needs adequately, there was also growing support in the belief that good workers deserved assistance of a non stigmatising kind in periods of temporary hardship.

For most of the nineteenth century, it had been to the craft unions in particular that workers looked in times of hardship, rather than the Council or the Poor Law authorities, since Sheffield was a heavily unionised town. Some processes had powerful unions, including the grinders, who boasted ten different specialised unions in 1861. Smith has pointed in particular to the antipathy of workers towards the New Poor Law⁸. In 1848 the Filesmith Union paid out £4000 in six months to its members rather than see them on the parish. Another way of dealing with the problem was to put men to work on union owned farms (i.e. edge tool grinders, and Britannia metal smiths), or to employ large numbers of men on part time work, rather than see people laid off completely⁹.

Slumps in 1873–9, and 1884–7 prompted the creation of Mayor's Relief Funds to collect and distribute aid beyond that available through trade unions or the Poor Law. In the slumps of 1903–05 and 1908–10 the Council tried to provide work for at least some of the unemployed. However, although large sums of money were spent on relief work, including £80,000 in 1908–10, there were complaints about its token nature; employing men for a maximum of 16 weeks, sometimes for as little as 2d per hour for stone breaking. Accurate figures for those affected by these slumps are impossible to come by, although qualitative evidence points to the hardship suffered, particularly in the winter months.

The employment boom in Sheffield, sustained by the demands of the war, broke dramatically in 1921. In mid-1920 the total unemployment in Sheffield was about 5,000. It climbed throughout the next 12 months, rising from 25,500 in March 1921 to 59,100 in April. A coal strike that summer saw the numbers of registered unemployed reach their high point at 69,400. The

⁷ KC Barraclough, *Sheffield Steel*, Sheffield, 1976.

⁸ D Smith, *Conflict and Compromise: Class Formation in English Society 1830–1914. A Comparative Study of Birmingham and Sheffield*, London, 1982.

⁹ The big new steel firms were not unionized to the same degree.

total hovered around the 40,000–50,000 level throughout 1922, and began to drop only in 1923. However, even during the 'good' years, which excluding a figure of 44,000 at the time of the general strike in 1926, lasted until the final quarter of 1929, there was an irreducible core of about 25,000 unemployed. Their numbers climbed steadily throughout 1930, reaching 62,300 in August 1931. The peak was steady until early 1934, when unemployment began very gradually to drop away again. The figure rarely fell below 20,000 until rearmament began in earnest in 1939. Even in July 1940 when the last monthly figure for Sheffield was calculated, there were still 6,100 unemployed in the City.

Interpretation of these figures is not simple, particularly given the rapid movement on and off the Register by many workers, and the invisible numbers of uninsured people affected. However, some light is shed on the situation by a survey into unemployment conducted in 1932 by the Sheffield Social Survey Committee¹⁰. ADK Owen, the author of the report, commented in the first draft that:

Although there are several areas in the country to-day where unemployment is more widespread than it is in Sheffield, there is no other large town, with the possible exception of Glasgow, which has suffered so chronically since the War from this scourge of social life. There have never been less than 20,000 people out of work in Sheffield at any time since 1921, and for a long period now there have been over 40,000 persons unemployed.¹¹

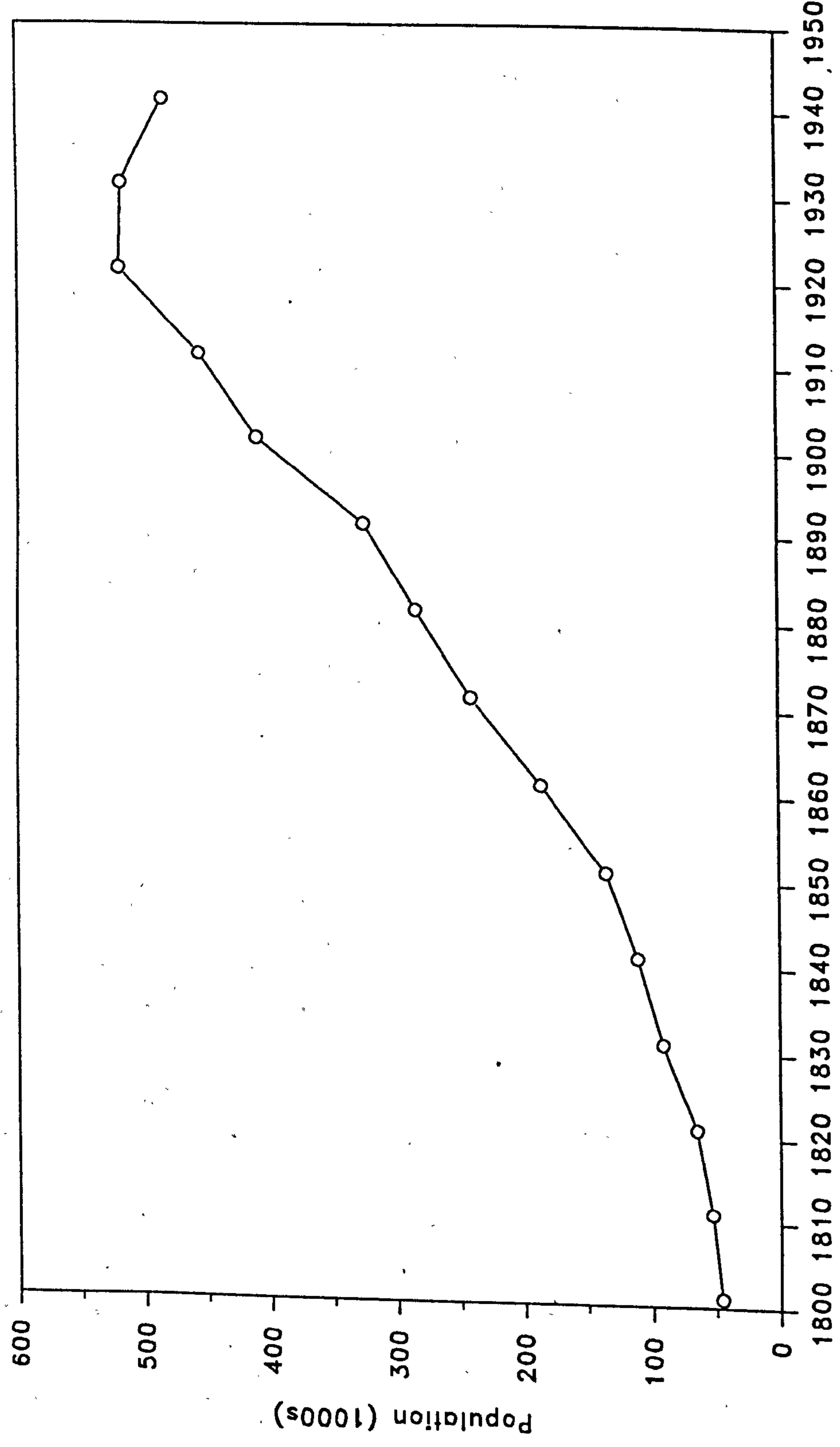
His survey of the problem in December 1930, found that 60% of those registered were wholly unemployed, and the remaining 40% temporarily stopped. 57.2% of all unemployed men were working in engineering, iron, steel and light metal trades. They were also responsible for over 80% of those temporarily unemployed; 'This is largely explained by the prevalent practise of short time working in these industries', '...the whole personnel of firms spent about 3 days at work and 3 days on the unemployment register each week.'¹² This bears out Pollard's view that *under* employment was a

¹⁰ The Sheffield Social Survey Committee was founded in 1928, and produced reports on subjects ranging from housing to children's matinees at the cinema. The Town Clerk was its Treasurer, and it employed Owen as its full time Secretary, with the hope of 'stimulating the forces of civic pride and civic shame' and fostering a sense of community in the city. The surveying stopped in 1933 when the organisation ran out of funds. see: ADK Owen, 'The Social Survey of a City', *Social Service Review*, 1930, 186–191.

¹¹ ADK Owen, *The Unemployment Problem in Sheffield*, manuscript, 1931

¹² Owen, *The Unemployment Problem in Sheffield*.

Total Population of Sheffield, 1801-1941



Year

Figure 3.2

Source: MOH Reports, Sheffield

chronic feature of Sheffield life, particularly in the 1920s and 1930s, and must have had a detrimental effect on the life and health of the whole family¹³.

Nearly 75% of the unemployed men surveyed in 1930 were out of work for periods totalling over 12 months in the previous 5 years; 28.8% totalled more than 3 years of unemployment in this period. Owen commented:

It is clear from these figures that the unemployment register is not made up of a shifting personnel to the extent that is sometimes alleged, but that it is largely made up of old standing cases. Unemployment is chronic in Sheffield not only in so far as the total number of unemployed remains high, but in so far as the burden rests persistently upon the same human shoulders.¹⁴

The unemployed had 49,330 dependants in all, including 29,370 children. Owen suggested that '...we reach the huge total of about 100,000 persons directly affected by the unemployment problem at the time when this investigation was made...'¹⁵ Part of the work of this study will be to attempt to trace the effect of such dislocation on infant and maternal mortality, and to ascertain how far industrial conditions influenced the various peaks and troughs in mortality figures. It is also significant for the financial impact it had on Sheffield, and the brake this put on potential schemes of welfare.

3.3: Social Development:

Sheffield's development as a major industrial centre, and its consequent population expansion, came relatively late in the century. Its population in 1801 was 45,755, and by 1821 had grown by nearly 20,000. Between 1851 and 1871, however, the population grew by over 100,000 (*Figure 3.2*)¹⁶. This was the period that saw the development of big steel and iron works in the north east of the town, away from the fast flowing rivers that had supplied the power for the workshops of the 'little maisters'. Sheffield was incorporated as a Borough in 1843, but did not achieve City status until 1893, relatively late in its period of growth and success, and perhaps indicative of the weakness of its local government.

Speaking at the annual meeting of the British Medical Association (BMA) in 1876, a local physician, Martin de Bartolomé, drew attention to some of the changes in Sheffield by comparing the town of 1845, when the Association last held their annual meeting there, to that of 1876:

¹³ S Pollard, *A History of Labour in Sheffield*, London, 1959, p.251.

¹⁴ Owen, *The Unemployment Problem in Sheffield*.

¹⁵ Owen, *The Unemployment Problem in Sheffield*.

¹⁶ JM Furness, *Record of Municipal Affairs in Sheffield*, Sheffield, 1893.

...the town occupied less than one fourth of its present area; it contained less than one third of its present population...it was entirely devoid of the numerous beautiful and elegantly appointed villas and pleasure grounds which now so lavishly surround it upon almost every side. The working population were pent up within the very narrow limits of the town itself, and the various branches of the cutlery and other trades were carried on in small ill-contrived and inconvenient premises...but nowadays all this is changed; large and commodious buildings, in many cases of classical dimensions, have been erected by both companies and individuals who employ large capitals, and the 'little maister' of former epochs is almost a thing of the past. Everyone who can do so gets out of the town, and the result of this thinning of the urban population has been a most wonderful improvement in the health of the district.¹⁷

In the above comparison, de Bartolomé encapsulated many of the developments which had made Sheffield one of the most successful and populous industrial towns in the country by the 1870s. Despite all that had changed, however, much of the life of the town remained unreconstructed, and the physical state of the town, including its housing and health, were sources of criticism. In contrast to the partisan view of a local commentator, many visitors to Sheffield also continued to remark on its shabbiness and apparent lack of civic pride; it did not possess a purpose built Town Hall, that potent symbol of Victorian municipal pride, until 1897.

Sheffield is too busy a bee-hive of modern industry to be beautiful...of stern nineteenth century utility rather than of beauty, of modern usefulness rather than of historical antiquities, there is little in Sheffield that attracts the eye as one moves about the streets...The prevailing characteristic of the place is utility – stern, hard and practical.¹⁸

The changing industrial situation, and allied growth in population, brought considerable challenges to the rulers of the town. In comparison to the intense locality of the unions, and the regional or national outlook of the big landowners or industrialists, the Town Council seems to have attracted relatively little support or influence. Dennis Smith, who has analysed class relations in Sheffield between 1830 and 1914, has argued that it had a very weak local government structure because of the corresponding weakness of the professional middle classes who would have been most likely to fill

¹⁷ 'Presidential address to the annual meeting of the BMA 1876'. Quoted in *BMJ*, i, 1876, p. 169. M. Martin de Bartolomé, was the Senior Physician to the Sheffield Royal Infirmary.

¹⁸ JS Fletcher, *A Picturesque History of Yorkshire*, 1899, quoted in Pybus, p.173.

municipal posts¹⁹. He has argued that until the 1870s, when major manufacturing concerns began to burgeon in Sheffield, there was no commercial or professional group able to challenge the dominance of big land owners such as the Duke of Norfolk. Indeed, Smith has suggested that the governance of the town was conducted on minimalist lines, although involving a multiplicity of bodies, such as the Town Trustees, the Council, and the Poor Law Guardians, with overlapping functions. Not until 1864 did the Council manage to take control over highways or improvement. In addition, the Council did not manage to acquire the local water company until 1888 despite the latter's unpopularity as a result of its responsibility for the 1864 Dale Dyke disaster, and its implication in lead poisoning scares in the 1880s²⁰. Failures such as these on the part of the Council meant that until the last decade of the century the town could not possess a coherent strategy for health, public order or development, even if it wanted to, as it simply did not possess the necessary power or respect.

...although Sheffield possesses a medal of honour conferred at the hands of the Emperor of the French, it is as devoid of the decencies of civilisation as it was in the Dark Ages.²¹

Smith has suggested that the weakness of the Council was reinforced by antagonism between worker and employer, fuelled by the size of the new factories and their residential separation²². However, in his discussion of the political polarisation of the north east and south west of Sheffield, Smith has perhaps overstated his case. Many of those involved in the light trades in the centre of the City and the north west retained their independent liberal outlook. The central Sheffield ward of St Philips returned Conservative councillors to all of its three seats between 1901 and 1919. The working class Conservative vote was assiduously pursued by the *Sheffield Telegraph* under the editorship of William Leng. Even the radical areas of Brightside and Attercliffe were obviously attracted to Conservatism; partly because of protectionist policies, and partly because of the support it demonstrated for the spending on armaments, an essential part of Sheffield's industry ²³. In the 'Khaki' election

¹⁹ Smith, *Conflict and Compromise*; H Mathers, 'The City of Sheffield, 1893-1926', in Binfield *et al*, *History of Sheffield*, vol 1 *Politics*, Sheffield, 1993, 53-83.

²⁰ The Dale Dyke was a reservoir in the hills north west of Sheffield. It burst on 11th March 1864, with the resulting flood destroying 798 properties and killing 270 people.

²¹ 'A Further Review of Blots on Sheffield.' *The Builder*, 19, 1861, 675-677.

²² Smith, *Conflict and Compromise*, p.245; S Pollard, 'Labour', in C Binfield *et al*, eds., *The History of the City of Sheffield, 1843-1993*, in 3 vols., vol 2 *Society*, Sheffield, 1993, p.260-278.

²³ Smith, *Conflict and Compromise*, p.243.

of 1900 Brightside went Conservative; the Party took four of the five seats in Sheffield.

Up to 1900, both employers and employees supported institutions such as hospitals through direct charitable donations or subscriptions. Smith has claimed that the involvement of the Council in social projects, including slum clearance and sanitary reform, did not begin until after 1903 when the Sheffield Labour Representation Committee (SLRC) was formed and began to exert pressure on the authorities. He suggested that '...the decisive pressures emanated from the development of class conflicts in the industrial sphere'²⁴. Again, this seems to overstate the case. The first slum clearance project started in 1893 in the notorious Crofts area of the town and the conversion of privy middens, which were a recognised source of ill health, to water closets began in 1894, albeit slowly. The Council seems to have lacked, partly the political will to act, but also the capacity to spend money. It was also up against the vested interests of landowners such the Duke of Norfolk, and the newly rich in the west of the town.²⁵ Mathers has commented that; 'After 1905, partly because of the campaigns of rate payers associations, economy had become uncontentious – it was the motto of the Sheffield corporation and had permeated both parties.'²⁶ Until their defeat in 1901 the Conservative group had held power in Sheffield since 1883, and been the party of radical policies, including the municipalisation of utilities, compared to the Liberals who were more of a loose alliance than a party. However, after 1901 it was the Liberals who became the reforming group, partly in response to the rise of Labour, who won their first three Council seats in 1905. Labour in Sheffield did not become a force until the 1920s, gaining its first Council majority in 1926 on the crest of support for the General Strike and the troubles of the early 1920s. Demonstrations by the unemployed had become a ritual in the spring and summer of 1921–22, with social and political polarisation becoming particularly acute after a police baton charge outside the Town Hall in August 1921²⁷.

²⁴ Smith, *Conflict and Compromise*, p.242.

²⁵ There was much opposition to a council proposal to built an estate for workers at High Storrs in the west of the town in 1899. Fears were expressed by residents that '...the persons who would be accommodated would go to the public house and create a disturbance.' (qu. SM Gaskell, 'Sheffield City Council and the Development of Suburban Areas Prior to World War One', in S Pollard and C Holmes, eds., *Essays in the Economic and Social History of South Yorkshire*. Sheffield, 1972, p.187–202: Original in *ST* 19/11/1899) The scheme was eventually dropped in favour of new building at Wincobank which was in the north east.

²⁶ H Mathers, 'The City of Sheffield, 1893–1926', in Binfield *et al*, *History of Sheffield*, vol 1 *Politics*, p.57.

²⁷ Mathers, 'The City of Sheffield, 1893–1926', p.72–74.

The impetus for the Council to become more involved in local social problems seems to have resulted from a build up of pressure in several areas, including labour groups, health professionals, the Medical Officer of Health (MOH), and the effect of national concern over issues such as unemployment or infant mortality. That it was desirable for the Council to become involved in the social life of the town was not itself without controversy at this time. There were those who believed that change had to come from the individual worker, with help only from charities filtered through the Church of England or the Guild of Help. Sheffield was quite liberally served by charities particularly with regard to family life, and the majority of them do appear to have worked effectively in tandem with the Council. Co-operation with the Poor Law Guardians, and even the voluntary hospitals also appears to have been quite high in Sheffield. This is perhaps the area where the small numbers of people involved in these types of organisations actually became a positive point, since it allowed for greater personal contact and understanding. In many the same people served in different capacities; in the early years of the twentieth century, Wycliffe Wilson was ex-Lord Mayor and an Alderman, but also chairman of the Sheffield Board of Guardians.

Health and housing were two of the most potent problems, and both were treated with initiative by the Council but, in the period under discussion, with little practical effect. The scale of effort needed to make an impact on, for example housing, was vast and at this stage the Council had neither the resources or the philosophy to follow its tentative policies through to their logical conclusion and undertake an extensive building programme. Even so, attempts to address the issue in Sheffield went further than in most other cities outside London.

Sheffield Corporation started to try and make an impact on the town's housing problems after the 1890 'Housing of the Working Classes Act', which gave local authorities the right to build on and manage land as well as to clear slums.²⁸ Pollard has suggested that although the Council was still unwilling to tackle housing problems, mainly on the grounds of cost, the Act had strengthened the hand of the MOH who now had the power to condemn property. The Corporation attempted to deal with the Crofts area in North Sheffield in 1894, but it took until 1907 to complete the project, at huge cost. Even then the scheme was not considered satisfactory because the small physical area of the inner city site, five and a quarter acres, meant that the new building had to be in flats, in order to provide sufficient housing for those moved out of the original slums. However, the high cost of the scheme,

²⁸ [53&54 Vict.c.70]

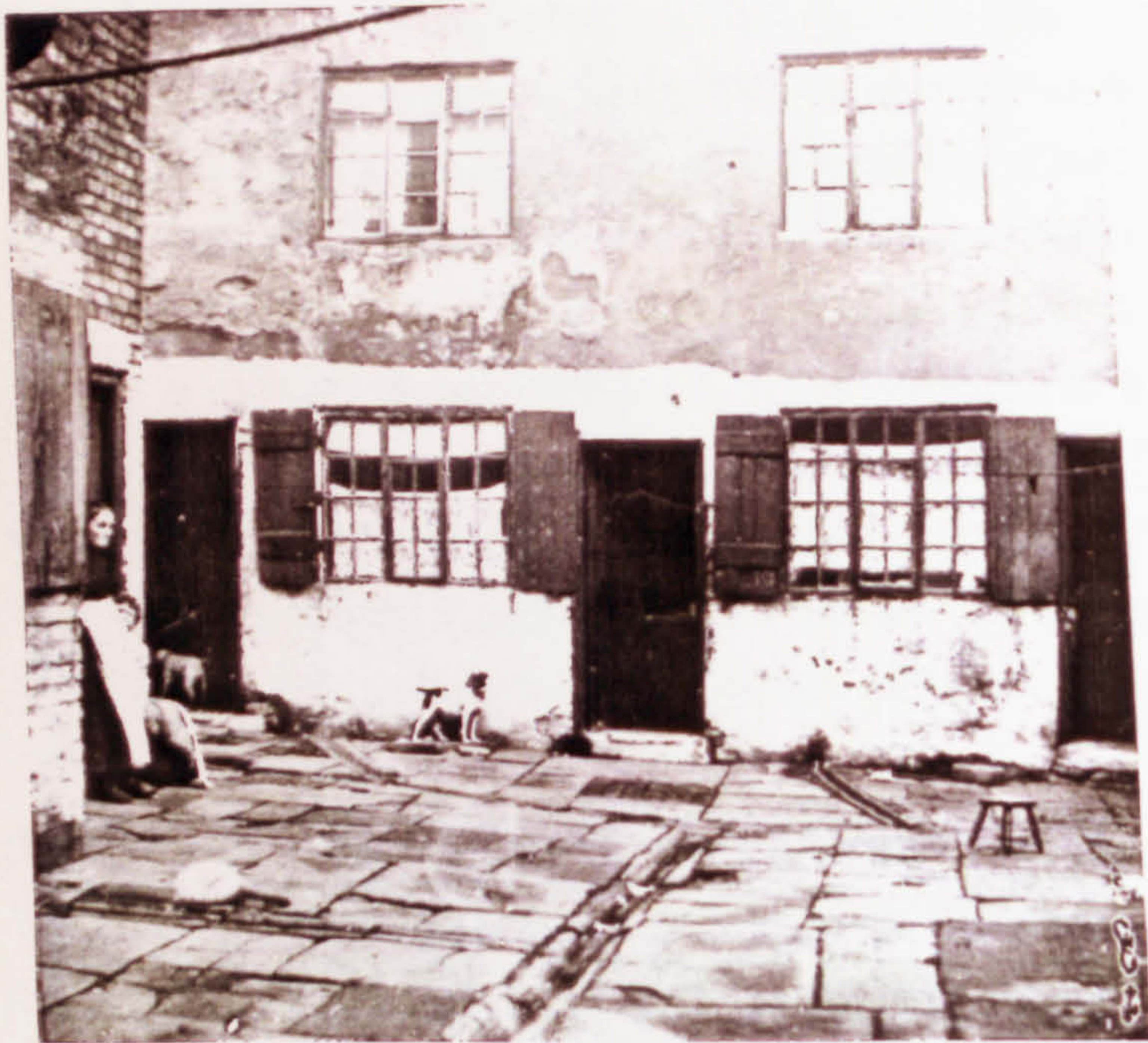


Plate 1. Bailey Lane, North Sheffield, c. 1905, showing two houses and the inner courtyard.



Plate 2. New development on the Crofts site, completed 1907, replacing the type of housing shown above.



Plates 3 and 4. Cottage-style housing on the housing estate at Wincobank, built c. 1910.

including the extortionate price paid for the site, had to be recouped and meant that the rents charged for the new dwellings were such as to put them out of the range of the tenants originally displaced. It was decided in future to build on new land, rather than try to provide suitable housing on slum clearance land²⁹ (*Plate 1* and *Plate 2*).

Land bought by the Council at Wincobank in the east of the City was used to build working class dwellings, although the scheme was not without problem. As it was felt that the rental of such housing should not be subsidised by the rates, rents charged meant that in practice only those in secure employment with good wages could afford to live in the two and three bedroom houses being constructed³⁰. Houses for rental at 7 shillings a week could not answer the needs of the very poorest in the City, yet even the building which did occur was politically controversial. Nationally, there were fears that municipal involvement in housing (or indeed in other areas of investment) would reduce the amount of capital available for private investment. Locally, the Conservative group on Sheffield Council voiced the same criticisms, and after its victory in the 1908 municipal elections, recommended the leasing of the remaining land at Wincobank to private developers. As Martin Gaskell has pointed out, housing policy split on party lines in Sheffield, although the national parties had no clearly defined policies on the subject. Conservatives preferred central flat building such as in the Crofts area, whereas Labour and the Liberals advocated suburban cottages with space for gardens³¹ (*Plate 3* and *Plate 4*).

By 1914, the Council owned a total of 578 houses and flats. Only 58 had a rental of below 5 shillings a week. Given the 16,000 occupied back-to-backs and the estimated 8,000 extra houses unfit for human habitation, it could be seen that, despite the expense and controversy generated, the Council's building programme had made very little impact on the housing problem in Sheffield. Yet the Wincobank scheme in particular had attracted the interest of national garden city movement, a sign that local initiatives could have an impact on national opinion, and eventually policy.

In 1920 it was estimated that at least 20,000 new houses were required to ease the overcrowding which had built up during the War. Through various

²⁹ AM Craven, 'Housing Before the First World War', in Binfield *et al*, *History of Sheffield*, vol 2 *Society*, 65-75

³⁰ Wages for skilled workers in Sheffield at this time were very good; earnings of up to 75/- per week could be made in the light trades, with the average being 40/-, although they could go as low as 16/-; Pollard, *A History of Labour in Sheffield*, p.209.

³¹ SM Gaskell, 'Sheffield City Council and the Development of Suburban Areas Prior to World War One', in S Pollard and C Holmes, eds., *Essays in the Economic and Social History of South Yorkshire*. Sheffield, 1972, 187-202.

central government Acts, and the commitment of the Labour group on the Council, 16,000 houses had been built by 1931. In the year of greatest productivity, 1926–27, 2714 houses were built, of which 1752 were local authority³². By 1931 there were 9292 council houses in Sheffield, mainly concentrated on big new estates.

A study was conducted by the Sheffield Social Survey Committee in 1931 of the effect on peoples lives of movement from central slums to new estates. The main finding was that although in general people preferred their new housing and felt their families were healthier as a result, 35% of families returned to inner city 'slum' dwellings. ADK Owen, the author of the report, suggested that the two main reasons were economic and social. New homes, however generously subsidised, were more expensive to rent than old ones; 66% of tenants paid less than 7/- before removal, and on the new estate they paid 10/6 for a three bedroom house³³. Bigger houses also meant that more was required in the way of basic furnishings, including floor coverings and curtains. These expenses, if they did not lead to removal back to slums, did result in a drop in the standard of living due to increased living costs³⁴. This was at a time of high unemployment and falling wage rates. Wage rates in the light trades, for example, fell from 50/- per week in 1928, to 41/- in 1931; the heavy trades were similarly affected³⁵.

The Wybourn Estate which was the focus of the survey, stood on a hill overlooking Attercliffe, and was felt by residents to be colder, and therefore more expensive to heat than central homes. New estates outside the city also meant higher food and transport costs; all features exacerbated during the period of the survey by the fact that nearly 40% of breadwinners on the estate were unemployed. Lack of money meant that modern resources such as baths were under used; these in general appear to have been reserved for children³⁶.

As Gittins has pointed out, council house building proscribed an acceptable limit on family size to a considerable degree³⁷. Space for internal bathrooms and toilets meant reduced living and bedroom space.

³² ADK Owen, *A Report on the Housing Problem in Sheffield*, Sheffield Social Survey Committee Pamphlet no.2, Sheffield, 1931, p.17.

³³ Owen, *A Report on the Housing Problem in Sheffield*, p.36.

³⁴ This finding was also recorded by Dr GCM M'Gonigle, the MOH for Stockton-on-Tees; quoted in JM Winter, 'Infant Mortality, Maternal Mortality, and Public Health in Britain in the 1930's', *Journal European Economic History*, 8, 1979, 439–62; p.461.

³⁵ Pollard, *A History of Labour in Sheffield*, p.303.

³⁶ Owen, *A Report on the Housing Problem in Sheffield*, p.41.

³⁷ D Gittins, *Fair Sex: Family Size and Structure, 1900–1939*, London, 1982, p.51.

Overcrowding still occurred on 12.5% of homes on the Wybourn Estate; including one where the bath was used as a bed due to lack of space³⁸.

Owen described the social isolation felt by many of those moving out of the city:

For their closely congested courts they have in exchange a windy hillside, sparsely spread houses and the old social intimacy of the doorstep broken by the unwanted gardens.³⁹

This is likely to have been particularly acute for women with young families. There was a major political storm in the 1930s over the difficulties pregnant women and mothers from new estates had in getting to the central welfare clinics, and there were calls for the development of estate based services. Despite the problems, slum clearance and the concomitant development of new estates continued to be seen as a good thing in Sheffield; by 1938 24,000 slums had been cleared of which 44% had been replaced with new dwellings, the highest rate in the country.⁴⁰

Although working class housing did not start to become an issue until the 1890s, the 1860s and 1870s were the peak years for the building of middle class villas in southern and south western Sheffield. Thereafter trade slumps reined in the conspicuous consumption which had led to steel entrepreneur John Brown reputedly spending £100,000 on Endcliffe Hall in the 1860s. Doe has suggested that the mansions of the wealthy steel magnates served functions similar to the country house of the landed gentry, and were expected to display similar facilities. If it was true that they '...set the seal on the rise of the middle classes', then it was of only a particular sector; the commercially rich. The professional middle class in Sheffield, including the medical community, was not wealthy enough to compete at this time and their influence remained secondary to the likes of Brown, Firth, and Jessop.⁴¹ It was from these big houses, together with middle class villas of lesser grandeur, that subscriptions to local charities came, including the voluntary

³⁸ This was according to the 'Manchester' standard which required separate bedrooms for both sexes, unless they were a couple, and also defined overcrowding as more than 2.5 people per bedroom. By this standard, slum dwellings gave a rate of 53.4%. Owen, *A Report on the Housing Problem in Sheffield*, p.45.

³⁹ Owen, *A Report on the Housing Problem in Sheffield*, p.39.

⁴⁰ However, 75% of the central area was still condemned in 1938: ADH Crook, 'Needs, Standards and Affordability: Housing Policy After 1914', in Binfield *et al*, *History of Sheffield*, vol 2 *Society*, 76-91.

⁴¹ V S Doe, 'Some Developments in Middle Class Housing in Sheffield, 1830-1875', in Pollard and Holmes, *South Yorkshire*, 174-186.

hospitals. Those involved in all types of philanthropic work in Sheffield actually came from a very small class and geographical base.

Control over, and development of, transport in Sheffield also had an impact on the way the City grew, and on housing and health policies. For much of the nineteenth century, Sheffield was served somewhat imperfectly by its transport system. The Town Council formed in 1843 found it had little control over the eighteen turnpike trusts which covered the entry routes to the town, and although it began to abolish toll bars in 1852, the final one was not removed until 1884. However, as far as transport within Sheffield was concerned, it was the development of the tram network which had the greatest impact. The first line opened in 1873 on track built by the Council, but with horse drawn vehicles operated privately. The earliest routes ran from the town centre out to the new industrial and residential areas of Attercliffe, Carbrook, and Brightside. The Council took over the running of trams in 1896 when the service still consisted of only nine miles of track. The trams received considerable levels of investment, with the introduction of electric trams in 1899, and a huge extension of the network to encourage, and then service, new suburban housing. Thus, control of one of the City's major transport services gave the Council opportunity for social engineering, and had a considerable effect on housing and health policy. Cheap fares meant that employees could be housed at greater distance from their work, and in particular encouraged the movement of people away from the oldest and most unhealthy districts in the centre. This in turn allowed the incorporation into the City in 1901 of newly developing areas such as Hillsborough and Norton.

Controversy over housing and transport policy illustrates some of the tensions and challenges that a rapidly expanding City such as Sheffield had to cope with. They were also important factors in the health of the town. 'Public health' should not be viewed simply as local authority attempts to address problems of sanitation. Other factors, including housing, poverty and employment affected how citizens viewed their lives and their health, and discussions of 'public health' should embrace these. There is also an argument that ideas of personal sanitation and health were passed from middle to lower class in this period. Reid has suggested that one of the ways that inter-class conflicts were resolved was through the 'pursuit of respectability', allowing the middle class and a large section of the working classes, to develop a common ideology⁴². She has argued that the potent division in the City was between 'rough' and 'respectable' rather than between

⁴² C Reid, 'Middle Class Values and Working Class Culture in Nineteenth Century Sheffield: The Pursuit of Respectability', in Pollard and Holmes, *South Yorkshire*, 275-295.

classes as such. Thus many of the poorest working class could still be 'respectable' if sober, thrifty family people. These distinctions do appear repetitively in the reports of local charities, and their middle class volunteers, and the divisions was relevant to those distributing alms.

Most of the labour which fuelled the rapid expansion of factories such as John Brown's Atlas Works, which increased from 200 men tending 6 puddling furnaces in 1858, to 2500 men manning 60 in 1863, was not local. The men pulling out the crucibles of steel at the Norfolk Works in 1867 were described as '..veritable giants, not town bred men but the very pick of agricultural size and strength of limb and muscle.'⁴³ Reid has argued that the rural immigrant would have been among those needing to seek a new ideological structure for his life, in the unfamiliar urban situation. 'Respectability' in a period of uncertain employment and wages was a potent stabilising force. The picture was probably more complicated than Reid's comment that respectability was:

...a system of values prescribed *by* the middle classes *for* the working classes, and acquiesced in by deferential elements within the working classes.⁴⁴

The working classes would have taken on its values out of more than mere deference. Although middle class writings moralising on the state of the workers seem very patronising, it is obvious that values including clean sober households were important to many in the working classes, especially women. In the absence of employment to give them status, they relied on the opinion of others to mark their social position. 'Respectable' was a term which gave them a positive status. Reid regards the concept as a tool of social control, consciously used by a united middle class to keep working class culture and power at bay. This suggests that, contrary to her assertion, there was a highly developed class structure in Sheffield. However, although it is tempting to view the situation in these polarised terms, the working class retained considerable autonomy, and were capable of accepting, or rejecting, concepts and values as appropriate. Thus in the area of maternal and child welfare, working class women took up that which was useful to them, such as the baby clinics, and rejected those values with which they did not agree, including strictures on abortion.

⁴³ *Sl* 1/1/1867. quoted in NP Howard, 'Cooling the Heat. A history of the Rise of Trade Unionism in South Yorkshire Iron and Steel Industry from the Origins to the First World War', in Pollard and Holmes, *South Yorkshire*, 59-73.

⁴⁴ Reid, 'Middle Class Values', p.281.

3.4: Health in Sheffield:

This section looks briefly at the development of Sheffield's health care structures, including its hospitals, Poor Law, and the Council Health Department, and outlines the problems and possibilities faced with regard to maternal and infant welfare.

3.4a: Medical Institutions:

Sheffield was something of a late developer as far as its medical life was concerned as the town did not get its first hospital, the Royal Infirmary, until 1797 and a dispensary was not opened until 1832⁴⁵. This reflected the fact that Sheffield was still a relatively small town at this time.

A medical society had been started in 1841, but folded in 1867 through lack of interest. At its close it boasted only thirteen members, and three of these never attended, with the average number of members at a meeting being four⁴⁶. The previous year Dr Aveling, a local GP and founder of the Sheffield Hospital for Women, in addressing the School of Medicine, had in fact complained about the lack of professional fellow feeling among doctors. Such a situation could be viewed as a failure by doctors to unite, and to see their potential as a powerful 'profession'. This was obviously what Aveling was suggesting, given his strictures on quacks, druggists, and an unappreciative working class in the same paper. However, given that the Medical-Chiurgical Society started in 1869, only two years after the demise of its predecessor, and that it claimed a membership of seventy six by 1871, the Sheffield medical establishment was perhaps undergoing a rapid process of self discovery⁴⁷. This might have been related to the changing nature of the town itself around this time, with its developing industrial structure, and growing population. The Sheffield branch of the British Medical Association (BMA) was started in 1903 with 124 initial members. Its work was primarily concerned with promoting doctors as a coherent profession, and the records of the branch illustrate the battles fought over such things as payment for midwifery cases, municipal appointments and pay scales, and opposition to the National Insurance Act⁴⁸.

The town's first MOH was appointed in 1872, heralding the cautious arrival of public health work carried out beyond the auspices of the Poor Law,

⁴⁵ The Dispensary became the General Hospital in 1860 with the opening of its first wards and later became the Royal Hospital. See *Appendix 2*.

⁴⁶ S Snell, *A History of the Medical Societies of Sheffield*, Sheffield, 1890.

⁴⁷ Snell, *A History of the Medical Societies of Sheffield*, p.41.

⁴⁸ They were not always successful in their campaigns for what was effectively a closed shop with rigid salary structures; for example Dr Ethel White was appointed Assistant School Medical Officer, a Council post, in 1924, at a salary lower than the BMA demanded, but when they challenged her she simply resigned her membership of the Association. A similar problem arose in 1926. *Minutes of the Sheffield Branch of the BMA*, 23/2/1925.

and signalling the growing influence that doctors in the town might exercise on wider questions of health in Sheffield⁴⁹. Doctors were involved in public health administration as early as 1853, with the smallpox vaccinations law administered under the Poor Law. Several doctors who did become involved, later went on to work in public health administration with the Council, notably Griffiths, who became the town's first MOH.

Two rival medical schools had been opened in Sheffield in 1828 and 1829. The first one, started by Mr Hall Overend, was burnt down in 1835 by a mob protesting at bodies being dug up and taken there for anatomy classes: 'It was notorious that Hall Overend had obtained subjects for his students at great personal risk from the law and the populace.'⁵⁰ However, the second institution survived and over the course of the century it developed from a place of mainly anatomical study to a medical school. In 1897 it joined with the Firth College and the Sheffield Technical School to become the nucleus of the University of Sheffield, which received its charter in 1905⁵¹. Sturdy has studied the response of the medical department of the new University to its heavy financial constraints⁵². He has suggested that the department created a role and an income for itself by becoming involved in the administration of public health. In 1897, the City's MOH, John Robertson, was made Honorary Professor of Public Health, an appointment also awarded to his successors to 1949. Through its work on routine laboratory tests for the Council, particularly TB samples, the department was able to fund a pathology department, including a full time professor. It also cultivated business from the local voluntary hospitals, and took on their routine testing and post-mortem work.

...such work also enabled the University's full time scientists to take an influential role in shaping new administrative and managerial responses to the problems of public health⁵³.

Both Sturdy, and Inkster, have suggested that from its inception, the medical school in Sheffield helped to give the local profession a sense of

⁴⁹ Relations between the Council and their MOH were not good however; the first incumbent was sacked in 1877, and no Annual Reports published again until 1885. See *Appendix 1* for MO'sH of Sheffield.

⁵⁰ JD Leader and S Snell, *Sheffield General Infirmary...a Brief Sketch of a Century's Work*, Sheffield, 1897, p.115.

⁵¹ DH Peacock, 'Jubilee of the University of Sheffield', *Nature*, 176, 1955, p.94; H Swan, 'Medical Education', in Binfield *et al*, *History of Sheffield*, vol 2 *Society*,130-141.

⁵² S Sturdy, 'The Political Economy of Scientific Medicine: Science, Education, and the Transformation of Medical Practise in Sheffield, 1890-1922', *Medical History*, 36, 1992, p.125-159.

⁵³ S Sturdy, 'The Political Economy of Scientific Medicine', p.134.

focus and common identity⁵⁴. It demonstrated publicly that entry to the profession was being controlled, and allowed local practitioners who taught at the school to influence the development of medicine in the City. It also enhanced the role of this medical 'elite' in their private practice and work for voluntary hospitals.

Much of the medical care in the town was done under the auspices of the 1834 Poor Law Amendment Act which had left Sheffield with two Poor Law Unions, which were not amalgamated until 1925. One, based at Kelham Island in the centre of the town administered the northern half of Sheffield; comprising Sheffield, and Brightside, Attercliffe and Handsworth in the west. It opened on that site in 1829, although the building dated from 1792 and had previously housed a cotton mill. It was not therefore a purpose built workhouse, and quickly became overcrowded. The southern Ecclesall Union initially had two workhouses, which were replaced in 1843 with a purpose built structure at Nether Edge. However, although increasingly inadequate as the responsibilities of the Poor Law Unions expanded, the Kelham Island workhouse was not replaced until 1880. Discussions on a new building had started in 1856, but resident opposition to the proposals had prevented any progress at that time. The new workhouse was eventually built at Fir Vale, on the northern limits of the town. Despite this being the period of Goschen's Minute, which reiterated the doctrine of less eligibility and the need to economise as far as possible, the new Fir Vale workhouse was based on a recognition of the growing need for workhouse services⁵⁵. The design of the building illustrated this acceptance, with separate sites being provided for the able-bodied poor, asylums, the school, the fever and general hospital, and the vagrants. In 1907, the Board of Guardians went a step further and made the management of the hospital separate from the rest of the workhouse. They argued that; '...a separate hospital institution secured the best nursing, the best doctors and the least degradation to the sick poor.'⁵⁶

The Fir Vale workhouse provided nurse and midwifery training from its inception, and in 1887, a school for midwifery was opened which trained midwives for the Diploma of the Obstetrical Society⁵⁷. However, many of the

⁵⁴ I Inkster, 'Marginal Men: Aspects of the Social Role of the Medical Community in Sheffield 1790–1850', in J Woodward and D Richards eds., *Health and Popular Medicine in Nineteenth Century England: Essays in the Social History of Medicine*, London, 1977, 128–163.

⁵⁵ The hospital associated with the workhouse was criticised by the LGB for the extravagance of its design and fittings; Scurfield, evidence to *Royal Commission on Poor Laws*, appendix, volume 4, London, 1909, p.279, qu.42017.

⁵⁶ ST 18/06/07. See *appendix 2*.

⁵⁷ For discussion of this qualification see J Donnison, *Midwives and Medical Men: A History of The Struggle for the Control of Childbirth*, London, 2nd edit., 1988.

more complicated maternity cases seem to have been transferred to the Jessop, and both Unions paid sizeable annual subscriptions (£21), allowing them to use the Jessop's recommend system for admissions.

Unfortunately, none of the Poor Law records for either the Sheffield or Ecclesall Unions survive, and tracing the work of their hospitals is therefore problematic. However, the Fir Vale Hospital seems to have served its purpose effectively, and after the First World War appears to have come under the same pressure for space that the Jessop Hospital for Women was experiencing. The maternity and labour wards were transferred to larger premises, and in 1930 the Medical-Superintendent, Dr. Clark, reported to the Wardens that:

The number of confinements increased from 128 in 1912 to 409 in 1929. In 1912 40 births were legitimate, and 88 illegitimate; in 1929, 322 were legitimate and 87 illegitimate so that the increase is entirely in legitimate births.⁵⁸

This seems to indicate the increasing acceptability of a hospital for 'normal' deliveries, even a hospital associated with a workhouse and all the negative connotations which that must have had. The question is how far this move was the free choice of women, and how much a spurious choice constrained by a lack of alternatives; these will be considered in more detail with reference to the Jessop Hospital, in a later chapter.

The Jessop Hospital for Women in Sheffield exhibited some of the classic features of nineteenth century charitable foundations, in that it was started by a small group of professionals, with a Board of lay governors, and suffered from repeated financial embarrassment. Opened in small premises in the centre of town, the Sheffield Hospital for Women, as it was then known, came into being primarily through the efforts of Dr JH Aveling, a local GP. At its inception in 1864, the hospital contained only six beds, since most of its work was with midwifery out-patients. Aveling's motive for setting up the hospital was his professed desire to help the poor of the town. In justifying the hospital's desire to treat 'diseases peculiar to women', Aveling commented:

If these diseases, instead of being checked when in their earlier and more tractable forms, are allowed, for want of proper medical treatment, to run their courses unheeded, they at length become unmanageable and frequently incurable; and the result of this neglect is an immense amount of misery. Women continue to suffer patiently, or become

⁵⁸ P Speck, *The Institution and Hospital at Fir Vale, Sheffield: A Centenary History of the Northern General Hospital*, Sheffield, 1978.

habitual opium eaters or spirit drinkers. Husbands become estranged from their wives, sometimes deserting them altogether, and leaving their families a burden upon the parish. From our personal experience, and from the frequent remarks of our professional friends, we are convinced that there exists in Sheffield a large amount of silent and unrelieved suffering among poor women; and the mitigation of which will be one of the most blessed effects of our new hospital.⁵⁹

Aveling seems to have been making rather optimistic claims for the specialism of gynaecology which was still very much in its infancy. However, the use of gynaecology was undoubtedly a career move as Aveling would have known that he had more chance of making his mark on the town in an area not yet open to serious competition among professionals⁶⁰. In this he seems to have succeeded, and it was said by a Sheffield correspondent that:

In many ways besides this [the foundation of the Jessop] he filled an important and prominent place in the medical life of the town more than twenty years ago. He lectured on midwifery at the medical school, delivered an opening address at a winter session, and took part in the working of the medical society. He was a cultured and well-educated man...⁶¹.

In fact he only stayed in Sheffield for four years after the founding of the hospital, before citing his wife's ill health as a reason to leave the area. He headed for London where he established the Chelsea Hospital for Women, and, in 1884, co-founded the British Gynaecological Society⁶².

The Sheffield Hospital for Women, attracted a fair measure of support from the small band of middle class families in the town. It is likely that the continuous failed appeals for cash would, however, have resulted in its closure were it not for Thomas Jessop (1804–1887), a wealthy steel plant owner:

His own munificence in supplying the town with Jessop's Hospital for Women is well known; it cost him £26,000 and stands as a monument to his benevolence.⁶³

This quote exemplifies what men such as Jessop hoped to achieve from their 'munificence'. It was a way of earning respect in the community,

⁵⁹ *SI*, 12/12/1863.

⁶⁰ See L Granshaw, 'Fame and Fortune by Means of Bricks and Mortar': The Medical Profession and Specialist Hospitals in Britain, 1800–1948', in Granshaw and Porter, *The Hospital in History*, 199–220.

⁶¹ 'Obituary of James Hobson Aveling', *BMJ*, ii, 1892, 1349–50.

⁶² O Moscucci, *The Science of Woman: Gynaecology and Gender in England, 1800–1929*, Cambridge, 1993, p.66.

⁶³ JH Stainton, *The Making of Sheffield 1865–1914*, Sheffield, 1924.

and also power both within and outside the workplace. Jessop was able to give tickets of recommendation to his workers for their wives to use. It also gave him a role in the development of health care in the town. It signifies the way that Sheffield was developing that an institution founded by a middle class professional required saving from closure by an industrialist. The class to which Aveling belonged was always quite weak in Sheffield and was increasingly squeezed out by the employers and employees of steel works. By the end of the century, workmen's contributions collected at the big steel works were able to make a significant impact on the finances of the Jessop, although it is interesting that workmen seem to have contributed via their firms, rather than through a Trade Union, and testifies to the weakness of Trade Unions in such works.

Sheffield's two general hospitals, the Royal Infirmary and the Royal Hospital, exhibited the characteristic traits of their type in terms of their finances, the type of patients they admitted, and the support they received from the wider community. Both were intended to treat only the 'deserving' poor, through the mechanism of a recommendation system, and they relied primarily on middle class subscribers to keep them afloat⁶⁴. The hospitals did become foci for medical prestige in the town, with their posts being eagerly sought.

The Children's Hospital was opened in 1876, in the face of opposition from the other voluntary hospitals worried about the competition for scarce resources⁶⁵. It appears always to have been the poor relation of the health institutions in the town; the Jessop refused point blank to consider amalgamating in 1878, and it had no influence on the development of University medicine. The most influential paediatrician of the early twentieth century in Sheffield, AE Naish, worked at the Royal Hospital and the Jessop, never the Children's. In some respects, however, the Children's Hospital was a pioneer, opening an East End branch in 1893, to provide a more local service. It was also the first hospital in Sheffield to appoint female House Surgeons, from 1897 onwards; 15 years earlier than the Jessop.

Before the establishment of hospitals for women and children, provision for these groups in Sheffield was scant and indeed, treatment for babies remained difficult into the twentieth century; the Children's Hospital did not

⁶⁴ When subscriptions were raised to build the Royal infirmary in 1790's, only 2.8% of donors (numbering 16) gave more than £100. 56% gave 10 guineas or less, reflecting the lack of a prosperous subscriber base for such endeavours and signalling financial difficulties throughout the century; MP Johnson, *Medical Care in a Provincial Town: the Hospitals and Dispensaries of Sheffield, c.1790-1860*, unpub MA Dissertation, Sheffield University, 1977, p.26.

⁶⁵ See Appendix 2.

admit under 3's until after 1916, and then only in the ratio of 1:6 older children. Women were better served, particularly after the opening of the Public Dispensary, later the Royal Hospital, which operated a midwifery service from its inception. There was, however, fierce opposition from local medical men who argued that; 'The employment of women in midwifery cases is highly injurious, and does not afford that protection to the patient which required at so critical a time.'⁶⁶ Initially controlled by the Dispensary's Apothecary, after 1835 the service had its own Surgeon–Accoucheur, and the patient could choose to be delivered by him and his pupils, or by a midwife. By 1860 he took on only complicated cases, and the majority were handled by midwives. At the height of the service its two principal midwives were attending approximately two cases a week at a fee of 4/- per case. Prior to the 1864 opening of the Hospital for Women, the Public Hospital had covered about 250 cases per year, by 1874 this had dropped to below 150, and the decision was taken to close the service⁶⁷. However, the services of the Surgeon–Accoucheur were retained, implying that midwifery, or at least its more complicated or interesting cases, were still potentially within the remit of the Hospital.

Both the Royal Hospital and the Royal infirmary had space for, and treated, about twice as many men as women. In common with many other general hospitals the rules of the Infirmary stated:

...no woman big with child, no Child under six years of Age (except in urgent or particular cases, such as fractures, cutting for the stone, amputations, couching, trepanning, or where some other surgical operation may be required)...be admitted as in–patients.⁶⁸

The loopholes were obviously many, and admittance of children and pregnant women was probably not that uncommon; the above list of exceptions covers most of the procedures a hospital would be attempting throughout the nineteenth century. Additionally it is difficult to say how many of these unwanted patients would have attended out patient clinics, as breakdowns of figures are not available. Departments for diseases of women had developed in both the Infirmary and the Hospital by the end of the century, and operations such as ovariectomy were attempted, with varying degrees of success.

⁶⁶ MP Johnson, *Medical Care in a Provincial Town*, p.122.

⁶⁷ *Royal Hospital Minutes*, 8/10/1874.

⁶⁸ *Annual Reports of the Royal Infirmary*, 1813, p.16

By 1919, all four voluntary hospitals in Sheffield had considerable overdrafts, and difficulties in meeting running costs. A Joint Hospital Board was set up in that year, and included representatives from the University and the Council as well as the Hospitals. The Board was the first in the country to set up the penny in the pound scheme to give some guaranteed income to its hospitals. This scheme, which involved workmen pledging 1d out of every £ earned to the hospital fund, was later swelled by contributions from employers. It emphasised the importance of the working class in contributing to hospitals in a city like Sheffield where the efforts of the numerically small middle class could not keep them afloat. It did give the hospitals security; in 1922 the income of the Royal Hospital exceeded its expenditure for the first time in 25 years, and in 1929, after 10 years of the contributory scheme the Royal Hospital had received a total of £240,000⁶⁹.

Co-operation between the voluntary hospitals in Sheffield always appears to have been quite good. The Jessop trained student nurses from the Royal Infirmary and Royal Hospital for the Central Midwifery Board (CMB) exams in the 1920s, and the two general hospitals took each others patients in an attempt to keep waiting lists down. There had actually been discussions on the possible amalgamation of the hospitals as early as 1924, with the acquisition of a site at Norton on the southern edge of Sheffield, for a new hospital. Eventually, however, it was decided that any new hospital should be sited centrally, close to the University, and the Norton site was leased to the Jessop for use as an open air fever wing. The Jessop pulled out of ongoing plans, but the two general hospitals did amalgamate in 1938, although the realisation of a new hospital took considerably longer.

There was also co-operation between the voluntary hospitals and their workhouse, and later local authority, counterparts, with the Poor Law Infirmarys taking contributory patients if no room was available at the general hospitals, at a cost of 10/- per week per patient. It is not recorded how many patients availed themselves of the chance to be treated under the auspices of the Poor Law⁷⁰.

3.4b: The Health Department:

This section looks briefly at the development of the Health Department within the Council in Sheffield. This grew from the very tentative approach that was initially taken to health problems, to the development of maternal and child welfare services, and, after 1930, the take over of the Poor Law services

⁶⁹ *Annual Reports of the Royal Hospital, 1922, 1929.*

⁷⁰ *Minutes of the Royal Hospital, 20/7/1921.*

and institutions allowing the development of a frame work on which to base a municipal health service.⁷¹

In 1860, the Council decided that: 'it is not expedient at the present time to consider the most efficient means of improving the sanitary condition of the Borough.'⁷² It was 'not expedient' primarily on the grounds of finance, even though outsiders were commenting that:

[There is no] adequate provision for the preservation of the health of all the inhabitants. We have surveyed Birmingham, Stafford, Wolverhampton, Newcastle-upon-Tyne, Hull, Shrewsbury, and other towns; but Sheffield, in all matters relating to sanitary appliances, is behind them all.⁷³

Concern had been expressed on the state of Sheffield's health in the 1840s in the wake of a major cholera outbreak, and Haywood and Lee had produced a report on the subject, which suggested improvements to the sewage system in particular⁷⁴. However, the next thirty years saw not only a failure to address issues of public health in the town, but also a decline in standards, as jerry-built houses without sanitation were thrown up to meet the needs of the expanding population, and longer hours were worked in largely unregulated factories. Despite earlier permissive legislation, the Corporation in Sheffield did not appoint its first MOH until forced to do so by the Local Government Board following the 1872 Public Health Act, when it also split the Town into nine sanitary districts. The Local Government Board (LGB) would pay half the salary of a qualified Doctor able to '...inform himself of all influences affecting, or threatening to affect injuriously the public health within the district.'⁷⁵ The appointee, Dr Griffiths, was duly employed for a three year period at a salary of £600 per annum, and produced his first quarterly report in February 1873. However, things did not run smoothly, because in their quest to save money, the Council decided that now they had an MOH, they no longer needed a separate Chief Sanitary Inspector, and that Griffiths could do both duties. By 1878 matters had come to a head, and in June of that year Griffiths was sacked, officially for professional misdemeanours, although he put up an impassioned defence and was supported by local doctors⁷⁶.

⁷¹ C Shaw, 'Aspects of Public Health', in Binfield *et al*, *History of Sheffield*, vol 2 *Society*, 100-117.

⁷² Quoted in Pollard, *A History of Labour in Sheffield*, p.93.

⁷³ 'Condition of Our Chief Towns - Sheffield', *The Builder*, 19,1861, 641-43.

⁷⁴ J Haywood, and W Lee, *Report on the Sanitary Condition of the Borough of Sheffield*, Sheffield, 1848.

⁷⁵ *Health Cttee Minutes*, 12/9/1872.

⁷⁶ Griffiths wrote to the Health Committee that 'I ask whether it is right that any man should be attacked as I was; whether any member of the Town Council would regard himself as

There had obviously been many tensions between Sheffield Council and their MOH. Griffiths produced very detailed Annual Reports covering the health of the town and including some vitriolic attacks on the state of the town's sanitation, and the role of the Council⁷⁷. In 1875 the *British Medical Journal (BMJ)* reported on the presence of enteric fever in Sheffield with the comment that:

The responsibility for this fever-epidemic would appear to fall in great measure upon the Town Council, as the urban sanitary authority for the Borough of Sheffield, if, as we are informed, it is a fact that they have neglected to provide any hospital accommodation for the isolation and treatment of infectious diseases, despite remonstrances both from the Local Government Board, and from their own Medical Officer of Health, Dr Griffiths.⁷⁸

Griffiths also produced a report condemning the Crofts district, an overcrowded and insanitary series of Courts in central Sheffield, in 1877. The report was rejected on the grounds of the cost that would be incurred in dealing with it. In fact, this was the first area to be redeveloped under a later MOH with more power, but not for another fifteen years.

The Council proposed to appoint a new MOH on half Griffith's salary but the LGB was not satisfied with the explanation by the Council that the new MOH could take a salary cut as they had once again appointed a separate Chief Sanitary Inspector, since he had never been intended by the LGB to do both jobs. They commented that :

Having regard to the circumstances of the District, as well as to the important nature of the duties attaching to the office of Medical Officer of Health, it appears to the Board that he should devote his whole time to the duties of the office.⁷⁹

The Health Committee stood its ground, however, and stated its opinion that:

...it is unnecessary to appoint a Medical Officer of Health to devote the whole of his time to the duties of his office, and they are fortified in their judgement by the fact that several properly qualified Medical Men

fairly dealt with if he were treated as I was, upon matters, many of which have been disposed of years ago, and none of which will upon examination, be found to carry any discredit to my door.' (*Health Cttee Minutes*, 20/6/78)

⁷⁷ Writing in 1868, the *Lancet* warned that MO'sH in general '...were in a very awkward position; if they conscientiously carry out the duties imposed, they can hardly fail to come into antagonism with the local authorities to whom they are subordinate.' *The Lancet*, i, 1868, p.265.

⁷⁸ *BMJ*, ii, 1875. p.762.

⁷⁹ *Health Cttee Minutes*, 5/9/1878.

are prepared to accept the office...and that this Committee are now prepared to proceed with the appointment of a Medical Officer, and must place upon the LGB the responsibility for any mischief that may result from the want of such an officer⁸⁰.

The LGB refused to pay their half of the salary of the future MOH, and the *BMJ* carried the editorial comment that the Council were '...pursuing a course which on every ground of public welfare and professional self-respect, is deserving of severe reprobation'⁸¹. None of this deterred the Council which employed a succession of local doctors in the post, and published no annual reports (although they were apparently written), until 1884. The controversy over the role of the MOH, illustrates how unprepared the Council was for the demands placed upon it by a large industrial town. They saw their role in very limited terms compared to their MOH, and indeed to the LGB, who demanded involvement in housing, sanitation, and the treatment of infectious diseases. Despite growing intervention in Sheffield's health in the 1880s and 1890s, with the building of the Winter Street fever hospital and the beginnings of work on replacing privy middens with water closets, the Health Department did not make the position of Medical Officer permanent until 1897. By this time the budget of the Health Department was over £50,000 per annum, and an additional £10,000 was being spent on the City's two fever hospitals. Growing commitment by the Council to the work of the Department was illustrated in 1899, when the staff rose from 24 to 37 in one year, and included the appointment of the first two women sanitary inspectors. The Council became involved not only in preventative work, but increasingly curative policies, without any coherent strategy, or even discernible enthusiasm.

It was the continued presence of epidemic diseases such as small pox and scarlet fever which provided the initial impetus for the development of the Health Department, although there was little that could be done to prevent them, except ensure that the city was well drained and ventilated. Much of the early work of the Department and its MOH was concerned with macro measures to deal with street cleaning, housing, and the privy middens. As the budget increased, and Council intervention became more acceptable, programmes to tackle these problems became larger. However, by the end of the century there was also an increasing interest in the possibilities of micro solutions, particularly to the problems of tuberculosis and infant mortality. The former was affected by compulsory notification in 1903, and the development

⁸⁰ *Health Cttee Minutes*, 19/9/1878.

⁸¹ *BMJ*, ii, 1878. p.897.

of sanatoria, and the latter by the creation of women inspectors, and the development of baby clinics⁸².

In 1899, a report was prepared by the MOH, John Robertson, on 'Women Sanitary Inspectors' (WSI's). Robertson had previously been employed as Assistant MOH at St Helens, one of the first areas in the country to appoint women inspectors and open milk depots. Although originally employed as inspectors of workshops, and to carry out home inspections for basic cleanliness, the work of the WSI's quickly became infant centred. This was in response to stubbornly high rates of infant mortality, and attempts by the Council to deal with this primarily through the exhortation and education of individuals. Finally, in 1907 the Council established its first milk depot in an attempt to combat infant deaths caused by 'summer diarrhoea'. By 1914, these depots had become primarily baby consultation clinics, where babies were weighed and advice given on care.

In the inter-war years, new types of municipal provision centred around the take over in 1930 of all the functions and institutions associated with the Poor Law⁸³. As early as 1907 the then MOH, Dr Scurfield, had advocated handing over the duties of the Poor Law Guardians to the City Council, to avoid any overlap of resources and to ensure that people got early medical attention. He objected to the stigma attached to seeking medical help through the Poor Law, and also to the difficulty of getting recommendations for treatment at the voluntary hospitals. Scurfield suggested that health should be placed on the same footing as education; administered by the local authority, with doctors providing a salaried service⁸⁴. Although this was not achievable in 1907, when take-over finally came, it was apparently 'very simple' to implement in Sheffield due to the high levels of co-operation already in place between the two authorities, including the fact that '...the only maternity beds that the Health committee possessed were situated in one of the Guardians' Hospitals.'⁸⁵ The local authority took over the Fir Vale Hospital, which became the City General, and also Nether Edge, which became the central administrative site for the authority's maternity services. An Assistant Medical Officer for Maternity was appointed to co-ordinate maternity policy; she divided her time between Nether Edge and the central

⁸² Sheffield was the first place in the country to establish compulsory notification of phthisis (pulmonary tuberculosis).

⁸³ *Local Government Act*, 1929; [19 Geo.5.c.17], pt1.

⁸⁴ *Royal Commission on the Poor Laws and the Relief of Distress*, appendix volume 4, London, 1909, qu 41884-42046.

⁸⁵ The Hospital was Fir Vale. *MOH Report*, Sheffield, 1930, p.8.

ante-natal clinic. Wider questions of policy and development were considered by the Sheffield Municipal and Voluntary Hospitals Joint Advisory Committee.

Moves were made to increase the provision of maternity beds, in the belief that these were necessary for treatment and desired by patients. In 1930 there were 91 lying-in beds across voluntary and municipal institutions and the decision taken to increase this to 200. By 1934 there were 165 beds, but also a commitment to the provision of home based care. In 1932 the Local Authority began to provide midwifery for a domiciliary service to 'necessitous cases' which relieved pressure on maternity beds⁸⁶.

3.4c: Maternal and Infant Welfare:

The manner in which children are killed off in Sheffield is something fearful to contemplate.⁸⁷

The concept of maternal and infant welfare was a very specific one, developed by, among others, McCleary, Newman, and Newsholme in the early years of the twentieth century⁸⁸. It was concerned mainly with the provision of a pure milk supply, or at least with clean or dried milk for infants, and with maternal education through health visiting, clinics and 'schools for mothers'. These measures were designed to address the problem of stubbornly high rates of infant mortality in the face of falling general death rates, and to some extent, stemmed from concern about racial decline, although the main motivation of most health workers involved was humanitarian.

By 1920 antenatal care was developing in hospitals and local authority clinics. Even this, however, was designed mainly for the protection of the infant, rather than that of the mother herself, despite high and rising levels of maternal mortality. Following the work of the Women's Co-operative Guild, and major surveys by Janet Campbell for the Ministry of Health, the reduction of maternal mortality became a goal of health workers in the 1920s. However, it did not seem as amenable to improvement as infant mortality had been, and rates did not actually start to drop until the mid 1930s and the introduction of the sulphonamides⁸⁹.

⁸⁶ *MOH Report, Sheffield, 1932, p.104.*

⁸⁷ J Taylor, *An Enquiry into the Causes of the Mortality of Sheffield*. Sheffield, 1873, p.7.

⁸⁸ McCleary was the MOH for Battersea; Newman was the MOH for Finsbury and later at the Board of Education, and at the Ministry of Health; Newsholme was MOH for Brighton, and later at the LGB.

⁸⁹ I Loudon, 'Puerperal fever, the Streptococcus, and Sulphonamides, 1911-1945' *BMJ*, 295, 1987, 485-490.

The MOH had started to highlight the issue of infant mortality as early as 1873 but the Council did not seriously attempt to take action until the turn of the century. This was not for want of trying on the part of successive MO'sH.

...a large proportion of infants born are scarcely viable at birth and it also follows that if such children be subjected to the surrounding influences of impure air, bad nursing, improper food, exposure to cold, narcotics and neglect, they will surely die; for these agencies will, in time, both deteriorate and destroy the strongest children.⁹⁰

This appalling mortality amongst young children is no doubt largely preventable, occurring chiefly in children of the poorest class, and being due to exposure, deficient and unsuitable nourishment, and, to a certain extent, insanitary surroundings.⁹¹

However, the weakness of the Council's position has already been considered; they did not possess the power, the money or the political will to attempt any action before 1900.

It is difficult to say what prompted the Council's change in attitude towards the health of Sheffield, and its growing focus on endemic problems rather than only epidemic diseases. It is likely that many of the pressures were local, wrought by the MOH and his staff, and the growing strength of labour representatives. Certainly, even by 1914, Sheffield Council was heavily involved in child welfare measures in particular; many it seems against its better judgement. The first women inspectors were appointed in 1899, and the service quickly appears to have taken on a life and independence of its own, with inspectors addressing national government committees, as well as local mothers meetings. In the summer of 1907 the first infant milk depot was set up in the City, a move which the Council and even the MOH, seem to have supported very reluctantly.

The Council always recognised that environmental factors, including the poor sanitation system, had a detrimental effect on the health of Sheffield, and made attempts to deal with both micro and macro aspects of the situation. However, although infant mortality, for example, was significantly reduced over the period in absolute terms, in line with national trends, the relative differences between areas remained as stark as ever. Welfare clinics, education programmes, and improved sanitation could not erase the basic differences caused by poverty. Working class babies were, and indeed still

⁹⁰ *MOH Report, Sheffield, 1873, p.16.*

⁹¹ *MOH Report, Sheffield, 1893, p.19.*

are, at greater risk of death in infancy⁹². Although figures for infant mortality in the districts of Sheffield were not highlighted until 1902, earlier totals can be extrapolated from the total numbers of births and deaths of infants under one year for each district. The relative position of different areas did not really change between 1885, when the first comparative figures are available, and 1939, even though their populations, and total rates of infant mortality did. West and North Sheffield, the crowded, central centres of population, had the highest infant death rates, while the western suburbs of Hallam and Ecclesall had far lower rates. For example; in 1886, the infant mortality rate (deaths under twelve months per thousand born [IMR]) was calculated at 251 for West Sheffield, compared to 150 in Ecclesall.

The variability in the rate of infant mortality in different areas was particularly noticeable in a city such as Sheffield, which exhibited a high degree of geographical separation according to class, as a map appended to the MOH report for 1913 demonstrated. The conditions in which people lived and worked had to play a part in their life chances. Newsholme accepted that:

In this connection, it is significant that prior to 1900, the average infant mortality in England and Wales failed to decline, notwithstanding steady improvement in the average economic condition of wage earners as a whole... Improvement...is, of course, not inconsistent with the continuance of extreme poverty in a considerable proportion of the total population; and such poverty is injurious to both mother and infant, diminishing the immediate prospect of life, and deteriorating the physique and health of the infants who survive an ill-nourished childhood.⁹³

Florence Greenwood, the first WSI appointed in Sheffield, illustrated this point when she gave evidence to the Inter-Departmental Committee on Physical Deterioration in 1904. When asked to account for the widely differing IMR across Sheffield, she remarked that:

...one district is in the best part of Sheffield, the residential part, with beautiful houses and gardens, well cared for children with nurseries; and the other is in a slum quarter with small back to back houses, and insanitary privy middens, and with the very ignorant mothers.⁹⁴

⁹² P Townsend, N Davidson, M Whitehead, *Inequalities in Health: The Black Report and the Health Divide*, Harmondsworth, 1992, p.43-45.

⁹³ A Newsholme, *Fifty Years in Public Health*, London, 1935, p.371-372.

⁹⁴ *HM Govt Report of the Inter-departmental Committee on Physical Deterioration*, vol. 1-3, London, 1904, p.313.

However, the Council represented only one strand of initiatives to develop maternal and child welfare programmes in Sheffield. In this sense it is useful to consider the concept of maternal and child welfare at its broadest; any policy or situation which had an effect on the health of mothers or their infants. The development of the Sheffield Hospital for Women, together with its midwifery training programme, had an impact on discussions about maternity both in Sheffield and nationally. The Jessop helped to pioneer the possibility of midwives as a solid but secondary medical service; secondary that is to male doctors. They were also involved in developing other aspects of maternal welfare; specifically moves towards the hospitalisation of childbirth cases, and to ameliorative surgery for some of the problems which women suffered as a result of childbirth. Problems such as fistulas represented huge personal burdens for the women concerned, and attempts to address problems of morbidity were likely to have been welcomed by women⁹⁵. The Children's Hospital was also involved in promoting measures of infant welfare.

The third major group involved in the formulation and implementation of maternal and child welfare policies in their broadest form were charities. These included religious organisations such as the Guild of Help and the Sheffield Diocesan Moral Welfare Council, as well as institutional groups like the Samaritan Society, which was run by ladies connected to the Jessop Hospital. The voluntary groups which dealt with family issues, including the welfare of mothers and children, were a varied selection. They ranged from groups specifically designed to influence and educate mothers, such as the Motherhood League, to groups intended to influence broader policy making such as the Sheffield Council for Social Service. By the early twentieth century, most of these were involved in casework, although unfortunately, case records do not appear to have survived. However, they were undoubtedly an important sector, and questions about the type and quality of advice and assistance which they offered need to be asked.

As Dunkley has demonstrated, women were the driving force behind many of the charities in Sheffield. However, although women did the day to day work, and particularly the fund raising, they were rarely involved in policy making and committee work, especially in the more prestigious charities, such as the voluntary hospitals⁹⁶. By the inter-war period, the type of woman involved in charity work had largely altered from an earlier model of spinsters, particularly daughters or sisters of prominent men, to married women. With

⁹⁵ ML Davies, ed., *Maternity: Letters from Working Women*, 1915, reprinted, London, 1978.

⁹⁶ SJ Dunkley, *Women Magistrates, Ministers, and Municipal Councillors in the West Riding of Yorkshire, 1918-39*, unpub. PhD Thesis, University of Sheffield, 1991, p.44.

smaller families, and most professional careers operating a marriage bar, these women took the lead in charity work; for unmarried women a paid career was more desirable and remunerative than voluntary work⁹⁷.

The inter-war years saw a major change in the constitution, aims and funding of voluntary organisations. As Dunkley has found, financial difficulties were a major theme of this period, partly caused by the economic dislocation suffered in the region. The House of Help, the Babies Home, and the Council of Social Service (SCSS) (successor to the Guild of Help), all ran up large overdrafts due to falling income, and were faced with closure. All these organisations turned to statutory bodies, principally the local council, for help. By the mid-1930s, the Babies Home was receiving £300 p/a, and the House of Help £62/12/0 p/a. A new group, the Sheffield Women's Welfare Clinic, which gave contraceptive advice, received £50 p/a and free premises. There was justification for this new reliance, which was described as 'the new philanthropy'.⁹⁸ The SCSS, which hoped to carry forward the motto of its predecessor, 'Not alms but a friend', stated its aims explicitly:

In the joint interchange of information, and in close co-operation in certain fields common to both statutory and voluntary bodies much overlapping of both money and service has thus been avoided.⁹⁹

Ideas such as these, although practised to a certain extent by groups such as the Motherhood League, were not explicitly formulated until the inter-war period¹⁰⁰.

Finally, the attitude and involvement of women themselves should be considered. This encompassed a wide range of activities, including the Women's Co-operative Guild, midwifery groups, the views of WSI's and female doctors. Organised political action by women does not appear to have been particularly significant, however. Sheffield's first women Councillors were elected in 1919; Eleanor Barton, and Gertrude Wilkinson were both long standing activists in the local labour movement. In her election leaflets, Barton had styled herself 'The true friend of the Women and Children', and this demonstrated the approach of women councillors, who targeted 'welfare'

⁹⁷ Dunkley, *Women Magistrates, Ministers, and Municipal Councillors*, p.48.

⁹⁸ E Macadam, *The New Philanthropy: A Study of the Relations Between the Statutory and Voluntary Social Services*, London, 1934. Liverpool City Council spent 21% of its maternal and infant welfare budget on voluntary groups; Macadam, p.130.

⁹⁹ *Sheffield Council of Social Service*, Annual Report, 1929, p.9.

¹⁰⁰ For discussion of the limits of voluntary action in relation to the Queen Victoria Jubilee Institute of Nursing, see; E Fox, 'District Nursing in England and Wales Before the National Health Service: the Neglected Evidence', *Medical History*, 38, 1994, 303-321.

committees¹⁰¹. They used the language of separate spheres to support their position. However, despite support for clinics, women doctors, and birth control, their numbers were never great enough to make a huge difference, and in fact declined in the 1930s.

3.4d: Motherhood and Employment in Sheffield:

...our Sheffield mothers, in many cases because they are employed away from home during the day, do not suckle their offspring, and to make bad worse, instead of rearing it on milk, they feed it with all kinds of farinaceous preparations...¹⁰²

This view of mothers in Sheffield was partly responsible for the attitude taken to their problems, and to the solutions suggested. Even organisations such as the Sheffield Labour Representation Committee became involved in the debate; producing a pamphlet on infant mortality, and the need for milk depots, and a clean milk supply, in 1905. Neither the causes or cures suggested by GBH Ward, the report's author, were particularly 'radical' in the context of the debate. He cited lack of knowledge of the care and feeding of infants, including the decline of breast feeding, as the principal reasons for the high infant mortality rate, together with bad housing and sanitation. His support for compulsory girl's education in domestic subjects and his call for 'respect for motherhood' very much represented mainstream thinking on this issue. Indeed 'labour' could be quite a conservative force when addressing such problems:

The Mother's Place is in the Home. God speed the day when human feeling shall demand and conditions allow it.¹⁰³

There was a prolonged national debate over the question of married women's work. Newman commented that; '...work of itself, unless of an exceptionally straining character, seldom causes premature birth.'¹⁰⁴ This reassuring statement was presumably designed to solve the dilemma that even pregnant women not engaged in out-work, would still be forced to undertake very heavy housework, including washing and cleaning, up to the point of labour. In fact, Newman suggested that those areas which exhibited low female employment, and high infant mortality rates, did so because of the

¹⁰¹ Dunkley, *Women Magistrates, Ministers, and Municipal Councillors*, p.174.

¹⁰² J Taylor, *An Enquiry into the Causes of the Mortality of Sheffield*. Sheffield, 1873, p.19.

¹⁰³ Sheffield Labour Representation Committee (GBH Ward), *Infantile Mortality: Its Cause and Cure: A plea for Infants Milk Depots and a Municipal Milk Supply*. Sheffield, 1905.

¹⁰⁴ G Newman, *Infant Mortality. A Social Problem*, London, 1906, p.89.

extremely heavy nature of the housework. This was the case in mining regions such as Durham and South Wales, and indeed of Sheffield. It tended to be argued that clothes washing and house cleaning were particularly laborious in these areas because of the dirt of coal mining; such concerns fuelled demands for pit head baths¹⁰⁵.

The employment of women outside the home was felt to be a problem as it discouraged breast feeding, and led to infants being looked after by unsuitable carers, such as elderly neighbours, or young siblings. The Government Inter-Departmental Committee on Physical Deterioration reported that: '...the facts seem to point to a strong presumption that [infant mortality] is also connected with the employment of mothers...' although it did admit that: '...the information is not as complete as might be desired.'¹⁰⁶ However one of the solutions often canvassed by women themselves, that of workplace crèches, tended to be looked on with disfavour. This was despite its popularity in France where long standing concerns about falling rates of completed family size, together with the recognition that many women needed to work for the economic well being of their families, led to the creation of many private and municipal crèches. It was felt in Britain that such establishments would *encourage* women to work for selfish reasons, such as to earn extra money, or to relieve loneliness and boredom. Ideally, unless the death or unemployment of the male bread winner made out work absolutely necessary, it would be preferable for women to remain at home.

Sheffield's first Woman Inspector, Florence Greenwood, wrote an article in 1901 entitled 'Is the high Infantile Death-rate due to the Occupation of Married Women?' Her answer was that 'It would appear that the occupation of married women is not so important a factor as has been supposed...'¹⁰⁷ She commented that it was an '...erroneous idea...' that infant mortality would decrease if married women were forbidden to work.¹⁰⁸ Greenwood claimed that women who worked were usually the most responsible ones, who worked for the extra wages that would give their children more food and warmth. She also argued that women who worked, for example in factories, acquired a skill which would allow them to keep themselves if deserted or widowed. Unskilled women left in such a position would be forced to do demanding, and poorly

¹⁰⁵ For example, see: *ST 21/6/35*, p.4.

¹⁰⁶ *Inter-departmental Committee on Physical Deterioration*, p45.

¹⁰⁷ F Greenwood, *Is the High Infantile Death Rate Due to the Occupation of Married Women?*, London, 1901, p.3.

¹⁰⁸ Greenwood, *Is the High Infantile Death Rate Due to the Occupation of Married Women?*, p.1.

paid jobs such as charring or washing, or be forced to rely on charity. Greenwood believed that:

My experience is that a clean woman will be clean and a dirty shiftless woman will be dirty and in confusion whether she be a wage earner or not.¹⁰⁹

However, as evidence gathered by the WSI's was demonstrating, very few mothers in Sheffield were in fact engaged in any employment, including homework. The exception to this was hinted at by a survey of eight married women workers in Sheffield for the Women's Industrial Council in 1909. The nationwide survey was eventually printed as *Married Women's Work*, with the tiny number of cases from Sheffield perhaps reflecting the relative unimportance of paid work for married women. The eight cases can only provide illustrative material, but are suggestive of the situation in Sheffield. One woman was working for a family firm, three because their husbands were unemployed, two because they were separated, one because her husband was a 'drinker', and one who had no children. These cases would seem to demonstrate that it was only in the face of exceptional domestic and financial circumstances that women worked¹¹⁰. Census data does bear this out, despite its limitations. The 1901 Census recorded that of 83892 married or widowed women, only 9261 (11%) were occupied, compared to exactly 50% of unmarried women. The majority of women workers were aged between 10–25 years, when they were likely still to have been single. In 1911 the proportion of married women working was 7%, and that of widowed women 29%, suggesting that of the 11% quoted for 1901, the majority were probably widows¹¹¹. This compared with textile towns in particular where the employment of married women was more common. The 1911 Census gave figures of 31% of married women in employment for Bury, 40% for Burnley, and 43% for Blackburn¹¹².

In 1905, the WSI's in Sheffield visited 6673 births, of whom 6338 were classed as 'healthy' and 5450 as 'entirely breast-fed'. Furthermore, only 167 mothers were said to be 'engaged in some occupation'. In the same year the City's IMR stood at 166‰, second only to Bolton (168‰) in the Registrar-

¹⁰⁹ Greenwood, *Is the High Infantile Death Rate Due to the Occupation of Married Women?*, p.10.

¹¹⁰ Women's Industrial Council, *Eight cases of married woman's work*, 1908–09; C Black, *Married Women's Work*, London, 1983 (orig pub 1915).

¹¹¹ *Census 1901*, table 35; *Census 1911*, table 13.

¹¹² HM Govt, 'Maternal Mortality in Connection with Childbearing and its Relation to Infant Mortality', *LGB 44th Annual Report, 1914–15, Supplement*, cd 8055, p.122.

General's list of 20 large towns. The comment of the MOH on these figures was that given the low rates of maternal employment:

There is, therefore, no excuse as regards Sheffield's unenviable position as regards infant mortality. There is no reason to suppose that the milk supply in Sheffield is worse than in other great towns. We are therefore driven to the conclusion that there is in Sheffield an excessive amount of ignorance, carelessness and wilful neglect on the part of mothers.¹¹³

This feature was borne out by a Home Office study carried out in 1908 which highlighted low levels of maternal employment, and perhaps connected to this, very high levels of breast feeding. The results for Sheffield were detailed in the 1909 MOH Report. 400 babies born each month for a year were examined, with those born into higher income families (father earning >40/- per week) being rejected. This gave a total of 4513 households which were included in the enquiry.

The proportion of women surveyed who were in employment was 10.2%; a little lower than the 11% employment rate for married women recorded in the 1901 census. The MOH report stated that, at the time of the survey, unemployment in the City was very high, so perhaps slightly more women would have been working in a more prosperous time. Although some figures suggest that the factory-employed woman was in a more unfavourable situation as regards childbirth, the numbers are generally too small to be significant. For example; 13.8% of births to factory employed mothers were premature, compared to 7.2% of non-working mothers. However, given the absolute disparities, this still gave a total premature birth figure of 34 for factory workers compared to 293 for women not employed. In fact it was the employed home workers who were at most risk of an unfavourable outcome to maternity. The enquiry suggested that per 1000 births, 222 of the children born to home workers would be dead by one year; compared to 163 born to factory workers; 185 born to those elsewhere employed (i.e., charwomen, servants); and 115 for those not employed.

Factory-employed mothers tended to be younger (58.2% were under 25, compared with 23.7% of non-working mothers), and to be on their first confinement (42.3% had no previous confinement, compared to 14.6% of non-workers). Furthermore, 22.3% of factory-employed mothers were single, compared to only 0.8% of non-workers. Factory work was perhaps the norm for a small percentage of first time mothers, but thereafter the vast majority did

¹¹³ *MOH Report, Sheffield, 1905, p.13.*

stay at home. Those who did return to work did so only a relatively long time after the birth; 30% who did return were at home with their baby a year before doing so. A further 40% did not return even after a year. For home workers and non-industrially employed women the figure for non-returnees was even higher, at around 59%. It is perhaps surprising to note that as many as 62% of factory mothers whose babies died within the first year, usually within the first weeks due to prematurity, still did not return to work within the year. Outside employment was probably the prerogative of young, usually unmarried women with no dependants.

Perhaps the tendency of mothers to be at home with their children, at least when they were very small, meant that the proportion of babies wholly breast fed was very high in Sheffield. In the case of babies surviving to one year, 85.3% of babies were fed by non-working mothers. 59.9% of mothers who had been factory workers were breast feeding at the same period, and 78.8% of those who had been home workers. Of those who died, a higher proportion were artificially fed, suggesting that they were more at risk from infectious disease. However, an even greater proportion were never fed, due to early deaths caused by prematurity or congenital problems. These figures seem to be born out by the report of the women inspectors for 1910 which suggested that only 220 children, out of a total of 9098 visited, were totally artificially fed. 2248 babies were still dependant entirely on breast milk for food at over 9 months of age¹¹⁴.

Low employment rates for married women in Sheffield also had a significant impact on another area of maternity; high fertility, and high abortion rates. Both Chinn and Szreter have observed that the poor take-up of contraception, together with the high use of the usually female mediated practice of abortion, was related to women's lack of power within the domestic context¹¹⁵. The evidence for Sheffield, which will be considered in Chapter 6, bears this out.

3.5: Conclusion:

The experience of motherhood for women in Sheffield across the period did vary with the waxing and waning of ideas and provision. However, it was also informed by more tangential issues, including women's reliance on husband's income, and the difficulties experienced in time of unemployment.

¹¹⁴ Fildes has produced comparable figures for London boroughs; V Fildes, 'Breast-feeding in London, 1905-19', *Journal Biosocial Science*, 24, 1992, 53-70.

¹¹⁵ C Chinn, *They Worked All Their Lives: Women of the Urban Poor in England, 1880-1939*, Manchester, 1988; S Szreter, *Fertility, Class and Gender in Britain, 1860-1940*, Cambridge, 1996, p.426-8.

This thesis will try to place the health of mothers in the context of their health as women, and the ways in which factors such as unemployment, housing, and family size impacted on this.

4: 'The manner in which children are killed off in Sheffield is something fearful to contemplate': Infant Mortality and Infant Welfare.

4.1: Introduction:

This chapter will examine the progress of the infant mortality rate (IMR) in Sheffield, and in particular, its diarrhoeal component. It will then consider the development of infant welfare policies intended to reduce IMR, concentrating on the fusion between public and private endeavour. It will argue that the work of agencies at the micro level, including home visiting, lecturing, and the provision of infant welfare clinics was useful and relevant to the women it targeted, and was supported by them, although this does not necessarily mean that it had a direct effect on IMR. However, contemporaries certainly believed that these factors were of primary importance in the reduction of rates, and the influence of such schemes has perhaps been underestimated. Changes at the macro level, including improvements to Sheffield's sewage system, and apparently tangential factors such as unemployment levels probably also had effects on IMR. However, drawing out the 'what' of infant mortality decline in this period is problematic; the 'why' is even harder to explain. Discussion focuses primarily on the period 1879–1920 as this was when the subject received greatest attention from contemporaries. IMR also began to decline decisively and permanently from c.1905; by 1920 this trend was well established.

Work with infants was the first aspect of maternal and child welfare to develop in Sheffield and in many ways demonstrated the most successful mix of Council and charity effort. There appears to have been little tension between the developing role of 'the state', as represented by local government, and both traditional and new forms of voluntary agency. However, by 1920, the charities previously involved in infant welfare, both independently and in conjunction with Council work, had largely disappeared¹. Co-operation became increasingly centred around the Council and voluntary hospitals, with the Council's role as co-ordinator and provider becoming stronger after it acquired its own hospital infrastructure with the take-over of Poor Law hospitals after 1930.

The development of infant welfare work is also important for the light it sheds on the power and unity of women as professionals, volunteers and mothers. Analysis of the WSI's (Women Sanitary Inspectors) in particular

¹ Peretz has suggested that it was Conservative held areas, such as Oxfordshire in her study, which maintained a strong voluntary tradition throughout the inter-war years: E Peretz, *Maternal and Child Welfare in England and Wales Between the Wars: A Comparative Regional Study*, unpub PhD, University of Middlesex, 1992, p.28.

shows them to have been a committed group of women who were able, with the support of the Council, to develop a professional ethos which reached beyond Sheffield. In becoming salaried officials they did not become simply subordinates of a 'male' state but were able to act as an influential and autonomous body. Voluntary groups appear to have been able to work effectively with the professional WSI's, suggesting that the concept of a 'mixed economy of welfare' was not problematic to either group. Generally there appears to have been little local argument between different agencies over the direction of policy and the philosophy behind it. Agreement centred around the beneficial effect of action, which could best be achieved through personal local assistance targeted at families, and specifically, at mothers².

Although more difficult from the point of view of evidence, it is also important to look at the views of mothers themselves; the people whom all the visitors and pamphlets hoped to address and influence. There is no uniform evidence that they either appreciated or resented the attention they were given, although attendance figures for clinics, and inter-war demands for service extensions suggest that they did fulfil a latent demand. Although it is tempting to see the WSI's as the precursors of a fully effective and intrusive state mechanism, destroying the self-respect of families, the evidence suggests that the situation was not that simplistic; much of the help does appear to have been welcome. However, as the evidence is overwhelmingly from one side, that of the advisors or visitors, it is difficult to perceive how mothers really felt, how much of the information they received they put into practice, and how much difference it would have made to IMR if they did. Some illustrative evidence is available from collections of oral evidence and contemporary sources such as letters to the Women's Co-operative Guild³. This is used to provide some qualitative evidence for the themes addressed in this chapter.

The Chapter is split into two major sections. The first deals with the reality of infant mortality; the form it took and the way it declined. It then considers why local agencies felt the need to tackle the situation, and looks in detail at the way they tried to this. Finally this section tries to assess how successful the policies aimed at securing a decline in infant mortality actually were. The second section examines the wider effect of local infant welfare policies; on the role of local government and the 'state', and on women themselves, both as providers and receivers of welfare initiatives. This section

² Chief WSI for Sheffield, Mrs Franks commented that local personal contact was more important than state legislation; G Franks, 'Women Workers in Public Health in Sheffield', *Sanitary Inspectors Journal*, 18, 1912, p.108.

³ ML Davies, ed., *Maternity: Letters from Working Women*, 1915, reprinted, London, 1978.

considers the importance of infant welfare, not just in fulfilling its explicit aim of reducing IMR, but also how successful it was judged to be, and how far it became the model for other welfare measures in the inter-war years; particularly those aimed at expectant mothers.

4.2: Infant Mortality and the Effect of Infant Welfare

4.2a: The Decline of Infant Mortality in Sheffield:

Infant Mortality is the most sensitive index we possess of social welfare and of sanitary administration, especially under urban conditions.⁴

The data for this chapter is drawn from the Annual Reports of the Medical Officer of Health (MOH) in Sheffield, which provide a reasonably full series of data over the period, although the very brief reports produced for Sheffield between 1916–20 leave an unfortunate, and un-fillable, gap in many of the series. In some cases the start date for certain runs of figures provides evidence for when they seriously began to be addressed, although in many cases earlier figures can be extrapolated from the available data. For example, the neonatal mortality rate was not mentioned in the reports until 1918, but can be found in tables of infant mortality across different age periods back to 1905.

Sheffield experienced its highest levels of infant mortality for the period 1885–1939 in 1900 and 1901, with figures of 200‰ and 201‰ respectively. These city wide averages concealed significant variations in different areas with North Sheffield having rates almost double those of Upper Hallam. From these peaks the situation improved steadily, dropping to 103‰ in 1920 and 67‰ by 1930. Rates for individual districts could, however, deviate quite significantly from the average; for example, in 1886 Park, a central district, had a rate of 268‰, and Upper Hallam, a rural district, had a rate of 22.2‰, when the rate for the whole town was 168‰. As late as 1930 rates still varied widely, with 159‰ in North Sheffield (area a), compared to 41‰ in Ecclesall North (area b). Even district figures are too crude for assessing which families were at greatest risk; rates across streets could vary widely, as could those between houses, with some families losing several children, and others none⁵. The expanding eastern districts of Sheffield, where the new heavy

⁴ A Newsholme, *Supplement to the 39th Annual Report of the LGB, 1909–10*, quoted in RM Titmuss, *Birth, Poverty and Wealth: A Study of Infant Mortality*, London, 1943.

⁵ For discussion on this point see: N Williams, 'Death in its Season: Class, Environment and the Mortality of Infants in Nineteenth Century Sheffield', *Social History Medicine*, 5, 1992, 71–94, p.93.

Infant mortality (per 1000 births) in Sheffield, 1885-1945

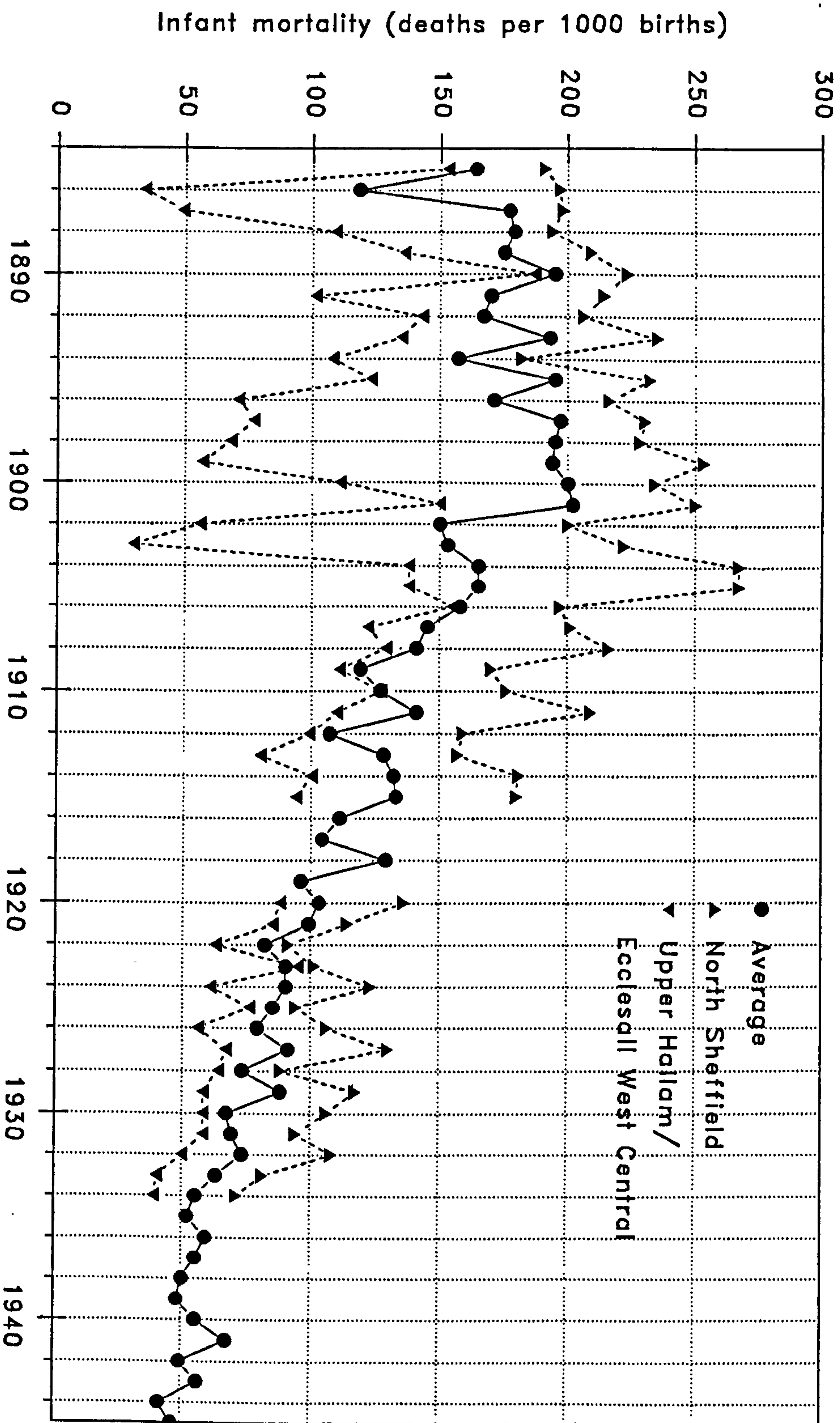


Figure 4.1

Source: MOH Reports, Sheffield

trades were based, experienced levels of IMR consistent with the average rate in Sheffield (see *Plate 5* and *Plate 6*, which give an indication of housing density in working class areas). Areas such as Brightside were overwhelmingly working class, with high birth-rates, yet had far lower IMR than central working class areas such as North Sheffield. This was probably due to their relative prosperity; the new steel works paid well, allowing families to enjoy a higher standard of living⁶.

Figure 4.1 shows the progress of IMR in Sheffield on an annual basis. It does not include Brightside as the figures for this area so closely mirror the Sheffield average; across the period 1894–1934 they were 98.3% of the City average. From about 1905 onwards IMR appears to have been falling fairly smoothly, with occasional peaks and troughs which are dramatically highlighted by the figures for the best and worst districts. Generally, the best district does not appear to have been effected by the high levels of IMR occurring in the 1890s, but more closely approached the average after 1905. The district with some of the highest rates of IMR appears to have remained vulnerable, with rates well above the average in to the inter-war period. Whatever the mechanisms acting to reduce total IMR, they obviously did have an impact on all areas, including that which had, for whatever reason, the worst rates. However North Sheffield, a central district which was socially deprived and physically run down throughout the period continued to experience peaks of IMR which were not reflected so dramatically in the average figures, and particularly not in areas which had good social and economic conditions, such as Upper Hallam/Ecclesall West Central (EWC).

Ten year running totals for IMR in the 'best' and 'worst' districts demonstrate that proportionally the gap between the two was narrowing. The worst area for IMR, North Sheffield, had an IMR 131.0% above the average for the City between 1894–1915, and an IMR of 131.8% of the City average between 1920–1934, suggesting that relatively its position was static. In contrast the position of the best district, Upper Hallam/EWC, deteriorated across the period. It had an IMR of 65.3% of the City average between 1894–1915, and an IMR of 78.7% between 1920–1934. These figures partially support the case which has been made by Winter for an optimistic view of health, despite high unemployment and poverty⁷. He has suggested that the

⁶ On the ability of people in these districts to spend well on food see; HM Govt, *Cost of Living of the Working Class*, London, pp 1908, cvii, cd 3864, p.413.

⁷ Winter claimed that IMR across all classes and all areas was improving in the 1930's, and the gap between 'good' and 'bad' areas was not widening; JM Winter, 'Infant Mortality, Maternal Mortality and Public Health in Britain in the 1930's', *Journal European Economic History*, 8, 1979, 439–62, p.451; see also J Winter, 'Unemployment, Nutrition and Infant Mortality in Britain 1920–1950', in *The Working Class in Modern British History*, ed, J



Plate 5. Attercliffe, c. 1930, showing the proximity of the big steelworks in the centre of the picture to the surrounding housing.



Plate 6. London Road, South Sheffield, c. 1930, showing the density of housing in working class districts.

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original

Total Infant and Diarrhoeal Mortality (per 1000 births) in Sheffield, 1885-1937

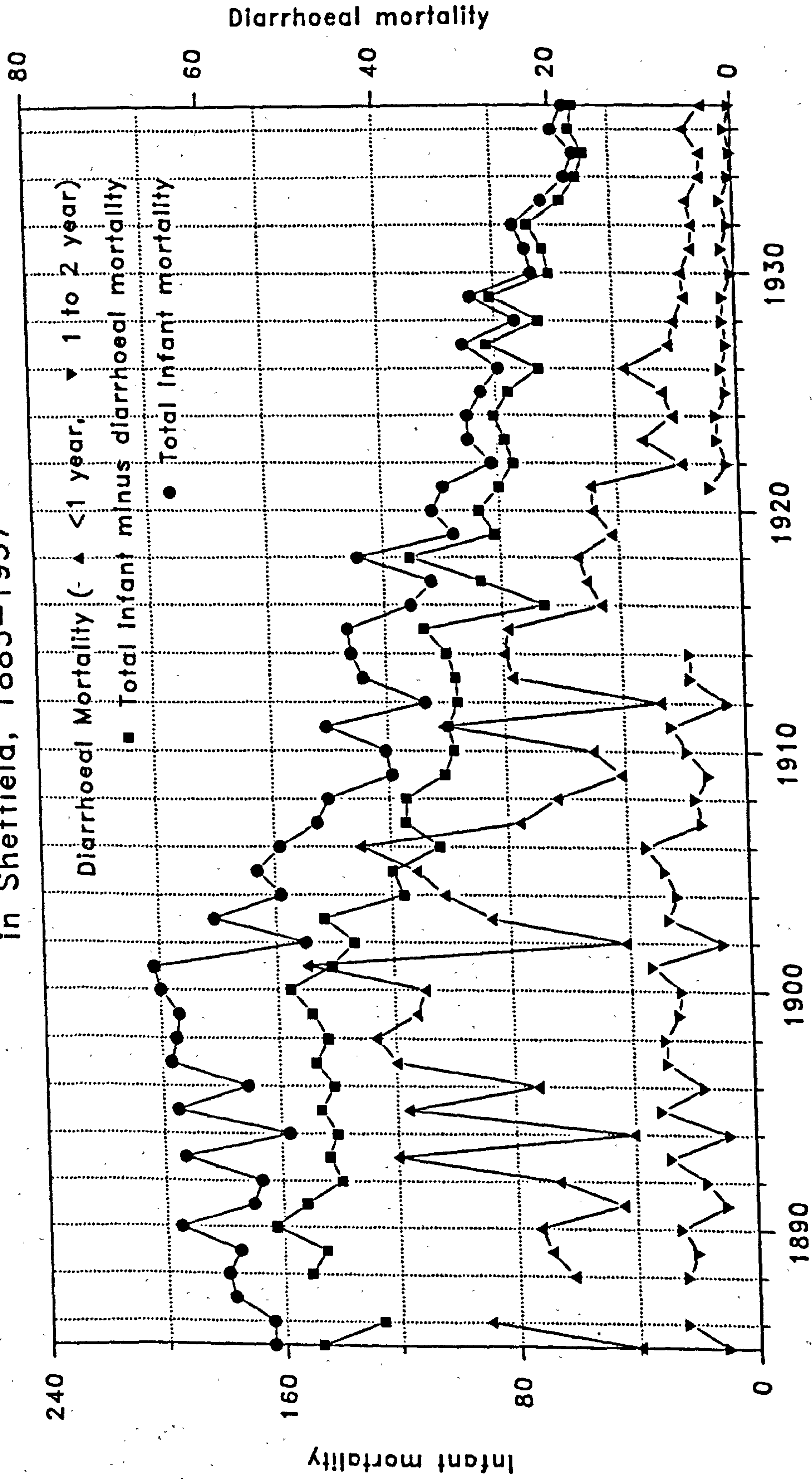


Figure 4.2

Source: MOH Reports. Sheffield

gap between IMR for the richest and poorest sections of society was narrowing by the 1930s. He further argued that IMR continued to fall even in areas most affected by the slump⁸. However the area with the highest IMR in Sheffield did not improve in relation to the City average, although it did decline absolutely. The area which had returned the best figures before the First World War continued to do so in the inter war period but moved much closer to the average. Perhaps the advantages which the area had possessed in terms of sanitation and hygiene before the First World War had spread more equitably across Sheffield in the inter war period, evening out differences in IMR due to these causes.

The experience of Sheffield was not uncommon, particularly for 'privy midden' towns⁹. The argument of Woods, Watterson and Woodward for the 'sanitary test' of the 1890s, with hot summers exacerbating diarrhoeal deaths and therefore skewing IMR up is persuasive for Sheffield¹⁰. The City's MOH report for 1901 commented that:

...it will be noted that for a number of summers past the temperature has been high, while at the same time there has been comparatively dry weather. Then during recent years we have had comparatively mild winters. During the summer of 1901 there was everything in favour of Epidemic Diarrhoea, so far as Sheffield was concerned.¹¹

Figure 4.2 demonstrates clearly the impact of diarrhoeal mortality on the total IMR. Throughout the 1890s the total IMR is raised by up to 50 points by the impact of epidemic diarrhoea. Once the diarrhoea component is removed, the line of IMR is appreciably smoothed. The rate of deaths from diarrhoeal causes, and its effect on total IMR diminishes to the point where by the mid-1920s its impact was negligible.

Diarrhoeal deaths rates for Sheffield appear striking in that the highest death rates were in the early months of life; mainly the third, fourth and fifth months, as *Table 4.1* shows. The death rate consistently doubled between the first and second months, which seems strange given the high rates of breast feeding, and the fact that infants of that age were not old enough to be

Winter, Cambridge, 1983, 232–256, p.246; for the opposing view, see RM Titmuss, *Birth, Poverty and Wealth: A Study of Infant Mortality*, London, 1943.

⁸ Winter, 'Infant Mortality, Maternal Mortality, and Public Health', p.449.

⁹ Williams, 'Death in its Season'; N Williams, *Infant and Child Mortality in Urban Areas of Nineteenth Century England and Wales: A Record Linkage Study*, unpub PhD, University of Liverpool, 1989

¹⁰ RI Woods, PA Watterson, and JH Woodward, 'The Causes of Rapid Infant Mortality Decline in England and Wales, 1861–1921', (2 parts), *Population Studies*, 42, 1988, 343–366 (part 1), *Population Studies*, 43, 1989, 113–132 (part 2).

¹¹ *MOH Report*, Sheffield, 1901, p.47.

**Infant Mortality Rate from Diarrhoeal Diseases per 1000 Living Children During Each Month of the First Year of Life,
Sheffield, 1905-9**

month	1905	1906	1907	1908	1909	average 5 years
first	2.7	2.2	1.0	1.5	1.9	1.9
second	5.0	5.4	2.1	2.2	2.3	3.4
third	5.3	6.4	3.5	3.4	3.0	4.3
fourth	5.7	6.7	4.7	3.2	1.7	4.4
fifth	5.6	6.0	3.7	3.5	2.5	4.3
sixth	3.8	7.1	2.7	2.9	2.2	3.7
seventh	4.2	4.9	2.8	2.0	1.6	3.1
eighth	4.0	3.7	2.0	1.7	1.8	2.6
ninth	2.8	4.4	2.9	2.8	1.6	2.9
tenth	4.4	3.1	2.8	1.8	1.8	2.8
eleventh	3.6	3.1	2.0	1.7	1.5	2.4
twelfth	2.1	2.9	1.5	1.5	1.1	1.8

Table 4.1

Source: MOH Report, Sheffield, 1909.

Total Infant and Neonatal Mortality (per 1000 births)
in Sheffield, 1885-1937.

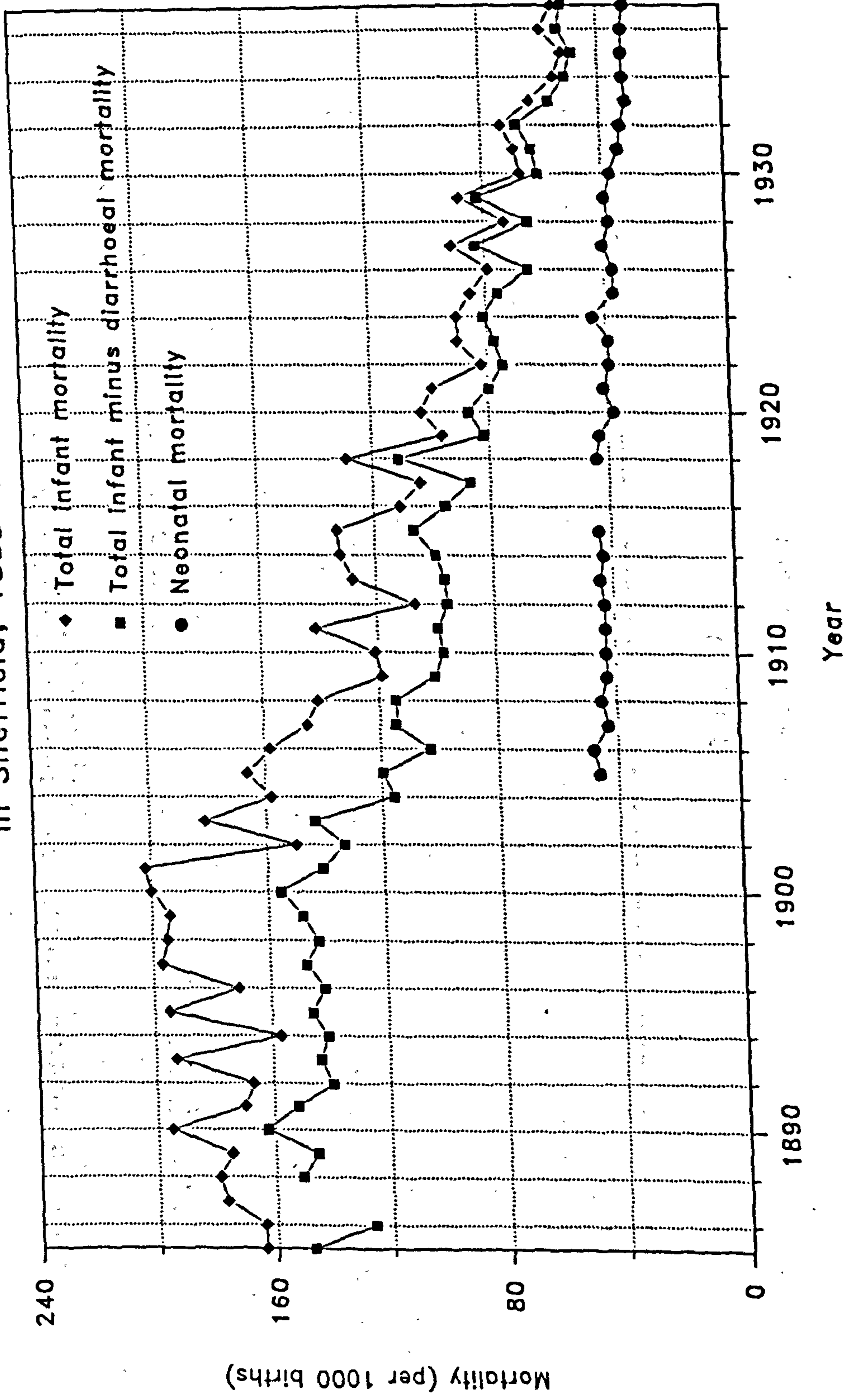


Figure 4.3

Source: MOH Reports, Sheffield

crawling in filthy courts. There are no available figures for attack rates for diarrhoea, so it is impossible to know what percentage of affected infants actually died, or whether those who died had suffered successive attacks which had progressively weakened them. The dehydration exacerbated by hot dry summers is likely to have killed more small infants. If these deaths were occurring among the small proportion of artificially fed babies in Sheffield, then initiatives at the micro level, such as attempts to improve domestic hygiene and to improve the quality of feed provided could have had a very significant impact.

Figure 4.2 demonstrates that the majority of diarrhoeal deaths occurred among the under 1's, suggesting that older children had built up some natural immunity by their second year, despite the fact that this was the period when, for the majority, breast feeding stopped, and when they were more exposed to their environment¹². It also shows that diarrhoeal death rates had the same peaks and troughs for the under 1's and the under 2's, suggesting that the same causal factors were operating on both groups. Williams has argued that similar patterns in both age groups imply the influence of external sanitary conditions on death rates, rather than patterns of feeding which were likely to have been different for the two ages¹³.

Even across the period represented by *Table 4.1* rates for diarrhoeal deaths fell by about half, even for the worst affected months. Whatever factors were acting to reduce diarrhoeal mortality, they were acting across all age groups, and quite rapidly.

The neonatal mortality rate (NMR) was also falling at a steady rate from 1905, when the first figures are available. *Figure 4.3* demonstrates the increasing importance of NMR as a component of IMR, as it was not falling at such a fast rate. This was partly due to the negligible impact of diarrhoea rates on NMR, and the failure of its main causes such as prematurity and development problems to respond to targeted measures, particularly directed through ante-natal care. By 1930 NMR represented over 50% of the total IMR.

¹² According to the figures from the WSI's for 1909/10, of 5698 babies whom they were visiting, and who survived their first year, 3898 had not been weaned. *MOH Report, Sheffield, 1910, p.xix.*

¹³ Williams, *Infant and Child Mortality in Urban Areas of Nineteenth Century England and Wales, p.125.*

4.2b: The Development of Concern about Infant Mortality:

...the lowered birth rate in this country makes the saving of infantile life a matter of Imperial importance.¹⁴

At the root of much of the interest in theories of social engineering lay a concern about the falling birth rate, coupled with persistently high levels of infant mortality. Between 1876 and 1899, the crude birth rate decreased by 14% from 35.5‰ to 30.5‰. The infant mortality rate remained at best stable with a rate of around 150‰.¹⁵ The fear was that a falling birth rate coupled with a stable infant mortality rate would lead to a rapid decline in the population. The problem was seen to be of national importance by commentators (such as MO'sH, eugenists, imperialists) although attempts at alleviating it were made far more on a local level. Until the turn of the century, however, public health was very much concerned with macro influences on the environment, including sanitation and housing. Individual health was felt to be a matter of individual responsibility. It was also far harder to tackle because it presupposed an understanding of the causes and effective treatments of common diseases including diarrhoea. The aetiology and cures of such diseases were still very much disputed¹⁶. After 1900, however, there can be demonstrated a growing interest in what was happening inside the (working class) home in terms of hygiene and nutrition. McCleary, MOH for Battersea, commented that at this time:

...it was seen that a decisive attack on infant mortality could not be made merely by measures of municipal sanitation: it was a problem not so much of sanitation but of personal hygiene.¹⁷

These opinions were backed up at the local level, where the annual reports of MO'sH in areas such as Sheffield gave voice to the developing views of health professionals. Since annual reports were often commented on in considerable detail in both the local press and medical journals, it is reasonable to assume that their words carried some weight. Pioneering MO'sH not only reiterated generally held views, but used their reports to extend the debate, or to exhort their councillors to action. Additionally MO'sH,

¹⁴ A Newsholme, 'Infantile Mortality', *The Practitioner*, ii, 1905, 489–500, p.494.

¹⁵ H Marland, 'A Pioneer in Infant Welfare: The Huddersfield Scheme, 1903–1920', *Social History Medicine*, 6, 1993, 25–50, p.25.

¹⁶ D Dwork, *War is Good for Babies and Other Young Children: A History of the Infant and Child Welfare Movement in England, 1898–1918*, London, 1987.

¹⁷ GF McCleary, *The Maternity and Child Welfare Movement*, London, 1935, p.7.

and later other professionals including WSI's, were called to give evidence on central Government commissions and enquiries.

Infant mortality was seen as a problem from the compilation of the first MOH report for Sheffield in 1873:

...a large proportion of infants born are scarcely viable at birth and it also follows that if such children be subjected to the surrounding influences of impure air, bad nursing, improper food, exposure to cold, narcotics and neglect, they will surely die...¹⁸

However, it was after 1900 that consciousness about the problem of infant mortality, and in particular diarrhoea deaths, seems to have increased, as the general death rate in Sheffield continued to fall. The infant mortality rate seemed, if anything to be rising, reaching 202‰ in 1901. As reference to Sheffield will show, local authorities, and other institutions such as hospitals tended to take action unilaterally and seek assistance from central Government, principally the Local Government Board (LGB), retrospectively. It seems likely that much of the impetus for action in this field came from local bodies, in response to problems and needs as perceived locally. This was despite a strong body of national literature on the general themes of national deterioration and maternal ignorance. At a local level the debate was generally more humanitarian, with a recognition that poverty and problems of poor sanitation had a large part to play. McCleary, writing in 1903, commented that:

It must be borne in mind that the artificial feeding of infants is a matter of great difficulty, demanding watchfulness, care, and the most scrupulous cleanliness, and it need not surprise us if many of the mothers in our poorer districts, with their wretched housing accommodation...should fail to carry out successfully the modification and storage of cows milk required in the usual municipal leaflet.¹⁹

Micro solutions to particular problems such as infant mortality undoubtedly became more significant across the period, but they in no way appear to have superseded macro solutions. In addition, although there was much written on the subject of the 'ignorance' of Sheffield mothers, there always seems to have been an acceptance that the Council had to take the lead in tackling the problem on a City wide basis. This applied in particular to the need to convert ashpits into water closets, with the reports of successive MO'sH highlighting Sheffield's deficient sewage disposal system. As early as

¹⁸ *MOH Report. Sheffield, 1873, p.16.*

¹⁹ *Journal Royal Sanitary Institute, 24, 1903, 562-576, p.563.*



Plate 7. Part of the Crofts, North Sheffield, c. 1910.



Plate 8. Privy middens in the Crofts, North Sheffield, c. 1920.

1874 the first MOH had argued for an improved system of privies, refuse bins and ashpits. Most of Sheffield used 'privy middens' into which only excrement and fine ash were supposed to be deposited, creating a saleable fertiliser (*Plate 7 and Plate 8*). In practise all sorts of water, coarse ash and household rubbish went in as well. The middens were infrequently emptied; perhaps just once or twice a year. In addition, poor construction and maintenance meant that they leaked into the surrounding earth.

The state of a large number of privy middens in the Borough, owing to their situation, infrequent removal of contents, and excessively foul condition, is such as to call for immediate action, and their abolition ought not to be longer delayed.

It is impossible not to recognise the magnitude of the work, which a general introduction of water closets will involve, but it ought to be proceeded with at once, steadily and methodically, and I do not fear, as progress is made, that many opponents of the system will be convinced of its advantages and of the improvement it will effect in the condition, moral and physical, of the people.²⁰

The MOH, Dr Littlejohn, seems to have been trying to persuade members of the Council into what they recognised would be a slow and expensive course of action.

...one cannot be surprised at the existence of the disease [summer diarrhoea] in many portions of the town where the yards are undrained, unpaved and sodden with sewage and liquid oozing from privy middens. I do not doubt that as these conditions are removed, we shall be able to record a great diminution in the prevalence of this disease and succeed in removing ourselves from the list of diarrhoea towns.²¹

In Littlejohn's comments there is no suggestion that the personal failings of individual mothers was the chief cause of diarrhoea; he saw it as a problem for the whole community, which had to tackle collectively the problems of its unhealthy environment. Work on removing privy middens started in 1892. By 1904 1547 had been converted and it was estimated that it would take approximately 17 years to deal with the remaining 25,000; because of the slow down during the 1914–18 war, conversion was not finished until 1928. As Williams has pointed out, there were significant variations in IMR between areas with different disposal systems, but judging the impact of conversion is not simple. IMR in Sheffield had been falling for nearly twenty years by the

²⁰ *MOH Report, Sheffield, 1891, p.31.*

²¹ *MOH Report, Sheffield, 1892, p.19.*

Conversions from Privy Middens to Water Closets, Sheffield 1890-1928.

	1890-1	1892	1893	1894	1895	1896	1897	1898	1899	1900	1901	1902	1903
number of houses converted	26	264	264	365	220	200	769	1027	1298	1750	1672	2181	2994

	1904	1905	1906	1907	1908	1909	1910	1911	1912	1913	1914	1915	1916
number of houses converted	3282	4034	4445	4530	3952	3009	3294	2453	2321	2586	2940	2528	301

	1917	1918	1919	1920	1921	1922	1923	1924	1925	1926	1927	1928
number of houses converted	70	43	182	1070	1155	1215	1380	2027	2570	2373	2033	213

Table 4.2

Source: MOH Reports, Sheffield.

Infant Mortality Sheffield, excess over English rate, 1897-1937.

	1897	1898	1899	1900	1901	1902	1903	1904	1905	1906	1907	1908	1909	1910
Sheffield	196	195	194	200	202	150	181	158	166	158	145	141	119	121
Excess Over English Rate	40	35	31	46	51	17	49	13	38	26	27	21	10	22

	1911	1912	1913	1914	1915	1916	1917	1918	1919	1920	1921	1922	1923	1924
Sheffield	141	107	128	132	133	111	104	129	96	103	99	82	90	90
Excess Over English Rate	11	12	15	27	23	18	6	31	7	22	16	5	21	15

	1925	1926	1927	1928	1929	1930	1931	1932	1933	1934	1935	1936	1937
Sheffield	85	79	91	73	88	67	69	73	63	55	52	59	55
Excess Over English Rate	10	9	21	8	14	7	3	8	-1	-4	-5	0	-3

Table 4.3

Source: MOH Reports, Sheffield.

time conversion was complete; the work added to the health of the City but could not be its only cause (see *Table 4.2*).

In 1897 the MOH began reproducing tables comparing the IMR in Sheffield with those of other great towns, and with the average English rate (*Table 4.3*). The comparisons were not generally favourable to Sheffield, and the importance of such symbols of civic 'failure' should not be underestimated. In 1903 Sheffield had the worst IMR of the 20 great towns, at 181‰, and in 1905 was beaten only by Bolton. Possibly the Council was shamed into action by its high figures in relation to comparable cities, in which case the Registrar-General's use of health 'league tables' to encourage initiative seem to have worked. Szreter has commented that:

The GRO (General Record Office) blatantly and successfully set out to foster an atmosphere of competition and rivalry between local authorities with respect to their widely varying levels of mortality and thereby to create a national forum of informed public opinion and urgent debate on disease and mortality and the need for preventative public health measures.²²

In 1906 a sub-committee of the Council's Health Committee was created to enquire into '...the high rate of infantile mortality in Sheffield and the best means of reducing such death rate'. The same year also saw the creation of several new volunteer groups, including the Sheffield Motherhood League, and the Guild of Help. It is unclear why 1906 appears to have been such a watershed year for attempts to tackle infant mortality, although the cumulative effect of bad figures, and bad publicity must have had an effect. There seems to have been little discussion on fears of the decline of the City or the race. Action seems to have started with the optimistic premise that it was possible to improve the situation; there was no sense of fatalism concerning infant death:

This appalling mortality amongst young children is no doubt largely preventable, occurring chiefly in children of the poorest class, and being due to exposure, deficient and unsuitable nourishment, and, to a certain extent, insanitary surroundings.²³

The fact that the problem was seen as 'largely preventable' is significant. Although these reports pointed to deficiencies in sanitation, and in child care by parents, they never referred to it as a hopeless situation caused, for

²² S Szreter, 'The GRO and the Public Health Movement in Britain, 1837-1914', *Social History Medicine*, 4, 1991, 435-464, p.437.

²³ *MOH Report*, Sheffield, 1893, p.19.

example, by the inevitable deterioration of the city dwelling working classes. It was always regarded as a problem which was capable of amelioration, if not complete eradication. Although attempts to tackle IMR coincided with bad IMR figures, action was at least partly prompted by the growing confidence of the public health department, and the belief that such problems could be effectively addressed.

4.2c: The Response to Infant Mortality:

In 1873 the MOH had written of IMR that; 'This subject is of such great importance that I have prepared a circular containing simple rules for the guidance of mothers in the management of infants.'²⁴ This leaflet was to be distributed by the registrars when the birth was notified. It included exhortations on the superiority of breast milk, and the necessity of sleeping in separate beds, as well as practical advice on the washing of bottles and the storing of milk. This was advice that would re-occur down to 1920 via various media including leaflets, lectures and health visitors.

A report compiled by the MOH for the Council in 1900 argued that the causes of high mortality in Sheffield could be remedied through the inspection and education of working class parents, particularly mothers, and through attention to the problems of sanitation. In this he was following the lines of national debate. George Newman (MOH for Finsbury, then at the Board of Education, then at the Ministry of Health after 1919.) drew attention to the many environmental factors affecting infant mortality: '...the conditions which operate in greatest force are urbanisation, housing and poor social life, alcoholism, and birth rates.'²⁵ However, despite this heavy emphasis on the role of the environment, including antenatal influences on the health of the child (though not the mother), Newman came back to the doctrine of personal responsibility, and maternal inadequacy which characterised most contemporary work on infant care, and concluded that:

...it becomes clear that the problem of infant mortality is not one of sanitation alone, or housing, or indeed of poverty as such, *but is mainly a question of motherhood.*²⁶ (italics in original)

He seems to have had no problem with the fact that this statement contradicted many of his earlier ones, and was indeed belied by his own work with milk depots in Finsbury, and later in helping to create a National Ministry

²⁴ MOH Report, Sheffield, 1873, p.16.

²⁵ Report of the Inter-departmental Committee on Physical Deterioration, London, 1904, p.57.

²⁶ G Newman, *Infant Mortality. A Social Problem*, London, 1906, p.177.

of Health. In fact, mothers, particularly in the pre-war years, were held uniquely responsible for problems of high infant mortality, and even the qualitative deterioration of the entire race. There was considerable debate on the influence of poverty, housing and sanitation on the infant mortality rate, but mothers were seen as reasonable targets for attack because of the theoretical and sentimental elevation of motherhood to a state akin almost to a religious vocation. Words such as 'duty' and 'sacrifice' abounded in discussion of motherhood. If mothers had a sacred duty towards their children, then infant mortality could be seen as their failure. John Burns, the President of the LGB, speaking at the 1906 London Conference on Infant Mortality, made the famous remark that people should '...glorify, dignify, and purify motherhood; for what the mother is the children will be.' Motherhood should be a woman's ultimate aim, and the conduct of any children should be laid at her door. The comment has been quoted many times as the embodiment of the early twentieth century view of women.

The explicit attack on mothers took two main forms; their competence inside the home, and their employment outside it; tangential were concerns about abortion and birth control which will be considered in Chapter 6. The generally preferred solution was the education of girls and women for domesticity and motherhood. These weaknesses in mothering manifested themselves primarily in the refusal of women to breast feed and their preference to rely on artificial feeding. It was the resolution of this problem; the provision of nutritionally and hygienically acceptable alternatives to breast milk; that led to the creation of municipal or private milk depots. It also led to calls to teach mothers about the importance of breast feeding, and about other types of food which were suitable, and how these might be stored and administered. The question of motherhood, and how women might be educated into a proper respect for, and performance of, their responsibilities was generally held to be more important than municipal provisions, although the latter did have a role to play in the dissemination of advice and information. One of the major roles of the emerging profession of municipal health visitors was the provision of advice, verbal and written. A contributor to the *Journal of the Royal Sanitary Institute (RSI)*, suggested that house to house visiting:

...will afford one more opportunity to our visitors to speak seriously on infant feeding – a subject upon which the ignorance of mothers is so gross and so fatal that it is hardly credible to ordinary people.²⁷

²⁷ *Journal Royal Sanitary Institute*, 24, 1924, 306–318, p.309.

Women Sanitary Inspector's Work with Respect to Births 1906

1.	No. of babies visited	9458
2.	No. of above who were first children	1857
3.	No. of above who were healthy	8824
4.	No. of above who were puny	634
5.	No. of above who were breast-fed entirely	7809
6.	No. of above who were breast-fed partly	812
7.	No. of above who were bottle-fed entirely	781
8.	No. of above who were fed otherwise, e.g. spoon-fed &c.	56
9.	Type of feeding bottle used – Boat-shaped	761
	Long-tubed	310
10.	Children put out to nurse (usually day time only)	63
11.	Cases in which mother was engaged in some occupation	251
12.	Cases where house was dirty	269
13.	Cases where separate cot used	721
14.	No. of cases where – midwives attended	4506
	doctors attended	3037

(information with respect to No.14 was not obtained until after February 1906)

Table 4.4

Source: MOH Report, Sheffield, 1906

She further commented that 'I do not think many of us have much doubt that individual attention to individual cases is the only way of practically helping any cause or any class.'

In 1899 Sheffield City Council put such ideas into local practice when it appointed its first women sanitary health inspectors (WSI's) whose duties included the visiting of the homes of the poor to give 'instruction' on infant rearing after childbirth²⁸. This work was initially slow to take off; in their second year only 466 children were visited. They were not appointed specifically to do this job, and their role as 'health visitor' evolved over the following ten years. Initially their work also included the wider problems of domestic sanitation. Thus in 1899, there were 943 orders given concerning the 'cleansing, whitewashing, and ventilation of houses'. Evidence from a survey by the Women's Co-operative Guild showed WSI's visiting all residents of a court, regardless of age or sex; they checked on home workers and the old or disabled as much as on children²⁹. In 1902 they made 793 visits specifically with regard to diarrhoeal deaths. After this date, notification of all births in the City was received, and those where advice might be found useful were visited. This would presumably have precluded middle class areas where visiting would be socially difficult. These first visits would have been when the baby was only a few weeks old. It seems likely that the inspectors kept detailed information on the first visit to each house, as information provided in tabular form in the MOH Reports now included details of whether infants were first children, how healthy they were, how they were fed, where they slept, if the house was dirty, and who attended the birth. (See *Table 4.4*) This table suggests that the role of the inspector was an increasingly complex one. It involved the dispensing of advice according to middle class standards of belief; i.e. over the co-sleeping of babies. It also involved the gathering of factual information, such as the type of birth attendant, together with the collection of very subjective information, presented in a factual way, such as the cleanliness of the house, or whether the infant was 'puny'.

²⁸ Sheffield was in the vanguard of this type of appointment; Nottingham had appointed Lady Factory Inspectors in 1892, Liverpool in 1897, and Leeds appointed WSI in the same year as Sheffield; C Davies, 'The Health Visitor as Mothers Friend: A Woman's Place in Public Health 1900-1914', *Social History Medicine*, 1988, p.47. Huddersfield, regarded as a pioneer of the infant welfare movement, although Marland has effectively disputed this impression, appointed health visitors relatively late, in 1905; although it did appoint female doctors; H Marland, 'A Pioneer in Infant Welfare: the Huddersfield Scheme, 1903-1920', *Social History Medicine*, 6, 1993, 25-50, p.35.

²⁹ 'Enquiry by Mrs Abbott and Miss LI Davies re. Poverty and Poor Areas', *Women's Co-operative Guild*, 1902.

It was the work of the Council sub-committee which looked into infant mortality which prompted the next new developments in Sheffield's welfare policies. The Committee was set up in 1906 and took evidence from many of the prominent figures in the child welfare movement, including Newman, and Alderman Broadbent from Huddersfield³⁰. The Committee did not come down in favour of milk depots or municipal clinics; both popular solutions in other cities. These worked on the assumption that many women were not breast feeding and that infants were given incorrect or dangerous foods in an unhygienic manner. This allowed them to contract diarrhoea when warm summer temperatures made it most prevalent.³¹ The idea had begun in France where the first 'goutte de lait' was opened by Dr. Leon Dufour in 1894, in Fécamp, Normandy. In 1899 the first British milk depot opened in St. Helens. However, the Sheffield report concluded that:

...whilst there are many factors bearing on the question of Infantile Mortality in Sheffield, the causes which stand out most prominently are the ignorance and apathy of a large proportion of the mothers.³²

In fact the main recommendation of the Committee centred around the perceived need for more education of mothers and potential mothers. They called for girls in their last year at school to spend at least one day a week on domestic subjects, including housewifery, laundry work, cookery and childcare. Evening classes in the same subjects were to be compulsory for those who had left school. The main demand of Florence Greenwood, Sheffield's first Chief WSI, in her paper on working women was for the provision of education to cut through some of the '...dense ignorance...' which she felt prevailed in the slums of cities such as Sheffield. However, demands for the teaching of domestic hygiene, cooking and childcare to schoolgirls, and for the provision of 'schools for mothers' for older women, relied on a growing belief that the rearing of the next generation could and should be conducted along scientific lines. Morant, chief civil servant at the Board of Education, issued a memo in 1910 commenting that:

If girls and women could be taught how to take care of infants, we might hope to diminish not only the high rate of infant mortality, but also

³⁰ For the role of Broadbent in the Huddersfield scheme of infant health see H Marland, 'A Pioneer in Infant Welfare: the Huddersfield Scheme, 1903-1920', *Social History Medicine*, 6, 1993, 25-50.

³¹ A Newsholme, *Fifty Years in Public Health*, London, 1935. GF McCleary, *The Maternity and Child Welfare Movement*, London, 1935, p.6.

³² *Report of Sub-Committee on Infantile Mortality*, 1906.

the large amount of unnecessary ill health and physical suffering caused by neglect in infancy and childhood.³³

Dr Scurfield, the MOH for Sheffield at this period, suggested that the franchise should be extended to those women who were of age and who obtained a 'certificate or diploma in domestic economy.'³⁴ The Council did not take up these recommendations, which the Secretary of the Labour Representation Committee, George Ward, had castigated as 'minor matters' which constituted the committee's 'inadequate report'.³⁵

As regards milk depots, the Infant Mortality Committee had argued that:

The majority of the committee are not convinced that the advantages to be obtained from the Infant Milk Depots warrant the establishment of such Depots in Sheffield...They hope that some local voluntary organisation will, as in some other towns, take in hand the provision of milk and food for expectant and nursing mothers of the poorer classes...

In a vote on the same issue all the doctors on the committee, including Lucy Naish, later a leading light of the depot and consultation programme, voted against milk depots, although the reasons were not stated³⁶. Only two of the Councillors and Ward, the labour representative, supported the proposal³⁷. The latter had published a pamphlet calling for milk depots as a cure for infant mortality the previous year and championed the cause in the pages of the *Sheffield Guardian*³⁸. The Committee did not seem to feel that the advantages of depots warranted their creation; and it is not clear why the full Council did in fact choose to set up an infant milk depot in 1907, although this provided only cost price dried milk, not the fresh milk originally envisaged, as the former was felt to be more hygienic, more easily digested and cheaper.

³³ Quoted in C Dyhouse, 'Good Wives and Little Mothers: Social Anxieties and the Schoolgirls Curriculum, 1890-1920', *Oxford Review Education*, 3, 1977, 21-35, p.29

³⁴ *SI*, 13/04/07.

³⁵ *Sheffield Guardian*, 8/3/07.

³⁶ The Naishs', were two doctors committed to the development of maternity welfare. Dr Albert Ernest Naish was born in Bristol in 1871 and trained at Cambridge and London where he met and married Lucy Welbourn. They entered joint practice in Hillsborough in 1902. They were both involved in the development of infant welfare clinics, and later antenatal clinics, although it was AE Naish who developed academic paediatrics in Sheffield. He was appointed assistant house physician at the Royal Hospital in 1906, and rose to become Senior Honorary Physician, Professor of Medicine at the University in 1931, and President of the British Paediatrics Association. He also held the post of honorary paediatrician at the Jessop Hospital for Women. Lucy Naish set up the Council ante-natal clinic, and was also a Poor Law Guardian.

³⁷ Ward described the doctors on the committee as 'a stumbling block to progress' on the creation of a milk depot or appointment of lady doctor; *Sheffield Guardian*, 8/3/07.

³⁸ GHB Ward, *Infant Mortality: Its Cause and Cure. A Plea for Infants' Milk Depots and the Municipal Supply of Milk*, Sheffield, 1905; *Sheffield Guardian*; 19/10/06, 16/11/06, 26/10/06, 15/2/07, 15/3/07, 7/6/07.

The scheme was considered so successful that it continued even after the diarrhoea 'season' was over. Yet the scheme dealt with only about 700 babies per year at its height; a very limited solution. Those needing milk received it at cost price, on the condition that they brought their babies every week for weighing and to be seen by the doctor³⁹. Although the supply of dried milk always remained small scale the provision of baby consultations quickly gained momentum, however. Figures for total attendance at the clinics suggest that there was a real demand for a service that would provide basic practical and health care advice (see *Table 4.7*). The first report on the milk depot signalled what would become its primary function; 'Any poor mothers with small babies who are in need of advice, and who do not necessarily require Dried Milk can also bring their babies to the consultations.'⁴⁰ Mothers having difficulty breast feeding were encouraged in an attempt to prevent early weaning.

One area where Sheffield was early to act was that of the notification of births. A voluntary scheme had been started in Huddersfield in July 1906, becoming compulsory in November of the same year, and carrying a 'reward' of 1/- for every birth notified to the Council⁴¹. Huddersfield was the first area in the country to adopt this idea, which was perceived to be successful in allowing babies to be visited early by inspectors, and helping to reduce IMR through advice and monitoring. As early as October 1906, the Council in Sheffield looked at the possibility of starting a similar scheme⁴². However, it was anxious to keep costs to a minimum, and proposed to drop the value of the 'reward' to 6d. It was also decided that to take advantage of the resulting new information, all new WSI should have a midwifery qualification, and those already in post should be sent for training at the Council's expense⁴³. A compulsory notification scheme was written into the Sheffield Corporation Act of 1907, but two months before it was due to be implemented, the Council discovered that the national permissory Act on the Early Notification of Births would give it the same powers at no cost, as there was no provision for a 'reward'⁴⁴. The local act was therefore dropped in favour of the national one, demonstrating the Council's continued determination to save money where

³⁹ Despite the fears of the Committee on Infantile Mortality, The Chief WSI was able to suggest by 1911 that the scheme was 'practically' self financing; G Franks, 'Women Workers in Public Health in Sheffield', *Sanitary Inspectors Journal*, 18, 1912, p.108.

⁴⁰ *MOH Report*, Sheffield, 1907, p.40.

⁴¹ H Marland, 'A Pioneer in Infant Welfare: the Huddersfield Scheme, 1903-1920', *Social History Medicine*, 6, 1993, 25-50.

⁴² *Council Minutes*, Sheffield, 23/10/06.

⁴³ *Health Committee Minutes*, Sheffield, 1/11/06.

⁴⁴ In addition, the provisions of the National Act were not time limited; the local Act would only have lasted until August 1911.

ever possible. The development of the local act did, however, demonstrate the Council's growing receptiveness to new ideas, and that it was noting the initiatives being taken in other areas.

By 1913 the Women Inspectors' department consisted of a head and 17 staff, all with the triple qualification of hospital nurse, midwife and sanitary inspector. This represented a major investment on the part of the City Council, and demonstrated their commitment to this type of community assistance, which they obviously believed represented the most effective method of tackling infant mortality. They visited approximately 60% of the 13–14,000 births occurring in Sheffield each year. By this time baby consultations were occurring on 5½ days in the week under the supervision of the two Naish doctors (husband and wife) and Dr Sophia Witts.

Philip Boobyer, MOH for Nottingham, described the routine at the Nottingham School for Mothers, the second to be established in Britain, after St Pancras in 1907.⁴⁵ The female inspectors sent or brought mothers to the School as soon as they could get around after their confinement. Once there they would be taught proper breast feeding, and infant care and hygiene. They would also be given 'wholesome and nutritious meals' if necessary. Classes on hygiene and cooking were held, together with advice on making infant clothes and on making cradles out of banana boxes '...being especially warned not to have their babies in bed with them.' Advice was given by doctors about problems and illnesses suffered by mother and baby, with treatment being given in acute cases such as diarrhoea. This description illustrates why such welcomes were increasingly popular with mothers, despite the attempts at social control. Free meals were provided as well as medical advice. It seems likely that mothers would have valued these aspects of the schools, whilst objecting to being told where their infants should sleep, or what they should wear. Perhaps for reasons of poverty they were unable to carry out such prescriptions even if they wanted to. Dyhouse has suggested that by the time of the First World War it was difficult to distinguish between schools for mothers, and infant consultation clinics in terms of their provision. The practical aspects of the clinics perhaps took increasing precedence over 'teaching'.⁴⁶ For Liverpool, as in Sheffield, clinics started as places to provide milk, but came to be primarily advice centres⁴⁷.

The war years saw a steady increase in the use of the clinic in Sheffield, assisted by grants from the LGB to cover part of the costs of

⁴⁵ The Nottingham School for Mothers was opened in 1908, a year after St Pancras: Dyhouse, 'Good Wives and Little Mothers', p.28.

⁴⁶ Dyhouse, 'Good Wives and Little Mothers', p.28.

⁴⁷ *BMJ*, i, 1916, p.737.

1920	1921	1922	1923	1934	1925	1926	1927	1928
29	9	14	10	11	6	7	3	16
1929	1930	1931	1932	1933	1934	1935	1936	1937
10	9	12	3	5	15	12	13	20

Notifications of Intention to Substitute Artificial Feeding for Breast Feeding in Sheffield, 1920-37.

Table 4.5

Source: MOH Reports, Sheffield.

maternal and child welfare schemes. By 1921, the issue of free milk alone to expectant and nursing mothers and infants was costing nearly £500 per year. A Council committee devoted to maternal and child welfare was set up in 1918⁴⁸. In 1920 there was a new development, following new rules laid down by the Central Midwifery Board (CMB); the attempt to enforce breast-feeding by making intention to feed noticeable to the MOH⁴⁹. There were 29 cases in 1920, reduced to 9 the following year, but creeping up again in later years. However, schemes to encourage previous bottle feeders to breast feed new babies through the welfare clinics appear largely to have failed:

No progress has been made with the new treatment for promoting breast feeding. Only 3 patients who have been unable to breast feed before presented themselves. Two of these promised to come back for their tablets but failed to do so, the third was very poor so the tablets were given. She was feeding baby when the inspector saw her two months after baby was born, in spite of the fact that she had had a serious illness. But on a later visit she had got tired of doing so and weaned her baby.⁵⁰

As *Table 4.5* demonstrates, the WSI's continued attempting to tabulate these figures, but little reference is made to them in MOH Reports. The figures were so tiny as to have represented only a fraction of those not breast feeding in Sheffield. If 10% of mothers were estimated to be artificially feeding, then a notification of, e.g. 10 in 1923, would have covered only 1% of the artificially fed babies in Sheffield that year.

The inter-war years also saw the development of branch clinics, particularly associated with the new housing developments. These were not without controversy, which will be considered in the section on what mothers felt about the services. Branches were opened at Woodhouse and Handsworth in 1922; on the new estate of Firth Park in 1938; and there was one under construction at Manor Top at the outbreak of war in 1939 (see *Plate 9* and *Plate 10* for an illustration of the Firth Park scheme. The plan of the Clinic shows the ground floor services; the floor above had an identical layout but was for ante-natal treatment). It was stressed that:

An appreciable amount of medical treatment will be given, but the essential aim of the service is a preventative one, the fundamentals

⁴⁸ This was in response to the *Maternal and Child Welfare Act* of 1918, [9. Geo.5.c.29].

⁴⁹ Rule E.12A, *Rules of the Central Midwifery Board*, 1919.

⁵⁰ *MOH Report*, Sheffield, 1926, p.105.

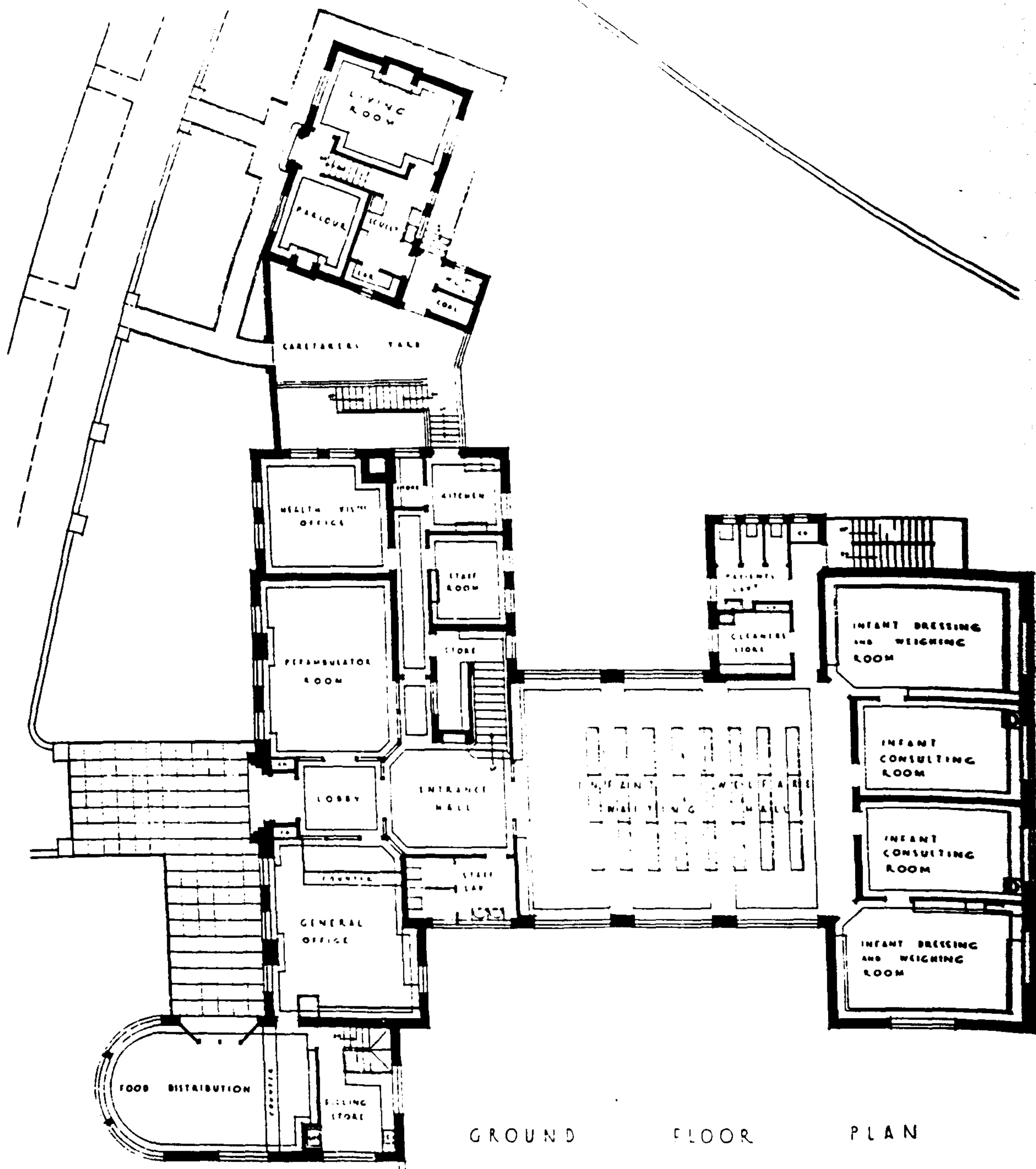


Plate 9. Plan of the Firth Park Maternal and Child Welfare Centre, opened 1938. *Source:* Sheffield City Council, *Firth Park Maternal and Child Welfare Centre, Opening Ceremony, 1938*, pamphlet.



Plate 10. The Firth Park Maternal and Child Welfare Centre, opened 1938.

being the care during the ante-natal stages and the ensuing of the well-being of the mother and the young child.⁵¹

By 1921 the IMR had fallen to 99‰ and never again rose to 3 figures in Sheffield as a whole. Also, and much to the relief of the Council, IMR in the City more closely mirrored national rates than had previously been the case; indeed by the early 1930s local rates were below the national average. Any weaknesses which remained in tackling infant mortality were not peculiar to Sheffield, and the Council was still taking credit for the success in the 1930s.

4.2d: The Work of Voluntary Agencies:

Council initiatives did not occur in isolation. As early as 1893, the MOH had been calling for co-operation between the Council and voluntary workers in providing a health visiting service for Sheffield along the lines of those in operation in Manchester and Salford:

Voluntary efforts can often effect good where official intervention is powerless, and an enthusiastic band of voluntary workers who would visit the homes of the poor, and impart instructions relating to ventilation, feeding and similar subjects, would be a great boon to the Town.⁵²

The 1906 report into infant mortality also favoured a voluntary scheme, yet in both cases the route actually taken was the professional rather than volunteerist one⁵³. Edith Maynard, one of two original WSI's later complained that voluntary groups should be discouraged from house to house visiting, as it made it very difficult for WSI's to enter if people felt they had already had their fair share of visitors⁵⁴. Florence Greenwood, the other original WSI, complained in her evidence to the Inter-Departmental Committee on Physical Deterioration that '...there are large tracts in Sheffield which are left – poor neighbourhoods with very poor churches – with very little visitation at all by voluntary workers. There is no charity organisation, and no central organisation, and the charities are very apt to overlap.' 'I would welcome every voluntary or charitable agency, and it has been my endeavour to get in touch with those which exist and to bring cases to their notice.'⁵⁵

⁵¹ *Firth Park Maternal and Child Welfare Centre, Opening Ceremony*, 1938, pamphlet, p.13.

⁵² *MOH Report*, Sheffield, 1893, p.15.

⁵³ *Minutes of the Special Committee appointed to consider the high rate of Infantile Mortality in Sheffield and the best means of reducing such death rate*, 1906.

⁵⁴ EL Maynard, *Women in the Public Health Service*, London, 1915.

⁵⁵ HM Govt, *Report of the Inter-departmental Committee on Physical Deterioration*, vol. 1–3, London, pp 1904, xxxii, cd 2175, p.313, qu 82246–7.

Of the voluntary groups operating in Sheffield before 1920, and dealing with maternal and child welfare, the one which had the most contact with the health professionals was the Motherhood League. This was a local organisation which grew out of the Sheffield Federated Health Association, a body which had campaigned on issues of public health including housing, smoke abatement and sewerage since 1899. The Motherhood League was formed in 1906 after the apparently successful reception of a course of four lectures given on motherhood in the City. Its aims, as stated in its constitution were:

- 1). To create higher ideals of parentage and home life.
- 2). To lessen infantile mortality.
- 3). To promote the welfare of all children.⁵⁶

The League's intended approaches to the realisation of these aims were through public lectures, and the printing and distribution of leaflets. By 1909, the League claimed that it had organised 168 lectures with attendances ranging from 40 to 200. The winter programme of lectures which took place at 20 different centres, mainly church halls, comprised of 8 core lectures; pregnancy, care of babies in health, care of babies in sickness, care of older children, food values and what to buy, cooking and the preparation of simple dinners, sick nursing in the home, and the clothing of children. Baby shows were also organised annually, and seem to have been popular; 400 babies were entered for the 1908 show and nearly 80 prizes distributed:

On the whole the Show was a great success, and gave a good deal of satisfaction and encouragement to the mothers. It was a revelation to many of the spectators, and even to some of the judges, as to what can be done in the way of "baby rearing" even in the worst districts of Sheffield. The judges were struck by the size and weight and general good condition of the babies, and this speaks well for the careful "mothering" of the members of the Motherhood League.⁵⁷

In its annual report for 1910/11 the League commented that: 'It is hoped that in time the League will become the recognised organ of the opinions and wishes of the best of working class mothers in Sheffield.'⁵⁸ The minimum annual subscription was 1d, suggesting that the group hoped to reach down into the ranks of the working classes. By 1913/14 there were

⁵⁶ Sheffield Federated Health Association, *Smoke Abatement Exhibition, 1909*, programme, p.25-9.

⁵⁷ *Smoke Abatement Exhibition*, programme, p.25-9.; see also *SI*, 29/09/08

⁵⁸ *Motherhood League Annual Report, 1910/11*, p.16.

2000 members on its books which suggests that the League did possess a level of mass appeal. It was very much a local organisation, and does not appear to have had contact with groups in other cities.

The public lectures, which were the mainstay of League efforts, demonstrate the close co-operation which the group received from the Council. From its inception, it was the lady Mayoress who fulfilled the position of president of the organisation, with one of the Councillors functioning as treasurer. The driving force behind the League however, appears to have been Mrs Scurfield, wife of the MOH for Sheffield between 1904 and 1919. On the resignation of her husband she left her post as Secretary, and the League voluntarily disbanded the following year with the comment that the welfare committee of the City Council was effectively doing the work of the League. This does not seem to say much for their wish to represent working women to the Council and other such bodies; rather they appear to have been the mouth piece of the Council in dealing with mothers. The League appears to have functioned, to a certain extent, as the propaganda wing of the Council's Health Department. This link was made explicit by the MOH in the year the Motherhood League was founded:

Another recommendation made by the Special Committee [on Infant Mortality] was with regard to lectures to mothers. An effort is now being made under the auspices of the 'Motherhood League'...to organise a system of lectures to mothers' meetings at various centres throughout the City. There are in existence a large number of well organised mothers' meetings, some of them being very well attended. I feel perfectly certain that if the cordial co-operation of the organisers of presidents of these meetings can be secured, an immense amount of good can be done in this way.⁵⁹

It is difficult to make an assessment of the views of local mothers on these activities. Certainly it seems that events such as baby shows were popular; perhaps because they were perceived primarily as social rather than educative occasions. It is also likely that mothers would have welcomed encouragement and praise, rather than blame, for their efforts. In the same vein were the annual teas organised by the League, which in 1911 was attended by 300 members and 80 invited midwives. The League also exhibited at the 1911 Health and Home Exhibition in Sheffield, where they sold paper patterns and 'non-flam' dressmaking material, together with the ubiquitous banana box cots.

⁵⁹ *MOH Report, Sheffield, 1906, p.9.*

The Motherhood League acted as informal foil to the formal house to house visiting by the WSI's. In fact during the war years the role of the League became more formal with:

The visitation of families in connection with the provision of layettes for newly-born infants and clothing for children under 2 years, organised by the Women Inspectors' Department and the Motherhood League.⁶⁰

Its activities did give mothers the chance to socialise and to receive and exchange ideas and knowledge, although it is doubtful how far the League succeeded in publicly representing the views of its mothers. Additionally, as the League itself stated, the aim was to attract the respectable working class, who were willing and able to attend evening lectures, and to make up paper patterns and wooden cots. Mothers at the lowest end of the social scale, perhaps those most in need of encouragement if not advice, would have been unlikely to attend.

Another voluntary organisation which became closely associated with the work of the Council, albeit in the provision of more general relief, was the Sheffield branch of the Guild of Help, which was started in 1906. The Guild was deputised to assess applicants for Council relief during the trade slumps up to 1914, and to distribute the funds raised by the Lord Mayor's Fund; this involved 2000 cases in 1907-8, and 7000 in 1908-9. It also became involved with the work of the WSI's. In 1908, 8 cases of poverty were referred by the WSI's to the Guild, thereafter the figure was about 20 annually, rising to 38 in 1914 and 1915, before disappearing from the record⁶¹. None of the records of the Guild of Help appear to survive for Sheffield, although it was apparently a large branch, with up to 1000 members, and a well developed system of case visiting. Laybourn has suggested that the Guild of Help movement:

...attempted to deal with the dilemma of what to do about the poor when voluntary effort had clearly failed and when state intervention had become more likely, by suggesting a half way house of co-operation between the voluntary help and state action.⁶²

In Sheffield this appears to have led to close co-operation between the Council and the Guild⁶³.

⁶⁰ *MOH Report*, Sheffield, 1914, p.42.

⁶¹ *MOH Reports*, Sheffield, 1908-1915.

⁶² K Laybourn, *The Guild of Help and the Changing Face of Edwardian Philanthropy: The Guild of Help, Voluntary Work and the State, 1904-1914*, Lampeter, 1994, preface.

⁶³ *ST*, 21/1/07, p.8.

Many of those at the bottom of the social scale continued to be served not by participatory organisations such as the Motherhood League, but by more obviously charitable and proscriptive groups. In Sheffield those working with mothers included the Samaritan Societies of the Jessop Hospital for Women (JHSS), and the Royal Hospital (RHSS)⁶⁴. Although conducting house to house visiting and keeping case notes, their main purpose was the distribution of alms.

The first Samaritan Society in Sheffield was started in 1886 by women connected with the Royal Hospital, including the matron⁶⁵. Like the RHSS, the JHSS which started in 1896, was comprised primarily of the wives or daughters of those connected with the lay governors of the hospital. The Society appears to have arisen from the work of the lady visitors who were expected to comment on the state of the hospital and its inmates, particularly with regard to housekeeping matters such as cleaning and food. The women visitors would have had far more contact with the patients and their lives than their governing husbands, and many of the personnel involved with the Samaritan Societies were the same. As Marks has noted, the existence of such societies involved the acceptance that social need could be as critical as medical need in affecting health⁶⁶.

Although drawn from the same restricted residential area of Sheffield, they appear to have had no connection with the Council or the Motherhood League in terms of their make-up, or in the work they attempted. The personnel of the two Samaritan Societies did not overlap, and only once is there a record of joint endeavour; in 1904/05 the Sheffield Ladies Orchestra held a joint concert for the two societies and raised £21/10 for each⁶⁷. Apart from this however there appears to have been no sense of a common purpose. The groups were explicit in their desire not simply to relieve, but to enable people to regain their dignity and independence; the stated aim of the JHSS was '...to aid deserving and necessitous Out-Patients of the Maternity Department of the Hospital, by providing them with food and other necessaries to assist their recovery to health and strength, and thereby enable them to resume their household work or earn their livelihood'⁶⁸. However, the aid distributed annually was too slight to have made more than a token impact on need. Between its inception in 1896, and its demise in 1913, the JHSS

⁶⁴ LV Marks, *Model Mothers: Jewish Mothers and Maternity Provision in East London, 1870-1939*, Oxford, 1994, p.169, for similar societies in London.

⁶⁵ The Royal Infirmary never had a Samaritan Society, or anything similar; there were very few women who worked with the hospital.

⁶⁶ Marks, *Model Mothers*, p.169.

⁶⁷ *Annual Reports of Royal Hospital, 1904-05*.

⁶⁸ *Annual Report of the Jessop Hospital, 1900*, p.45.

claimed to relieve between 100 and 300 cases annually. Relief was always in kind, and consisted partly of new and repaired clothing for mothers and babies, and food parcels. The latter included meat, milk and Bovril, occasionally coal, and cab or tram fares home. In 1901, for example, only 191 cases were relieved, although this exhausted nearly all available funds, perhaps not surprising given that subscriptions totalled only c.£60 annually.

The concept of recipients as more or less 'deserving' remained a potent one to these groups:

The most numerous class of cases requiring help, are wives of Labourers, who rarely get a full weeks work, or who have no regular work and are dependent on "catch jobs". The wives often wash or char to add to the small earnings, and so, when their need is greatest their funds are least. Some of these homes are almost bare of furniture; beds have little or no covering and sheets are quite a rarity. Some are furnished houses for which high rents are charged, and no arrears allowed. But there is another and more deserving class of patients who often need such help as the Society gives. Cases where the wage earner has been laid aside by illness or accident, or after constant regular work has been reduced to two or three days a week because of slack trade.⁶⁹

Despite the deserving/ undeserving tag, unemployment and the sudden poverty it brought obviously horrified the ladies; they were aware of the economic causes of poverty, beyond the personal failings of individuals. The RHSS generally appears to have been more radical in its attitudes than the JHSS. They tried to influence the behaviour of those they helped:

Another encouraging feature in the work is the improvement in many of the homes being visited. Dirty houses and untidy inmates often give way to such brightness and cleanliness that "you might eat off the floor."⁷⁰

Again, however, the moralistic tone was not clear cut and in 1900/01 their report called for better sanitation for working class homes, together with improved food storage facilities and larger living areas⁷¹.

Often do the Visitors hear patients say, "I don't know what I should have done, or how I should have got about again, except for your help." If only the ladies who in illness are surrounded by comfort, luxury, and tender care, could see some of the homes visited and realise what it is for poor

⁶⁹ *Annual Report of the Jessop Hospital*, 1908, p.50

⁷⁰ *Annual Reports of the Royal Hospital*, 1892-93, p.53.

⁷¹ *Annual Reports of the Royal Hospital*, 1900-01, p.72.

women when confined to have no change of bed or body linen (often none at all), nothing but bread and tea for sustenance, and obliged from sheer necessity to be up and about their household work at the end of the week, their hearts would indeed be touched, and their purses opened.⁷²

4.2e: Macro Factors:

Although this chapter has concentrated on the impact of personal, micro factors, both on infant mortality and women, the importance of other, macro factors also needs to be considered. The impact of patterns of employment, or unemployment, is perhaps one of the most important, but least quantifiable of factors. The relation between employment, including that of women, and IMR was not a simple one; particularly given that the years of highest IMR were those of greatest economic prosperity. The heavy and prolonged slump of the 1920s and 1930s does not appear to have had any upward impact on IMR⁷³. Writing of the period 1920–50, Winter has argued that:

The conclusion that will be drawn is that unemployment was not the decisive cause of fluctuations in infant mortality rates during this period.⁷⁴

Evidence for Sheffield does suggest that this contention appears to have been true. However, there is qualitative evidence to suggest that contemporaries believed that even short term slumps had an impact on the health of mother and baby, although these were not constant over time. In 1908, a year of high unemployment in Sheffield, the MOH commented that:

This work [maternal and infant welfare] has been unusually difficult owing to the depression in trade and the large amount of poverty prevalent; e.g. there have been many cases where a mother has been unable to breast feed her baby owing to the fact that she was not getting sufficient food herself; there have been many cases of large families where the reduction of the wage has made it impossible to provide

⁷² *Annual Report of the Jessop Hospital*, 1900, p.46

⁷³ Mitchell has argued that although IMR's were generally improving in the inter-war period, the situation of the long-term unemployed is hard to extrapolate, as in official statistics they were subsumed in social class V, which included the unskilled employed; '...a rising standard of living for those in employment, masks the existence of the severe and increasing deprivation of the substantial numbers of women and children affected by long term unemployment.'; M Mitchell, 'The Effects of Unemployment on the Social Condition of Women and Children in the 1930's', *History Workshop Journal*, 19, 1985, 105–27; p.119.

⁷⁴ J Winter, 'Unemployment, Nutrition and Infant Mortality in Britain, 1920–50', in *The Working-Class in Modern British History*, ed., J Winter, Cambridge, 1983, 232–256, p.233.

sufficient milk for the baby, a not inconsiderable number of such cases being provided with dried milk through the Guild of Help.⁷⁵

In the same year the JHSS commented:

Owing to the dearth of employment, so many men have for months been working 1 to 3 days only each week; many more are on relief work, and when rent has to be paid and a family maintained out of weekly earnings averaging 8 to 12/–, one can imagine how bare the subsistence is, and how weak and ailing many of the poor mothers when the hour of their trial comes.⁷⁶

In the inter war period, the MOH noted that numbers attending the Maternal and Child Welfare Centre (MCWC) were affected by general conditions in the City:

The year 1923, however, was marked by a lamentable continuance of unemployment and consequent poverty in Sheffield, and this was reflected in a much reduced sale of dried milk at the Infant Welfare Centre... This must mean that a considerable number of infants have had a less suitable diet, at all events, during parts of the year, and I believe that this fact will go far to account for the increase in Diarrhoea...the price of dried milk has already been reduced, and in view of these considerations, further reductions might have to be made by the Committee, a policy much to be preferred from the Public Health point of view to any large increase in the distribution of free milk, since it is essential that the Child Welfare Centre should continue to be a place for the dissemination of instruction rather than the distribution of "Relief" .⁷⁷

However, this does show that although diarrhoea was increasing, this did not have a consequent effect on IMR suggesting that other factors were contributing to infant survival. Significantly, given contemporary concerns about female employment, it has been shown, and was accepted at the time, that this was not a factor contributing to IMR in Sheffield, since for married women in particular it was always at a fairly low level.

Harder to assess is the impact of general sanitary conditions, which, as Williams has argued, were poor across the City⁷⁸. Dr SGH Moore, MOH for Huddersfield, argued at the time that the LGB put too much emphasis on the role of general sanitary improvements in reducing IMR, and that the drop had been major and quick around the time of the development of welfare

⁷⁵ *MOH Report*, Sheffield, 1908, p.39.

⁷⁶ *Annual Report of the Jessop Hospital*, 1908, p.53.

⁷⁷ *MOH Report*, Sheffield, 1923, p.24.

⁷⁸ Williams, *Infant and Child Mortality in Urban Areas of Nineteenth Century England and Wales*.

schemes; sanitary change was too gradual to account for this⁷⁹. In Sheffield attempts to tackle the privy midden system in the City were only made after repeated exhortations by successive MO'sH. The work did not reach significant levels until the additional influence of micro factors such as the WSI's began to emerge, making it difficult to disentangle the relative importance of different factors. However, as *Table 4.2* demonstrates this work was slow to take off and even if its effect was cumulative it would have taken a considerable time for the benefit to be felt in City wide health figures. Probably of greater immediate significance, as Hardy for example has argued, was the role of the WSI's in propagating ideas of domestic sanitation and improvement.

4.2f: Conclusion:

It is likely, as researchers have found for other areas, that a multiplicity of factors impacted on levels of IMR in Sheffield⁸⁰. Undoubtedly the fall in diarrhoea death rates was the most significant component of IMR to fall in the period. The provision of WSI's and clinics probably was relevant in tackling this problem, both in the impact they had on domestic sanitation and the advice and assistance they gave to mothers. Contemporaries certainly believed that the development of these services had an impact on IMR, and this informed decisions about later welfare policies, such as those to tackle maternal mortality.

4.3: The Impact of Infant Welfare on the State and the Individual:

4.3a: Introduction:

The second section of this chapter will concentrate on the impact that infant welfare measures had on the lives of people in Sheffield, beyond the narrow effect that they had on the reduction of IMR. As has been suggested, the influence of micro measures of infant welfare did have an effect on the downward trend of IMR, but it also had wider implications for the work of the Council, for voluntary organisations, and for women as employees and mothers.

⁷⁹ *BMJ*, i, 1916, p.660; but see also; H Marland, 'A Pioneer in Infant Welfare: the Huddersfield Scheme, 1903–1920', *Social History Medicine*, 6, 1993, 25–50, who argued that Huddersfield's most significant drop in IMR was during the period of general sanitary improvements, rather than targeted personal measures.

⁸⁰ For example; E Peretz, *Maternal and Child Welfare in England and Wales Between the Wars: A Comparative Regional Study*, unpub PhD, University of Middlesex, 1992.

Infant welfare was one of the first areas of personal as opposed to public health to see major involvement by the state, in the form of local government money and personnel. The perceived success of the work of the WSI's had a significant impact on the way that future problems were tackled, including maternal mortality and maternal welfare in the inter-war years.

4.3b: State Involvement:

...let the State step in between the mother and her child and... Domestic confidence is destroyed, family privacy invaded, and maternal responsibility assailed. For the tender care of the mother is substituted the tender mercies of the State; for the security of natural affection, the securities of an unnatural law.⁸¹

One of the dilemmas faced by the Council in its early welfare work was how far they were morally justified and legally entitled to become involved in people's private lives. Given that personal advice and instruction were accorded such high priority in the saving of infant life, employees of the Council had to gain access to the family, and specifically the mother. Although many of those involved stressed the reciprocal roles of mother and expert, and emphasised the need for mutual respect, this was largely illusory and the mothers involved appear to have been aware of this. Inspectors came in uniform, despite protests by mothers, and successive MO'sH argued for the ultimate power to break up a family⁸². Their attitude was bound up with their views on the ignorance of working class parents:

It is difficult to ascertain exactly the extent to which ignorance and carelessness operates, but most medical men who practise among the poorer artisan classes have the opportunity of forming an opinion. From information obtained from medical practitioners, and from personal and other inspections, one can state, without fear of exaggeration, that at least a thousand healthy infants die every year on account of the ignorance or carelessness of their parents.⁸³

Such views also illustrated the tensions in a service which was designed specifically to combat 'ignorance' and therefore had to be targeted at specific families. In 1901, MOH Robertson commented that it should be possible to

⁸¹ Factory Inspector 1874, quoted in AS Wohl, *Endangered Lives: Public Health in Victorian Britain*, London, 1984.

⁸² Miss Kilner, a Sheffield WSI, commented in 1914 that people did not like the WSI in uniforms, suggesting that distrust of the 'official' still loomed large; *Sanitary Inspectors Journal*, 19, 1914, p.147.

⁸³ *MOH Report*, Sheffield, 1899, p.16.

take punitive measures against those who '...endanger the lives of young infants by carelessness in feeding and rearing.' He further commented that: 'The question resolves itself into one of determining how far the State is justified in interfering with the parental authority of those who are careless or ignorant.'⁸⁴ This was a potent moral problem for the Council. Although sewage, and even over-crowding, were increasingly seen as acceptable spheres of influence for a municipal authority, the role of the Council in dispensing advice and instruction, not to mention food or sanctions, to individuals was hotly contested. To enter people's homes, even those of the working classes, was a potentially fraught thing to do. The later popularity of Sheffield's municipal babies clinics demonstrated that there was a demand for non-judgmental advice and assistance. However, to go voluntarily to a clinic was different to having an Inspector impose herself upon the home, and it could be argued that those who most needed help did not go out to seek it.

In 1902, MOH Robertson complained about the difficulty in finding infants and imparting instruction; he commented that advice could only be given by the WSI's if 'by accident they come across a house with an infant in it.' The Registrar for the City did not have the power to inform the Sanitary Authority about the births that had taken place. Robertson managed to circumvent this, however, by using Sheffield's role as Educational Authority to obtain the information, which was perfectly legal⁸⁵. Sheffield adopted the 1907 Early Notification of Births Act and used the information to visit 77% of births by 1909. The remainder, totalling about 3000, '...all occurred in houses where it was not thought necessary to visit.'⁸⁶ More deaths did occur in the poorer districts, but there was also the question of gaining access to people's property and lives. Entering a middle or upper class home with advice and instruction was probably socially impossible; however desirable it might have been on health grounds.

in 1907, the new MOH, Dr Scurfield called for 'children to be under the control of a partnership of the father and mother, and that control will be supervised by the State.' He advocated sterilisation of men and women who were 'unfit to have the care of children', and the State adoption of their existing children, without entering the thorny question of how the decision should be taken, and by whom. However his 'Utopia' was not entirely punitive; he demanded a 'public medical service, available for all without the stigma of pauperism' and an increase in the minimum wage. He discounted fears of

⁸⁴ *MOH Report*, Sheffield, 1901, p.24/25.

⁸⁵ *MOH Report*, Sheffield, 1902, p.18

⁸⁶ *MOH Report*, Sheffield, 1909, p.xviii.

racial degeneration⁸⁷. As late as 1923, the MOH for Sheffield, Fred Wynne, felt the need to defend the work of his profession in attempting to reduce infant mortality, against the charge that:

...infant mortality is selective in its action, and that its reduction involves an undue survival of hereditary undesirables, thereby progressively deteriorating the race.⁸⁸

He believed that public health policies to reduce infant mortality, especially through the fall in deaths due to diarrhoea, were contributing to the survival of basically healthy infants. He argued that the congenitally unfit were still dying as neonates; and that these deaths were largely attributable to heredity, not environment. It is interesting that his defence of environmental solutions was couched in eugenic terms.

The problem of state involvement in people's lives was highlighted in 1916 when a correspondent to the *BMJ* complained about the use of 'birth inquiry cards' by women visitors:

If...she gets her information by stealth – that is, by a series of friendly visits and show of sympathy without letting her victims know of the card and its purpose – she is in my opinion, and I am sure in the opinion of many of my fellow general practitioners, acting very wrongly.

In this age of the craze for inspecting everybody and everything, it is time that we made a stand for professional secrecy, and now is the time to nip the activities of these officials in the bud. The poor are as much entitled to domestic privacy as the rich...⁸⁹

This last point was of course open to debate, and many officials and charity workers did not feel the same rules and rights applied to both groups. The question of professional duty cropped again the following year in Salford when doctors refused to notify births to the public health department:

The feeling was strongly expressed that the confidential relationship between Doctor and patient is being insidiously undermined by the legislation of the last few years, the notification of births act being a glaring example of this.⁹⁰

Despite these reservations, the general feeling was that the situation should be tackled at any price. However, despite fears, or in some cases hopes, of the state take-over of families, the services were not imposed on

⁸⁷ *SI*, 13/4/07.

⁸⁸ FE Wynne, 'Should Infant Mortality be Reduced?', *Lancet*, ii, 1923, 211–213, p.211.

⁸⁹ FA Brodribb, 'Health Visitors and Birth Inquiry Cards', *BMJ*, ii, 1916, p.408.

⁹⁰ *BMJ*, i, 1917, p.745.

hostile families. An attitude of co-operation and mutual help was increasingly stressed. The MOH report for 1909 mentioned the need for 'friendly co-operation' between the mother and the WSI's. Naish, one of the doctors involved in the milk depot, was even more explicit:

For any progress to be made...it is essential that the confidence of the mothers should be thoroughly gained. They must realise that it is not a meddlesome interference with their home affairs, or a police surveillance, but a helping hand that we wish to extend to them.⁹¹

The importance of co-operation appears repeatedly in MOH reports, in connection both with mothers and with midwives, and highlights Lewis' views on the 'mixed economy of welfare', with the mother in particular seen as a necessary participant in, as well as recipient of, welfare⁹².

By 1921, with IMR at 99‰, the Council felt able to congratulate itself on the success of its policies:

This great improvement [in diarrhoea] rates can only be attributed to the greater attention given to child welfare, the actions of the Lady Inspectors, and the large substitution of Dried Milk for fluid milk, the measures taken for the prevention of fly breeding...and the lessened number of privy middens in the congested parts of the town.⁹³

This view was important because by the inter-war period, the Council was the only major supplier of infant welfare services. Despite the apparent successes of the charities involved and the harmonious mix of public and private assistance to mothers and babies, very few survived the war. The development of National Insurance, and more structured Council policies appear to have been primarily behind this, although the 1918 Maternal and Child Welfare Act provided for charitable funding to command equal status with that of Councils. In the 1920s groups such as St Agatha's Baby House did receive grants to carry out their work. Most of the funds and much of the co-operative endeavour were increasingly channelled not into traditional charities, however, but into the voluntary hospitals, with, for example, Council support for infant cots, and beds for expectant mothers. Generally, however,

⁹¹ *MOH Report*, Sheffield, 1907, p.40.

⁹² The need for trust and co-operation was the reason giving by the MOH for insisting that all WSI hold the triple qualification of nurse, midwife and sanitary inspector, allowing them to carry out all related duties, and avoid the need for several different officials to visit mothers. *MOH Report*, Sheffield, 1913, p.xxxiii. J Lewis, 'Family Provision of Health and Welfare in the Mixed Economy of Care in the Late Nineteenth and Twentieth Centuries', *Social History Medicine*, 8, 1995, 1-16.

⁹³ *MOH Report*, Sheffield, 1921, p.7.

the role of the Council became more encompassing in the inter-war years, and perhaps more accepted; it was no longer necessary to channel its efforts through voluntary groups such as the Motherhood League⁹⁴.

In 1913 the Jessop Hospital Samaritan Society (JHSS) closed itself down in the belief that National Insurance would now effectively take the place of charity. The Royal Hospital Samaritan Society (RHSS), in contrast, continued up to the amalgamation of its hospital with that of the Royal Infirmary in 1938; they felt that their help was still necessary, as long illness or unemployment could wipe out club or insurance benefits.

On the issue of the development of local authority health policies, there was no philosophical comment by either the Council or its officials on the merits of curative and preventative policies. Once the Council had overcome its primarily financially based misgivings about involvement in welfare policies, there appears to have been no discussion over further developments. This acceptance was understandably helped by a belief that the Council's foray into welfare, in the guise of infant welfare, were successful, and made subsequent policies easier to implement.

4.3c: The Development of Professionalisation:

It has already been illustrated how, thanks mainly to the dilatoriness of the Council, the concept of a 'professional' MOH was slow to develop in Sheffield; John Robertson, appointed in 1897, was the first career MOH that the City had, with earlier appointments being primarily local doctors (see *Appendix 1*)⁹⁵. The fact that his term coincided with the development of infant welfare policies, together with those for the other scourge of Sheffield, tuberculosis, is significant. The MOH increasingly possessed the expert knowledge, the professional back-up of journals and societies, and the specialised staff, to not only produce detailed data but also to demand and implement action upon it⁹⁶.

However, the MOH was first and foremost a doctor and this was evident in the way that mothers were viewed:

⁹⁴ The exception to this was the controversial area of birth control; see chapter 6 of this thesis.

⁹⁵ Leicester (1846), and Liverpool (1847) were the first places to appoint MO'sH; Leeds did not appoint one until 1866, Manchester in 1868, and Birmingham in 1873; Wohl, *Endangered Lives*, p.181.

⁹⁶ The Society of Medical Officers of Health was set up in 1865, partly to campaign for tenure for MO'sH, which was not in fact granted until the 1921 Public Health (Officers) Act; Wohl, *Endangered Lives*, p.191. For influence of MO'sH see also, JL Brand, *Doctors and the State: The British Medical Profession and Government Action in Public Health, 1870-1912*, Baltimore, 1965, p.108-36.

As the result of infant consultations and the writings of men who have devoted special attention to the subject, we are beginning to realise that such matters as the management of breast feeding cannot be left to the instinct of mothers, aided by the advice of more or less ignorant grandmothers⁹⁷

The MOH, Dr Scurfield stressed the need to propagate ideas of scientific motherhood, but also the retention of medical pre-eminence; if infant management was taught initially to midwives then 'they would be in the anomalous position that the midwives would know more about the subject than the doctors.'⁹⁸

However, doctors and MO'sH were not alone in their search for professional recognition and pre-eminence. The WSI's in Sheffield were also a committed group, many of whom obviously saw their work in terms of a career, as many served for upwards of 20 years. Sheffield's first two WSI's, Greenwood and Maynard, stayed in the profession, though not in Sheffield, and developed their ideas in articles and lectures; Greenwood went to London, and Maynard was Chief WSI in Leeds by 1911. Initially the MOH had been vague about the duties and qualifications of the women appointed, and in 1901 commented that:

...the personality of the Inspector goes for a great deal more in obtaining effective results than does the actual amount of work done, or legal power which the Inspector possesses...the work is of a very monotonous character, and from this fact alone is apt to be less effective.⁹⁹

Early evidence illustrates that the WSI's were concerned with general living conditions, rather than the condition of mothers or babies specifically; their house to house visiting encompassed all houses in a court or street, and took in home workers and old people as well as children and babies; this emphasised their role as sanitary inspectors rather than merely health visitors¹⁰⁰.

However, there were initial difficulties with the women appointed. The first Chief WSI, Mrs Greenwood, claimed that her assistants had trouble

⁹⁷ H Scurfield, 'The Need for Infant Management Being Given a More Important Place in the Medical Curriculum', *Public Health*, , 25, 1913, p.111.

⁹⁸ Scurfield, 'The Need for Infant Management Being Given a More Important Place in the Medical Curriculum', p.113.

⁹⁹ *MOH Report*, Sheffield, 1902, p.75.

¹⁰⁰ 'Enquiry by Mrs Abbott and Miss LI Davies re. Poverty and Poor Areas', *Women's Co-operative Guild*, 1902; the local police chief, Inspector Stevens commented that: 'The Women Inspectors go everywhere and have earned the respect of the police by going into places where they would not venture.'

dealing with some of the mothers because they were lower middle class, not ladies, and several of them only had a Board School education. As a result they did not have the 'weight and influence' with mothers that she did¹⁰¹. This was in contrast to the Manchester model which had employed respectable working class women as 'missionaries' to be the link between poor women and lady superintendents. However, by 1914 Greenwood, now working in London, was commenting that: 'The general education of the women who take up this profession is, on the whole superior to that of the men.'¹⁰² This suggests that, with the development of recognised qualifications and professional autonomy, educated women increasingly saw sanitary work as a potential option.

The development of professionalisation among the WSI's became quite strong, partly through self effort, and partly through the support of Councils such as Sheffield. Their cause was helped by the fact that their work was felt to be having a beneficial effect on IMR. It is misleading to see these women as subordinate adjuncts of a male state; they developed their own ideas and power structures, admittedly within the male organisation, but were able to claim distinct professional knowledge and skills; particularly through their child welfare work:

In addition to a sanitary certificate, a woman should specialise in the subjects of infant care and personal hygiene and allied subjects; for example elementary physiology, without which it will be impossible for her to utilise her other knowledge intelligently. She, in most instances, an unmarried woman, and quite young, will be called upon to advise a member of a family as to the upbringing of her children. Therefore if her visits are not be an impertinence, she must have expert knowledge to offer the mother.¹⁰³

In April 1901 a meeting of WSI's from Leeds, Sheffield, and Bradford agreed to set up an Association of Women Sanitary Inspectors for the Midland and Northern Counties. They decided that an informal forum for professional support was necessary, particularly given the hostility of some of the male sanitary inspectors to the presence of women, and the reluctance of the male

¹⁰¹ HM. Govt Report of the Inter-departmental Committee on Physical Deterioration, vol. 1-3, London, 1904, p.314, qu 8318. Dingwall has suggested that the presence of Greenwood and others like her in health visiting demonstrated the changing structure of the profession with middle class women working in a paid rather than voluntary capacity. R Dingwall, ' "In the Beginning was the Work..." Reflections on the Genesis of Occupations', *The Sociological Review*, 31, 1983, 605-24.

¹⁰² F Greenwood, 'Women as Sanitary Inspectors and Health Visitors', in EJ Morley, ed., *Women Workers in Seven Professions: A Survey of Their Economic Conditions and Prospects*, London, 1914, 221-234.

¹⁰³ EL Maynard, *Women in the Public Health Service*, London, 1915, p.13.

association to admit women¹⁰⁴. Greenwood agreed to act as the honorary secretary of the new group; she explained that:

Women needed to co-operate with and encourage each other, to keep up the standards of work, conditions, salary and status generally. She spoke of the isolation entailed by their work and the social and intellectual needs of an educated woman. She depreciated women receiving pocket money wages, thus injuring those who have to work for their living. Women were supposed to be content with smaller salaries than men, but why should they be? ...she wished they all worked under the same favourable conditions which existed in Sheffield.¹⁰⁵

The creation of the organisation, however small and informal, demonstrated the unity of purpose between women from different areas, and their wish to be seen as a professional body deserving of recognition.

The above comment also illustrates the support which the work being done in Sheffield received from its WSI's, and also the support which the Council gave to their view of themselves as a profession. Sheffield appears to have been quite forward looking in the way it treated its WSI's. Although not receiving equal pay with male sanitary inspectors, their department became increasingly autonomous. Additionally no marriage bar operated, although in practise most WSI's tended to be unmarried. They were encouraged to lecture, attend conferences, and study for qualifications¹⁰⁶. Importantly they were officially sanitary inspectors, not health visitors, whose qualifications, pay and responsibilities were lower¹⁰⁷. This was in contrast to other areas such as Birmingham who first advertised for 6 'women visitors' in 1899, and by 1904 were describing them as 'lady health visitors'.¹⁰⁸ In 1907 Sheffield Council made provision for the training of those inspectors without a nursing qualification. They were to train at the Children's Hospital, sitting an exam at the end of their time. Further to this, the Council agreed to appoint only those holding the triple qualification of hospital nurse, midwife, and sanitary inspector. Dingwall has commented on the absorption of the WSI's into a medical remit, with qualified nurses in particular relishing the pay and security of the work¹⁰⁹. The Council was the first in the country to demand such

¹⁰⁴ For debate on whether to allow the women's association to amalgamate with the men's association, see: *Sanitary Inspectors Journal*, 15, 1909–10, pp.160; 185; 199; 200; 232.

¹⁰⁵ *Sanitary Inspectors Journal*, 7, 1901–02, p.20.

¹⁰⁶ For example; Franks lectured to the Annual Meeting of Sanitary Inspectors, held in Sheffield in 1912.

¹⁰⁷ C Davies, 'The Health Visitor as Mothers Friend: A Woman's Place in Public Health 1900–1914', *Social History Medicine*, 1988, p.39–59.

¹⁰⁸ Dingwall, 'The Genesis of Occupations', p.614.

¹⁰⁹ Dingwall, 'The Genesis of Occupations', p.617–8.

Duties of Women Sanitary Inspectors (continued)

	1923	1924	1925	1926	1927	1928	1929	1930	1931	1932	1933	1934
cleansing	-	-	-	-	-	-	-	-	-	-	-	-
feeding	-	-	-	-	-	-	-	-	-	-	-	-
births	44891	46200	43343	45161	31154	30880	27027	27311	24864	23788	22126	21751
midwives	175	193	137	194	253	138	163	155	123	149	104	90
lodgings	808	759	651	774	549	415	535	356	453	409	214	268
antenatal	106	110	105	162	261	383	753	1619	1831	2504	2940	3044
puerperal fever	110	129	111	91	288	275	312	241	234	184	188	238

	1935	1936	1937	1938	1939	1940
cleansing	-	-	-	-	-	-
feeding	-	-	-	-	-	-
births	20721	22464	21949	22264	21504	20526
midwives	197	261	226	181	171	193
lodgings	162	66	68	97	43	1
antenatal	3247	4419	5749	5318	3853	3322
puerperal fever	269	262	261	48	49	280

Table 4.6 (continued)

Source: MOH Reports, Sheffield.

Duties of Women Sanitary Inspectors in Sheffield, 1899-1940.

	1899	1900	1901	1902	1903	1904	1905	1906	1907	1908	1909	1910
cleansing	943	2762	7630	9521	11034	8220	-	-	-	-	-	-
feeding	466	1287	2735	3394	5825	10775	-	-	-	-	-	-
births	-	-	-	-	-	6704	11941	15935	18402	22064	30811	33200
midwives	-	-	-	-	-	-	176	203	166	358	287	344
lodgings	-	-	-	-	-	6130	2418	2016	3120	2468	2276	1644

	1911	1912	1913	1914	1915	1916	1917	1918	1919	1920	1921	1922
cleansing	-	-	-	-	-	n/a	n/a	n/a	n/a	n/a	-	-
feeding	-	-	-	-	-	n/a	n/a	n/a	n/a	n/a	-	-
births	36592	36901	40133	42740	40737	n/a	n/a	n/a	n/a	n/a	46753	48548
midwives	246	222	225	200	137	n/a	n/a	n/a	n/a	n/a	133	169
lodgings	2632	1767	1932	519	801	n/a	n/a	n/a	n/a	n/a	830	747
antenatal						n/a	n/a	n/a	n/a	n/a	80	93
puerperal fever						n/a	n/a	n/a	n/a	n/a	103	85

Table 4.6

Source: MOH Reports, Sheffield

qualities and to demonstrate its commitment to the WSI's as a professional group¹¹⁰. At no point in the available evidence is it clear why they took this step.

In 1919, the Ministry of Health required that health visitors no longer need have any specific qualifications, apart from the two year approved training programme leading to the health visitor qualification. The *BMJ* noted:

It must be remembered that the course of training is for women health visitors, whose greatest qualification should be the possession of womanly sympathy and consideration.¹¹¹

Davies has detailed the debate over what many regarded as the declining role of the WSI's and the rise of the less highly qualified health visitor¹¹². Sheffield WSI's did not in fact become designated 'health visitors' until 1934, implying their continued local strength. *Table 4.6* illustrates the changing role of the WSI's across the period. Their initial appointments as inspectors of general domestic sanitary conditions is evident in the first years of their work, with visits specifically with regard to births not beginning until 1904.

A further change in the work of the WSI's occurred after the First World War as attempts to influence high levels of MMR began to take priority. Visits concerning births peaked in 1921 and thereafter declined, partly due to falling birth rates. Visits to expectant mothers began to feature in the same year, and this work rose dramatically in the late 1920s. Declining visits to houses let in lodgings show how all other work by the WSI's declined in the face of their increasing involvement with maternal and child welfare. Although not specifically appointed to do so, they became the main plank of policies aimed at reducing IMR and later MMR. No policy statements were issued; but there was obviously a feeling that the WSI's had worked for IMR, and could do so again for MMR. This will be considered more fully in the next chapter.

One of the most interesting of the early WSI's was Florence Greenwood whose beliefs and activities have already been noted. She was atypical in terms of her background as the previously leisured widow of a doctor, and because of her outspokenness. Her views demonstrate some of the tensions inherent in the developing service. In 1902 Margaret Llewelyn

¹¹⁰ Dingwall has suggested that cities such as Sheffield were vital in developing health visiting as a professional occupation; R Dingwall, 'Collectivism, Regionalism, and Feminism: Health Visiting and British Social Policy, 1850-1975', *Journal Social Policy*, 6, 1977, 291-315.

¹¹¹ *BMJ*, ii, 1919, p.572.

¹¹² C Davies, 'The Health Visitor as Mothers Friend: A Woman's Place in Public Health 1900-1914', *Social History of Medicine*, 1988, 39-59.

Davies and a Mrs Abbott spent six days in Sheffield as part of their survey for the Women's Co-operative Guild on co-operating in cities. They went slum visiting with the WSI's, and interviewed both Mrs Greenwood, and Dr Robertson, the MOH. Their notes suggest that the service was under strain in the early days due to a major clash of personalities between Mrs Greenwood and the MOH; the former was in fact always rather outspoken, a trait which was eventually to prove her downfall. Whilst Robertson was diplomatically commenting that, 'The work that has been done here in Sheffield is quite remarkable, the standard of cleanliness is higher, and there are fewer filthy houses', Mrs Greenwood was lambasting him for being:

...hard as nails – "life is cheap in these parts", a tremendous worker himself, and can't understand women need rest and holidays. A man of few words – never praises – tyrannical – keeps women quite under him – never go before health committee. Never consults Mrs G. He issued quite useless notices re infection, which were only saved by her additions, made based on her knowledge and experience. She drew up a Baby-feeding Notice, his much too long, but he wouldn't have it...¹¹³

She further complained about the uniform ('this has with some trouble been modified by Mrs Greenwood'), the WSI's office ('no lavatory; have to go outside to public lavatory'), and the tedium of the work ('great monotony, want of variety in the work').

However similar their basic aims, the differences between the Council and their chief WSI, which were highlighted by her poor relationship with the MOH, came very publicly to the fore in 1904, when Mrs Greenwood was one of the witnesses asked to give evidence to the Inter-Departmental Committee on Physical Deterioration, which had been set up in response to rising fears of national decline. Her evidence was detailed, and included case histories of families in Sheffield, and a copy of the 'advice on the feeding and rearing of infants' leaflet which was considered a model. However the Council took strong exception to some of her remarks when the report was finally published. She had complained primarily about the poor state of housing and sanitation in Sheffield, and about the dilatoriness of the Council, accusing them of being 'very much behind the times' on these issues¹¹⁴. She also claimed 'There is one insanitary area, for which a provisional order was

¹¹³ 'Enquiry by Mrs Abbott and Miss LI Davies re. Poverty and Poor Areas', *Women's Co-operative Guild*, 1902.

¹¹⁴ *Inter-departmental Committee on Physical Deterioration*, p.310, qu 8111.

obtained fifteen years ago, and it has not been cleared yet.'¹¹⁵ On the issue of poor old housing stock she was asked:

And it is entirely due to municipal neglect?

Yes, in the past.

But you do not seem to think that they are doing as much as they might with regard to this building question?

It is the opinion of a great many that the Corporation are not pushing things on as they ought.¹¹⁶

When asked to whom the courts and back-to-backs belonged, Greenwood said '...various owners – to the city councillors and various private owners.'¹¹⁷ However factually correct she may have been, her lack of diplomacy did nothing for her relations with the Council, who were furious at her evidence¹¹⁸. The Health Committee insisted that Sheffield did not have 15,000 back-to-backs as Greenwood had claimed, and commented:

The Health Committee are therefore much astonished that the Inter-Departmental Committee should have thought fit to examine Mrs Greenwood on matters with reference to which she was utterly unfitted to give an opinion, either by her education or her experience.¹¹⁹

However, a 1908 Report by the Board of Trade into the cost of living of the working classes estimated that Sheffield still had 16,000 back to backs, although none had been built since 1864; the same point had in fact been made by the MOH for Sheffield in his Annual Report for the previous year¹²⁰. This suggests that Greenwood could not be accused of inaccuracy. The Education Committee also took exception to her opinions, and suggested that:

...Mrs Greenwood appears to have drawn largely upon her imagination in reference to the position of affairs and to have expressed opinions on matters with which she was not qualified or competent to give an opinion on.¹²¹

¹¹⁵ *Committee on Physical Deterioration*, p.310, qu 8131.

¹¹⁶ *Committee on Physical Deterioration*, p.310, qu 8147/48.

¹¹⁷ *Committee on Physical Deterioration*, p.314, qu 8299. *The Lancet* had 5 years earlier commented on the same problem in relation to MO'sH; 'It is not an uncommon thing for a medical officer whilst endeavouring to have some insanitary property put in a proper state of repair to find that a quantity of it is owned by a member of the Sanitary Authority ie., by one of his masters, by one of the men who have absolute power to discharge him...' *The Lancet*, ii, 1899, p.1760.

¹¹⁸ She also lambasted the Education Committee for failing to enforce cleanliness of pupils and premises in their Board Schools.

¹¹⁹ *Health Cttee Minutes*, 8/9/1911.

¹²⁰ *Cost of Living of the Working Class*, London, 1908, p.407–414; *MOH Report*, Sheffield, 1907, p.xiii; *Bye law relating to back-to-backs*, Sheffield, 1865, p.7, section xii.

¹²¹ *ST* 22/9/1904.

However, by this time Greenwood had already left Sheffield, and gave an interview to the *Sheffield Telegraph* from London in which she stuck by her opinions:

I see nothing in my evidence which I would like to withdraw. The sanitary arrangements in Sheffield are abominable. There is no other word to describe them, and the large infant mortality is due to this fact...I was surprised myself at the condition obtaining [in Sheffield]. You hear people talking of the awful poverty and filth in London slums. I am now engaged in one of the poorest districts in London (St Luke's) and really, I must say that I have seen worse conditions in Sheffield.¹²²

It is difficult to assess her motives for being so relentlessly outspoken, although judging by her work both during and after her time in Sheffield she held strong views and was always willing to express and attempt to implement them. She was obviously an articulate and forceful woman; facts which probably said something about her class and background. It is possible that she intended publicly to shame the Council in to what she regarded as necessary reforms, and felt free in doing so because she had already secured a new post in Finsbury, and had no real need to be diplomatic.

The service settled down after the departure of Greenwood, and the views of the WSI became less prominent. This was probably because the profession was becoming more mature and less fluid both locally and nationally. The WSI had, by c.1910, a well delineated role in the local provision of public health and they came under less scrutiny.

4.3d: The Response of Mothers:

The views of the mothers towards whom all the attention was directed is hard to gauge, and for the early period in particular the evidence available is largely tangential. Qualitative evidence from other sources suggests that there was a desire for non-judgmental advice and assistance about pregnancy and childcare:

Much of the suffering entailed in maternity, much of the damage to the life and health of women and children, would be got rid of if...[women] could obtain medical advice and supervision during pregnancy and motherhood.¹²³

¹²² ST 18/8/1904.

¹²³ ML Davies, ed., *Maternity: Letters from Working Women*, London, 1915, p.7.

There is some evidence about the way that women in Sheffield felt about the initial work which was done. The Womens' Co-operative Guild survey of 1902 gave a suggestion of the relationship between the WSI's and mothers at this early stage:

It was very striking to observe that there was no opposition offered to the action of these ladies, who heroically faced every possible horror, entering bedrooms, examining children etc. Occasionally the doors of some of worst rooms were shut and bolted when the Inspector was seen and she had to hasten sometimes to get in before this occurred. To the more self-respecting the work of the Inspectors is naturally acceptable, getting insanitary conditions put right and raising the standard of health, and to the poorest they often come as friends with help and advice.¹²⁴

The biggest problems of access and acceptance which the early WSI's appear to have experienced were with owners rather than tenants of the courts they visited:

The Harpy who owns the Court follows us from door to door, only kept within bounds by the presence of the Lady Inspector – quite inclined to be impertinent if chance offered.

Many houses are shut and locked against the Lady Inspectors in this court – an effort is made to make her believe that various occupants are not in.¹²⁵

However, there is evidence to suggest that some mothers regarded the WSI's as a useful resource, who was willing to be consulted on any matter. The same survey told of an Irish women who asked Mrs Greenwood to visit her friend, ill after childbirth:

But though life is cheap in such quarters, the Women Inspectors do not act as if it were. They add to their already severe and trying work by being their friends as well as their Inspectors, and Mrs G went at once to find a Doctor to attend this poor woman.¹²⁶

Mrs Greenwood's successor, Mrs Franks later commented that; ' "T'lady Inspector" has become quite an institution in the poorer parts of Sheffield, and our advice is sought on all sorts of difficulties and

¹²⁴ 'Enquiry by Mrs Abbott and Miss LI Davies re. Poverty and Poor Areas', *Women's Co-operative Guild*, 1902.

¹²⁵ 'Enquiry by Mrs Abbott and Miss LI Davies re. Poverty and Poor Areas', *Women's Co-operative Guild*, 1902.

¹²⁶ The doctor's wife said he would not come unless he got his 2/6 call out fee.

Infant consultations (Sheffield)

Year	1907	1908	1909	1910	1911	1912	1913	1914	1915	1916	1917	1918	1919	1920	1921	1922
Total Attendance	1332	2830	5322	6975	7181	9425	11912	14521	22281	26068	35590	36180	39361	51456	54078	45004
New Babies Attending	-	-	-	-	-	-	-	-	-	-	3146	3373	3794	4862	4860	3794
Total births	14125	14268	13296	12664	12650	12902	13307	13023	12162	12063	11945	10785	10416	13186	11909	10804
New Babies Attending (as % of total births)	-	-	-	-	-	-	-	-	-	-	26.3	31.3	36.4	37.0	41.0	35.1

Year	1923	1924	1925	1926	1927	1928	1929	1930	1931	1932	1933	1934	1935	1936	1937
Total Attendance	42820	45529	46580	48307	48249	53553	55142	56954	57194	51913	52721	55046	64922	74354	77417
New Babies Attending	3541	3809	3841	3825	3630	4020	3911	3809	3974	3713	3739	3855	4368	4756	5014
Total births	10215	9654	9261	8969	8472	8392	7976	7798	7736	7351	7148	7414	7676	7884	7962
New Babies Attending (as % of total births)	34.7	39.5	41.5	42.6	42.8	47.9	49.0	48.8	51.4	50.5	52.3	52.0	56.9	60.3	63.0

Table 4.7

Source: MOH Reports, Sheffield.

emergencies.'¹²⁷ She also drew attention to the value of the depots for relationships between WSI's and mothers; 'Small mistakes in the management of the baby are pointed out to the mother from time to time, and she is thus freed from unnecessary anxiety.'¹²⁸ Maynard, another Sheffield WSI, wrote of the need to cultivate a reciprocal relationship with mothers:

...the capable and sympathetic official will not only find these working class mothers exceedingly interesting, but she will learn as much from them in diverse ways as they will learn from her. Moreover, she will learn to admire them for their wonderful pluck and hopefulness against tremendous odds, and in spite of what may be said on the other side, the capacity which very many of them have for making a small income go a long way.¹²⁹

The most persuasive quantitative evidence supporting the idea that mothers found the services offered useful and helpful is the record of attendance's at infant consultation clinics. Although started primarily for bottle fed babies, they appear to have been rapidly taken up by mothers who were breast-feeding. *Table 4.7* illustrates the success of this service, with particular gains being made at the start and end of the war; the latter figure reflecting the short lived post-war 'baby boom'.

The support of ordinary mothers for the Clinics was evident in the inter-war period when there were many calls for the extension of clinic services to the new estates. The Labour Council insisted that their model of one large central clinic was effective, but this was challenged by women. In early 1935 the dispute between various interested groups flared up with the sacking by the Council of 3 part-time women doctors from the Maternal and Child Welfare Centre (MCWC) apparently in an attempt to save money. The National Council for Women, Sheffield Medical Women's Federation, and the Women's Freedom League all complained to the Health Committee and the Ministry of Health, but to no avail¹³⁰. The doctors concerned received no notice, despite having served periods of 7-15 years. Complaints came from mothers about the dismissal of women doctors whilst retaining the services of the male doctor on the staff. One letter to the *Sheffield Independent* said:

¹²⁷ G Franks, 'Women Workers in Public Health in Sheffield', *Sanitary Inspectors Journal*, 18, 1912, p.109.

¹²⁸ Franks, 'Women Workers in Public Health in Sheffield', p.108.

¹²⁹ Maynard, *Women in the Public Health Service*, p.95.

¹³⁰ *SI* 29/1/35, p.7.

I had no parents or anyone to ask advice at my first birth, but thank God I knew I had Dr Alice White to go to anytime afterwards for advice...I could not have gone to a male Doctor in the circumstances.

I think in this matter I am expressing the view of most mothers.¹³¹

The women's page of the *Sheffield Telegraph*, a traditionally Conservative paper, accused the Council of under funding the service with only two centres instead of the 18 it should have if it followed Ministry of Health guidelines of 1 to every 400 births. Leeds had 20 centres, and Nottingham, with half the population of Sheffield, had 15. The demand made was for more centres, particularly in the new outlying estates. Although most of the inter-war debate centred around the effect of clinics on MMR, and will be discussed in the next chapter, it does demonstrate that women found the service useful and worth defending. It also shows that women's groups had their own ideas about how the service should be developed.

4.3e: Conclusion:

Infant welfare measures, designed primarily to reduce what were perceived to be high levels of infant mortality, were among the first major welfare services to put into place by Sheffield City Council. The response of the City was typical of others across the country, and the solutions attempted were generally those which had been tried elsewhere. Charting the efforts of statutory and voluntary bodies to tackle infant mortality demonstrates that nationally or theoretically based debates were not significant in determining the form of solutions, although eugenics in particular probably provided a new language to describe long standing ideas about, for example, the deserving and undeserving.

The decline in IMR in Sheffield as elsewhere, was multi-causal and cannot be reduced to the action of one significant factor. However, the development of micro solutions such as the WSI's and clinic provision probably had a greater impact than has been accepted by historians previously. Macro issues such as the improvement of sewage and refuse disposal systems would have had a long term effect on IMR, but ideas about personal and family hygiene, and food preparation and storage, were probably equally significant.

Apart from the possible impact of infant welfare on IMR, it was important for the role it played in the development of Local Authority care and the professional impetus it gave to certain workers, particularly the MO'sH and WSI's. Their positions and the type of care they were delivering became

¹³¹ *SI*, 1/2/35, p.6.

significant in inter-war attempts to expand maternal and child welfare, and in discussions over the development of state medicine.

The example of Sheffield also highlights the support of mothers for the new services, particularly non-stigmatising ones such as the MCWC or the Motherhood League. They were not passive in the face of state encroachment into their lives, but in many cases appear to have welcomed advice and assistance, and were able to turn institutions to their own needs; for example the rapid metamorphosis of the milk depot into a MCWC.

5: '...there exists in Sheffield a large amount of silent and unrelieved suffering among poor women...': Pregnancy and Childbirth.

5.1: Introduction:

Pregnancy and childbirth have always been central issues in women's lives. This chapter will focus on what was an unchanging biological experience, although carrying varying degrees of risk, but one deeply influenced by culture and society.

For pregnant women in 1930 as much as in 1880, childbirth was a time of potentially fatal risk. The maternal mortality rate (maternal deaths per 1000 births [MMR]) was as high in 1934 as it had been fifty years earlier, and maternal morbidity, although almost impossible to quantify, appears from anecdotal evidence to have been very widespread. The situation was considered to be particularly acute in Sheffield which experienced rising levels of MMR during the 1920s and early 1930s. The first part of this chapter will look at the progress of MMR, its possible causes and attempts by interested authorities to tackle the problem.

The second part of the chapter will focus on the social construct of childbirth, and in particular the development of professional midwifery and specialist hospital services. In contrast to some feminist works which have argued that women lost control over childbirth with the coerced move to hospitals for normal delivery, the evidence for Sheffield demonstrates that the development of hospitals and maternity homes appears in many respects to have been demand led¹. Additionally the 1936 Midwives Act allowed for the survival of a significant proportion of home births up to the Second World War, with the introduction of a salaried midwifery service². Writers such as Heagerty and Donnison have argued that the Midwives Acts of 1902 and 1936 removed the independence of midwives leaving them subservient to the medical profession. The views of midwives in Sheffield, although vital in determining their approach to the changing service are hard to draw out.

¹ NS Dye, 'Modern Obstetrics and Working Class Women: The New York Midwifery Dispensary, 1890-1920', *Journal Social History*, 20, 1986-7, 549-64; A Oakley, *Women Confined: Towards a Sociology of Childbirth*, Oxford, 1980; A Oakley, 'Wise Woman and Medicine Man: Changes in the Management of Childbirth', in, J Mitchell and A Oakley, *The Rights and Wrongs of Women*, Harmondsworth, 1976, 17-58. Although Marks in particular has put forward the revisionist view that women did attempt to shape services to suit their needs; LV Marks, ' "They're Magicians". Midwives, Doctors and Hospitals: Women's Experience of Childbirth in East London and Woolwich in the Inter-War Years', *Oral History*, 23, 1995, 46-53; LV Marks, *Metropolitan Maternity: Maternal and Infant Welfare Services in Early Twentieth Century London*, Amsterdam, 1996.

² *Midwives Act*, 1936 [26.Geo.5.+1.Ed.8.c.40].

There is evidence that the midwifery elites were not wholly representative of their members in following the government line on professionalisation³. Groups such as the British Union of Midwives and the National Association of Midwives both stressed the need for the increased articulation of the midwife but at the local level this appears to have been muted. Most midwives continued to be married and part time even after 1902, and demonstrated little solidarity of purpose. There was tension between the new 'professional' midwives and their old style counterparts, which would have impeded their unity of action. Some of the argument can be gleaned through local papers, and will be considered in more detail below⁴.

In many respects, the development of maternity services demonstrated the most comprehensive move by local government into maternal health and welfare. By the mid-1930s services covered antenatal, peri-natal, and post-natal care, with the provision of Council midwives, hospital beds and clinics. This appears partly to have been the result of the extension of infant welfare measures, and partly in response to perceived failures in maternity care, with MMR failing to respond to targeted measures. There generally appears to have been a consensus across local political parties, and other groups, including professional and women's groups, that alternative strategies such as provision of nutrition were not relevant, and only comprehensive maternity services would eventually solve the problem. As with infant welfare, local responses were based along pragmatic lines according to what was considered practical and affordable.

5.2: Maternal Mortality:

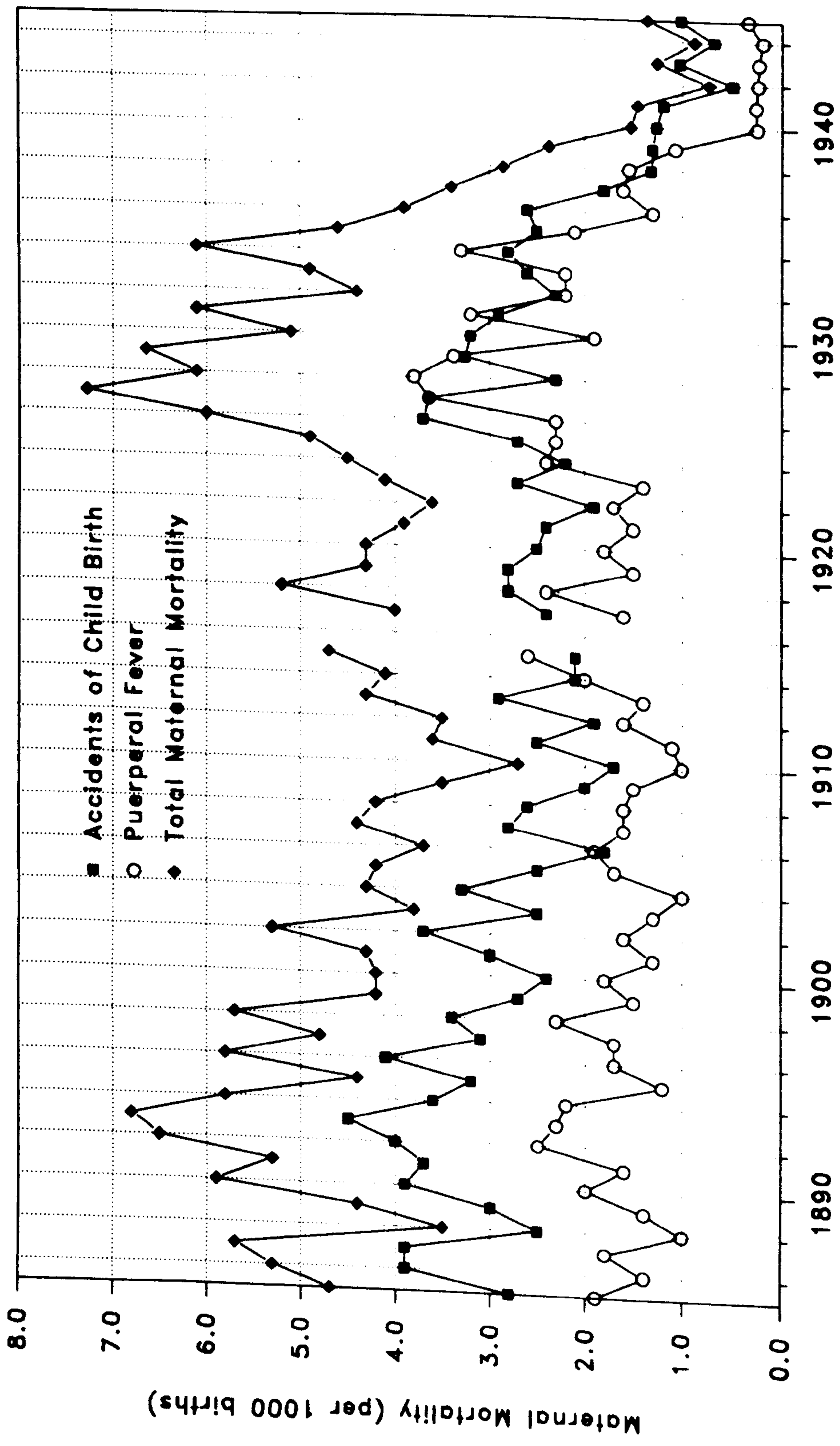
5.2a: Introduction:

MMR was not generally considered to be a problem until after the First World War, because it was believed to be at acceptable levels. In his Annual Report for 1875 the MOH for Sheffield drew attention to figures for the Town of 1 maternal death to every 304 children born, compared to equivalent figures of 1 to 195 in London. He commented that; 'This speaks well, both for the skill of the medical profession in Sheffield, and for the health and stamina of the

³ BV Heagerty, *Gender and Professionalisation: the Struggle for British Midwifery, 1900-36*, unpub PhD thesis, Michigan State University, 1990.

⁴ The principal sources used for this chapter are the reports of the Medical Officer of Health, and the archives of the Jessop Hospital for Women in Sheffield, although the lack of extant records for the Jessop sets limits on the understanding which can be gained. These are supplemented by material relating to other maternity hospitals, and by the reports and surveys of central government, which addressed the problem of high MMR.

Maternal Mortality (per 1000 births) in Sheffield, 1885-1945



Year

Figure 5.2

Source: MOH Reports, Sheffield

Maternal and Infant Mortality (per 1000 births)
in Sheffield, 1885-1945.

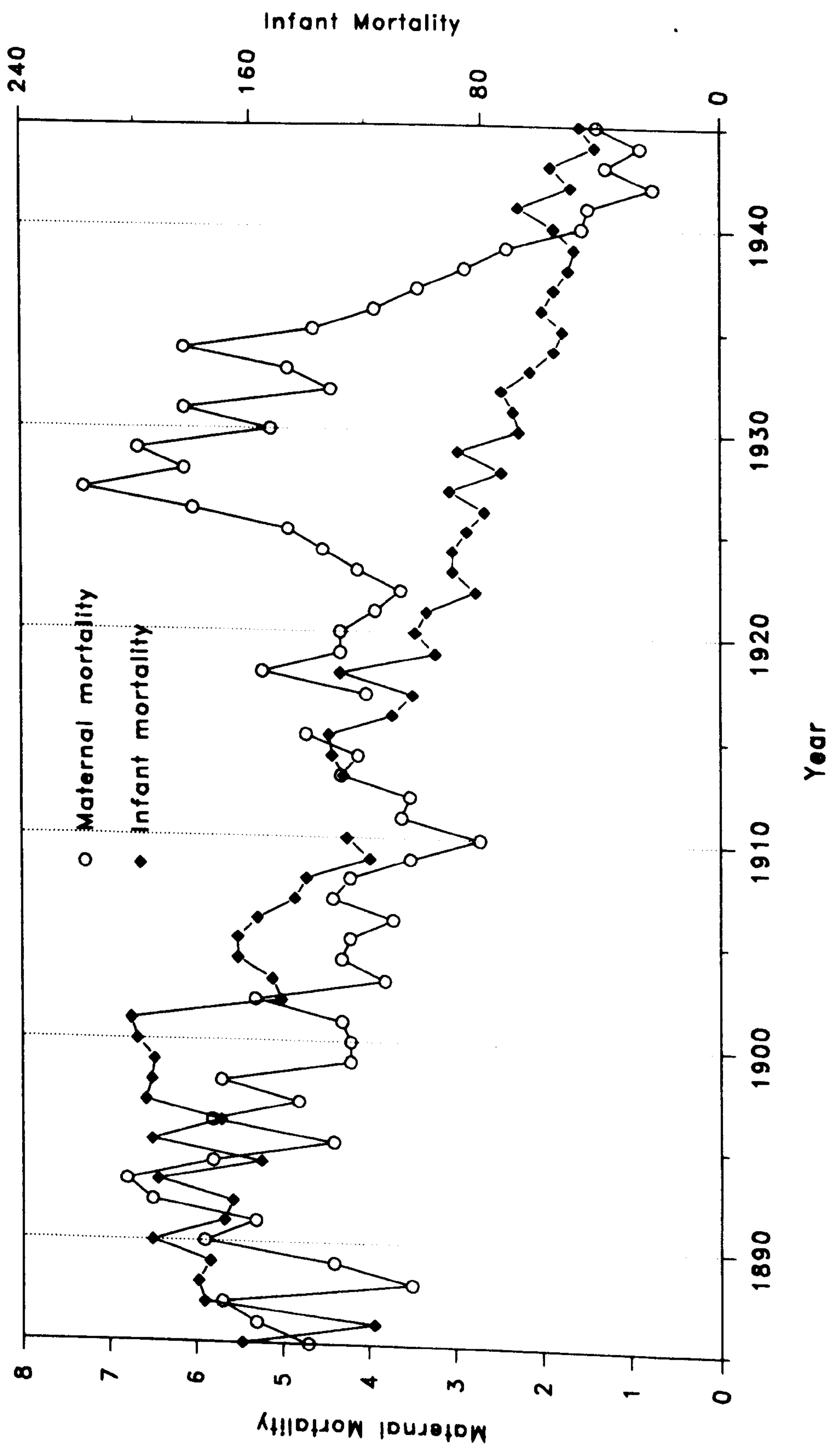


Figure 5.1
Source: MOH Reports, Sheffield

adult female population of the Borough.⁵ During the first fifteen years of the twentieth century, when concern over the infant mortality rate (IMR) was at its height, MMR appeared to be demonstrating falls in line with those of IMR (*Figure 5.1*). After the First World War, however, IMR continued to fall even in the difficult economic and social conditions of the depression, but MMR remained stable in England and Wales. In Sheffield, along with several other areas, rates rose to record levels. Concern over the high infant mortality rate was always a priority in the pre-war period, and maternal mortality or morbidity was only seen to be a problem where it touched on infant mortality. Discussions about the benefits of antenatal care, for example, centred around their effect on the health of the baby, not of the mother⁶. It was therefore really only after 1920, when IMR was felt to be vanquished, that MMR began to be perceived as an issue of national importance, as IMR had been twenty years before. In this respect, measures to tackle MMR were superficially more easy to implement; the Rubicon of state intervention had been crossed with the work of infant welfare clinics. Efforts to tackle MMR followed many of the same routes, and utilised the same structures; particularly the expansion of Maternal and Child Welfare Centres (MCWC) to provide antenatal and post-natal care for women, and the supervision of midwives and puerperal fever cases by the Women Sanitary Inspectors (WSI's). However, the essential difference between measures to tackle IMR and MMR was that the latter did not start to fall in response to state and voluntary action. In fact, in areas like Sheffield, it continued to rise, peaking in the late 1920s and early 1930s⁷. Sheffield reached a high of 7.27‰ births as late as 1927 and 6.11‰ in 1934, even after the inclusion of stillbirths in the calculations, which had the effect of slightly reducing the total MMR by increasing the total of births into which deaths were divided. This figure compared with an English rate of 4.60‰ for the same year (*Figure 5.2*). It was not until the mid-1930s that the MMR began its sudden and steep decline. Earlier efforts, including antiseptic, and aseptic regimes, midwifery regulation, and antenatal care, had no downward effect on the MMR.

⁵ *MOH Report*, Sheffield, 1875, p.17.

⁶ JW Ballantyne, *Expectant Motherhood: Its Supervision and Hygiene*, London, 1914.

⁷ Figures for 1911-14 showed that Sheffield had a relatively favourable MMR at this time of 4.05‰, below the national average of 4.62‰. This compared with other West Yorkshire and Lancashire towns such as Rochdale (7.21‰), Halifax (6.23‰), Burnley (6.57‰), Blackburn (6.55‰) and Dewsbury, with the highest MMR in the country at 8.54‰; HM Govt, 'Maternal Mortality in Connection with Childbearing and its Relation to Infant Mortality', *LGB 44th Annual Report, 1914-15, Supplement*, cd 8055, p.36.

A whole series of investigations were undertaken on MMR by the Ministry of Health; Webster has suggested that the sheer number proved that they were not calming public fears⁸. However, none of the reports addressed issues of poor nutrition and poverty, even though the highest MMR's were recorded in areas of highest unemployment and deprivation. The Ministry preferred to see the problem as one of inadequate medical attendance rather than economic factors. Discussions of the failings of birth attendants, which in practice meant General Practitioners (GP's), led to a polarisation in the views of the medical profession. GP's felt that they were being castigated for carrying fever and for over enthusiastic intervention, and were defensive in the face of obstetricians such as Miles Phillips, of the Jessop Hospital in Sheffield, who looked to the total eradication of home births as the solution to MMR. This chapter will trace the effect of nationally led theoretical debates on the design and implementation of local policy.

Women very rarely died in childbirth; more commonly there were antenatal problems such as toxæmia or hæmorrhage, and post natal conditions such as sepsis and, again, hæmorrhage. These three major groups accounted for the majority of maternal deaths.

Toxæmia or eclampsia was responsible for 15–20% of maternal deaths, and is still a little understood condition⁹. Attempts to reduce its mortality centred around prevention rather than treatment; many antenatal procedures such as urine testing and blood pressure monitoring were designed explicitly to diagnose pre-eclampsia, and prevent it becoming full blown eclampsia. One case from the records of the City General Hospital in Sheffield (originally the Fir Vale Workhouse Hospital, but taken over by the City Council in the 1930s; see *Appendix 2*) illustrates its course:

One woman...had attended the Ante-Natal Clinic regularly but became ill soon after one visit and did not report her illness until a fortnight later, when in response to a telephone message the ambulance was sent for her. She then had very pronounced toxæmia and was in a comatose condition. In spite of vigorous treatment she did not improve. She delivered herself of a stillborn macerated foetus spontaneously, but did not recover consciousness and died 8 days after admission.¹⁰

Ante- or post-partum hæmorrhage was responsible for 15–20% of deaths. Another case from the City General Hospital illustrates this condition:

⁸ C Webster, 'Healthy or Hungry Thirties?', *History Workshop Journal*, 13, 1982, 110–29.

⁹ Editorial: 'Eclampsia Still Kills', *BMJ*, 296, 1988, 1209–1210.

¹⁰ *MOH Report*, Sheffield, 1933, p.90.

Another emergency patient was admitted in a state of profound collapse after ante-partum haemorrhage. The child was dead. After blood transfusion Craniotomy was performed and a hydrocephalic foetus removed without difficulty. In spite of all stimulation she did not recover, and died the following day.¹¹

However, of the three main conditions, it was puerperal fever which fascinated and frightened doctors and patients alike, as it struck women who had apparently survived childbirth unscathed, and its repeated incidence could destroy the reputation of a doctor. It accounted for between 33–50% of maternal mortality. The condition had been effectively described as a contagious disease in the mid nineteenth century, spread by staff, family, or self-infection by patients themselves¹². Yet the MMR, and in particular its fever component, only began to fall in the mid-1930s when sulphonamide treatment was introduced. One example illustrates the condition:

One emergency case was admitted with obstructed forceps delivery having failed before admission. She was then infected and had a pure growth of *Streptococcus Haemolyticus* in her blood taken soon after admission. The patient was delivered after Craniotomy but did not recover from her Septicaemia.¹³

The hospital was careful to point out that they did not infect her but that she carried the bacteria before admission, with the implication that it was due to the actions of her doctor who had attempted to use forceps.

The question as to why MMR was the last major mortality group to fall, and the reasons behind its precipitous decline, is not simple to answer. This is partly due to the multi-causality of the problem, and the difficulties of assessing the relative merits of the various solutions attempted. Difficulties of interpretation are compounded by the incomplete nature of the evidence. There are four major difficulties associated with the evidence for maternal mortality. The first is that MMR, and in particular the important fever component, were notoriously under reported, with deaths often being ascribed to more 'acceptable' causes, as maternal deaths were unpleasant for the family, and professionally damaging for the attendant¹⁴. In this respect it was

¹¹ *MOH Report*, Sheffield, 1933, p.90.

¹² For documentary sources on the development of knowledge about puerperal fever, see I Loudon, ed., *Childbed Fever: A Documentary History*, London, 1995.

¹³ *MOH Report*, Sheffield, 1932, p.98.

¹⁴ For example, in research into maternal deaths on the Isle of Man there were 8 'hidden' maternal deaths found in the Death Registers; they had been ascribed to other sources; CG Pantin, 'A Study of Maternal Mortality and Midwifery on the Isle of Man, 1882 to 1961', *Medical History*, 40, 1996, 141–172.

easier for doctors to cover up than midwives as the former were responsible for writing their own death certificates, and could ascribe a 'better' cause of death, such as heart failure to which no blame attached. Although notification of cases of puerperal fever was compulsory after 1893, rates of notification were notoriously low. A GP suggested that poor notification would continue as long as subsequent blame for the condition attached to the medical attendant; 'As long as puerperal fever is considered by the laity to be due to bad midwifery, notification will remain a farce.'¹⁵ It could ruin a doctor's career if he was found to be spreading fever, so as the MOH for Sheffield complained in 1897: 'In the majority of cases the patient is moribund or dead before the report [of puerperal fever] reaches the health office.'¹⁶

The second problem concerns confusion over the terminology and definition of deaths traceable to the puerperal state. Puerperal fever was a very vague condition, not traceable to one single organism. In an attempt to tighten up notification, the term 'puerperal pyrexia' was adopted in 1926 and defined as fever of any cause within 21 days of childbirth with a temperature of 38°C which was sustained or recurred within 24 hours¹⁷.

The third major area of concern, particularly in Sheffield, where its influence was felt to be considerable, was the impact on the figures of illegal abortions. Shorter has claimed that puerperal sepsis was falling after the introduction of antiseptic and aseptic techniques in the 1880s, but that these favourable figures were obscured by high abortion rates which carried high fatality rates¹⁸. Loudon and Fox have both disagreed with this interpretation. Loudon has argued that if childbirth mortality was improving then accidents in childbirth should show a drop commensurate with the abortion induced rise in fever cases. In fact the total share of MMR accounted for by fever fell from 57% in 1880–85 to 41% in 1935¹⁹. Many areas confirmed this experience; in 1919–22, of 44 maternal deaths in Breconshire, only 9 were due to fever, and of 30 deaths in Westmoreland, none were due to fever²⁰. However, in Sheffield the high peaks in MMR of the late 1920s and early 1930s were characterised by very high rates of puerperal fever (*Figure 5.2*). This suggests that looking at the national picture alone masks significant regional variations.

¹⁵ C Berkeley, 'Save the Women and Children', *BMJ*, i, 1926, 4–8.

¹⁶ *MOH Report*, Sheffield, 1897, p.31.

¹⁷ I Loudon, 'Deaths in Childbed', *Medical History*, 30, 1986, 1–41

¹⁸ E Shorter, *A History of Women's Bodies*, London, 1983, p100.

¹⁹ Loudon, 'Deaths in Childbed', p.26.

²⁰ Heagerty, *The Struggle for British Midwifery*, p.166.

Contemporaries such as Janet Campbell, Medical Officer for Maternal and Child Welfare at the Ministry of Health, the obstetrician JM Munro Kerr, and the Medical Research Council did not believe that there was evidence of a fall in full term mortality masked by abortion deaths, but directed all their research efforts towards full term deaths. Loudon has suggested that there was no evidence of doctors deliberately registering abortion deaths as full term ones, but that the statistics were confused by the lumping together of 'post-abortion' and 'post-partum' sepsis as 'puerperal sepsis'. Loudon has accepted that rising death from induced abortion did have a significant impact on mortality figures²¹. MOH reports for Sheffield claimed they could distinguish between 'abortion' which included spontaneous miscarriage and criminal abortion. However, unless there was clear evidence of botched instrumental abortion, it was difficult to tell what caused the expulsion and whether it was spontaneous or procured. Women themselves would never have been entirely certain; modern estimates put the spontaneous abortion rate at c.20%. Attempts at self abortion might have introduced infection, although the miscarriage itself was spontaneous. Blame for Sheffield's high rate of MMR centred round the belief that the cause was the high rate of illegal abortion. The evidence for this will be considered in more detail in the next chapter, but the belief was significant in wider discussions of MMR. It was constantly reiterated that little could be done to tackle MMR because of abortion. The Chairman of the Council's Health Committee commented in 1935 that:

The one black spot is maternal mortality. Unless [we] can make some headway in the direction of reducing the number of sepsis deaths arising from abortion, over which the local authority [has] no control, the maternal mortality rate must inevitably remain high.²²

The final factor which confuses any discussion of MMR is the introduction in 1936/7 of red prontosil; the first of the sulphonamide drugs, aimed at curing sepsis. It was discovered in Germany in 1935, and taken up enthusiastically in Britain in the following year²³. It appears that the drug had an immediate effect on MMR, which was sustained after the Second World

²¹ Loudon, *Death in Childbirth*, p.113.

²² *ST*, 24/5/35, p.8.

²³ The first trial conducted in Britain is described in L Colebrook and M Kenny, 'Treatment with Prontosil of Puerperal Infections Due to Haemolytic Streptococci', *The Lancet*, ii, 1936, 1319-1322. This was mentioned in the *Sheffield Telegraph* as early as 8/6/36, p.5, when the trial was still in progress, and illustrates the interest surrounding any any possible 'cures' for problems in maternity.

War with the introduction of blood transfusion, flying squads and penicillin. However its success obscured two important factors. The first was that contemporaries noted that MMR was falling before the 1937 general introduction of sulphonamide, possibly due to a sudden decrease in the virulence of the infective *streptococci*. Researchers Colebrook, and Webb and Weston–Edwards all made this point²⁴. There was evidence from some hospitals, including the Jessop, that some, possibly cyclical decline in streptococcal virulence was occurring before this time, but the influence of sulphonamide on the figures makes it impossible to determine accurately²⁵. However, as Loudon has commented, the decisive turning point in MMR came not in 1935 when rates did fall but only to previously attained levels, but in 1937 when they dropped to historically new lows, attributable to sulphonamide²⁶.

The second factor that can be obscured by the apparent success story of sulphonamides is that until their discovery, doctors and researchers continued to have very little idea about how to tackle MMR. This was particularly evident in relation to sepsis, with a constant stream of articles in the medical press attempting to describe and proscribe its spread²⁷. Debate centred around the possible source of infection, endogenous or exogenous²⁸. Dr Paine, the bacteriologist at the Jessop, helped to prove that the majority of infections came from external sources, and developed a delivery mask to combat transmission from attendant to mother²⁹. Strict sepsis and calls to lower the intervention rates were the best that could be achieved. By *curing* sepsis prontosil saved lives but did little to *prevent* its initial occurrence. In

²⁴ L Colebrook, 'The Story of Puerperal Fever – 1800 to 1950', *BMJ*, i, 1956, 247–252; J Webb and P Weston–Edwards, 'Recent Trends in Maternal Mortality', *The Medical Officer*, 86, 1951, 201–204.

²⁵ Colebrook, L, and M Kenny, 'Treatment with Prontosil of Puerperal Infections Due to Haemolytic Streptococci', *The Lancet*, ii, 1936, 1319–1322, p.1322; the example of the Jessop is mentioned in this paper, but I have not come across any direct evidence relating to the issue. However deaths from abortion seen at the City General Hospital in Sheffield dropped dramatically between 1934 and 1935, despite the numbers of abortion related cases rising; this might suggest a possible cyclical decline in *streptococcal* virulence. See Chapter 6.

²⁶ I Loudon, 'Puerperal Fever, the Streptococcus, and the Sulphonamides, 1911–1945', *BMJ*, ii, 1987, 485–490.

²⁷ WHF Oxley, 'Prevention of Puerperal Sepsis in General Practise', *BMJ*, i, 1934, 1017–1019; J Young, 'Maternal Mortality from Puerperal Sepsis', *BMJ*, i, 1928, 967–971; L Colebrook, 'Some Laboratory Investigations in Connexion with Puerperal Fever', *Proceedings Royal Society Medicine*, 19, 1926, 31–42.

²⁸ CG Paine, 'The Source of Infection in a Minor Outbreak of Puerperal Fever', *BMJ*, ii, 1931, 1082–1083; F Garland Collins, 'A Midwife as a Carrier of Infection', *The Lancet*, ii, 1934, 718; L Miller Wood and FE Camps, 'Puerperal Infections in Relation to Midwifery Attendance', *BMJ*, ii, 1937, 811–812.

²⁹ CG Paine, 'The Aetiology of Puerperal Infection', *BMJ*, i, 1935, 243–246.

fact it made hospital deliveries and increasing intervention more acceptable by removing much of the risk of death from infection.

Even more difficult to quantify and assess than maternal mortality, is the incidence and severity of maternal morbidity. Evidence from *Maternity* and *Working Class Wives* suggests that problems were widespread, but in general there appears to have been official reluctance to investigate the possible scope of the problem³⁰. The Ministry of Health did look at MMR but was reluctant to undertake studies into maternal morbidity. The Chief Medical Officer at the Ministry, George Newman, admitted that an official inquiry would result in: '...the demonstration of a great mass of sickness and impairment attributable to childbirth, which would create a demand for organised treatment by the state.'³¹

However, even given these limitations, it is possible to use the available evidence to investigate particular aspects of MMR.

5.2b: Maternal Mortality and Social Class:

One of Loudon's main contentions, supported by nineteenth and early twentieth century writers, has been that MMR is very sensitive to factors surrounding the treatment of the birth, but is little influenced by environmental factors. Loudon has cited the quality of care given during labour as the main indicator of maternal outcome. Issues such as quality of housing, quality and quantity of diet, and the type of work engaged in by the mother appear to have been only marginally significant³². The primary cause of death in (or rather, after) childbirth was puerperal fever; septicaemia caused by a wound infection. Loudon has argued that deaths from such causes were not most common among working class women, who were likely to be attended by midwives, or else to enter charity hospitals where the staff were likely to be relatively skilled. A GP and researcher, Geddes had commented in 1926 that:

The statistics procurable all tend to prove that neither the patients *social position nor her hygienic surroundings* have much, if any, influence upon her susceptibility to puerperal sepsis. Indeed it may be assumed that *the well-to-do in industrial districts* are more often the victims of puerperal sepsis than those in humbler circumstances.

³⁰ ML Davies, ed., *Maternity: Letters from Working Women*, 1915, reprinted, London, 1978; M Spring Rice, *Working Class Wives: Their Health and Conditions*, 1939, reprinted London, 1981.

³¹ Quoted in; C Webster, 'Healthy or Hungry Thirties?', *History Workshop Journal*, 13, 1982, 110-29, p.121.

³² Loudon, *Death in Childbirth*, p.244

Maternal Mortality by Class, England and Wales 1930-2

	Class				
	I + II	III	IV	V	all
all MMR	4.44	4.11	4.16	3.89	4.13
haemorrhage	0.50	0.44	0.48	0.60	0.49
sepsis	1.45	1.33	1.21	1.16	1.29

Table 5.1

Source: HM Govt, Report on an Investigation into Maternal Mortality, 1937, p.111.

Therefore *poverty is not a factor* in the causation of puerperal fever.³³
[italics in original]

Winter has argued that:

To have demonstrated that the risks of puerperal sepsis diminished as one went down the social scale was to show the impossibility of making a direct link between economic insecurity and maternal mortality.³⁴

The 1937 Government Report into MMR supported this contention, citing figures for 1930–32 which suggested that social classes I and II were at greater risk (*Table 5.1*). Geddes suggested that the MMR was highest in middle and upper class women, because they were most likely to be treated by GPs whose experience would have been limited, and whose assistance tended towards the interventionist³⁵. The use of internal examinations and forceps when antisepsis was probably rudimentary was a fertile area for the introduction of infection. The evidence of Cullingworth for London in 1898, and Fairbairn for Leeds in the 1920s suggested that MMR was higher in well off areas and was accepted as proof of the dangers of high GP delivery rates³⁶. For, example, in Leeds between 1920 and 1921 the maternal death rate was 4.49‰ for the city, but up to 5.93‰ in middle class areas, and only 3.01‰ in working class areas. However, in 1929, the MOH for Leeds commented that although two residential wards had the highest MMR in 1921–25, the next four highest were working class wards. He was cautious about reading too much into middle class MMR, arguing that:

A considerable proportion of the cases of puerperal fever occur in the cottages of the working classes, many of which are small, poorly furnished, and ill-equipped for lying-in purposes. The mother, for one


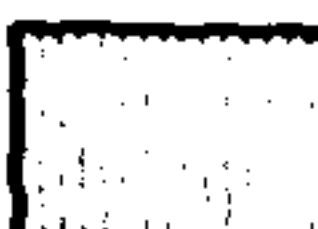

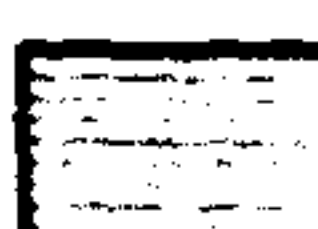
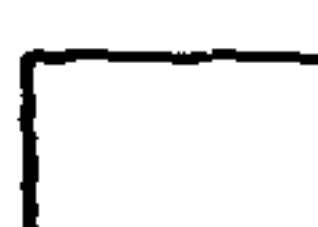
³³ G Geddes, *Puerperal Septicaemia: Its Causation, Symptoms, Prevention and Treatment*, Bristol, 1926, p.92–3. Shorter has also speculated that precisely because middle class homes were so much more hygienic than working class ones, middle class patients were less likely to have built up immunity to infection through exposure to low level infections; Shorter, *History of Women's Bodies*, p.128.

³⁴ JM Winter, 'Infant Mortality, Maternal Mortality, and Public Health in Britain in the 1930's', *Journal European Economic History*, 8, 1979, 439–62, p.455.

³⁵ MD Crawford, 'The Obstetric Forceps and its Use', *The Lancet*, i, 1932, 1239–1243.

³⁶ Loudon, *Death in Childbirth*, p.244–6. Cullingworth's map of London was reproduced in Kerr, JM Munro, *Maternal Mortality and Morbidity: A Study of Their Problems*, Edinburgh, 1933, p.14–15; see also JS Fairbairn, 'The Medical and Psychological Aspects of Gynaecology', *The Lancet*, ii, 1931, 999–1004, p.1003.

Geographical Variations in Maternal Mortality, Administrative Counties of England and Wales, 1924-33.

-  Rates higher than that of England and Wales by an amount which is definitely significant
-  Rates higher than that of England and Wales by an amount which is very probably significant
-  Rates which do not differ significantly from that of England and Wales
-  Rates lower than that of England and Wales by an amount which is very probably significant
-  Rates lower than that of England and Wales by an amount which is definitely significant

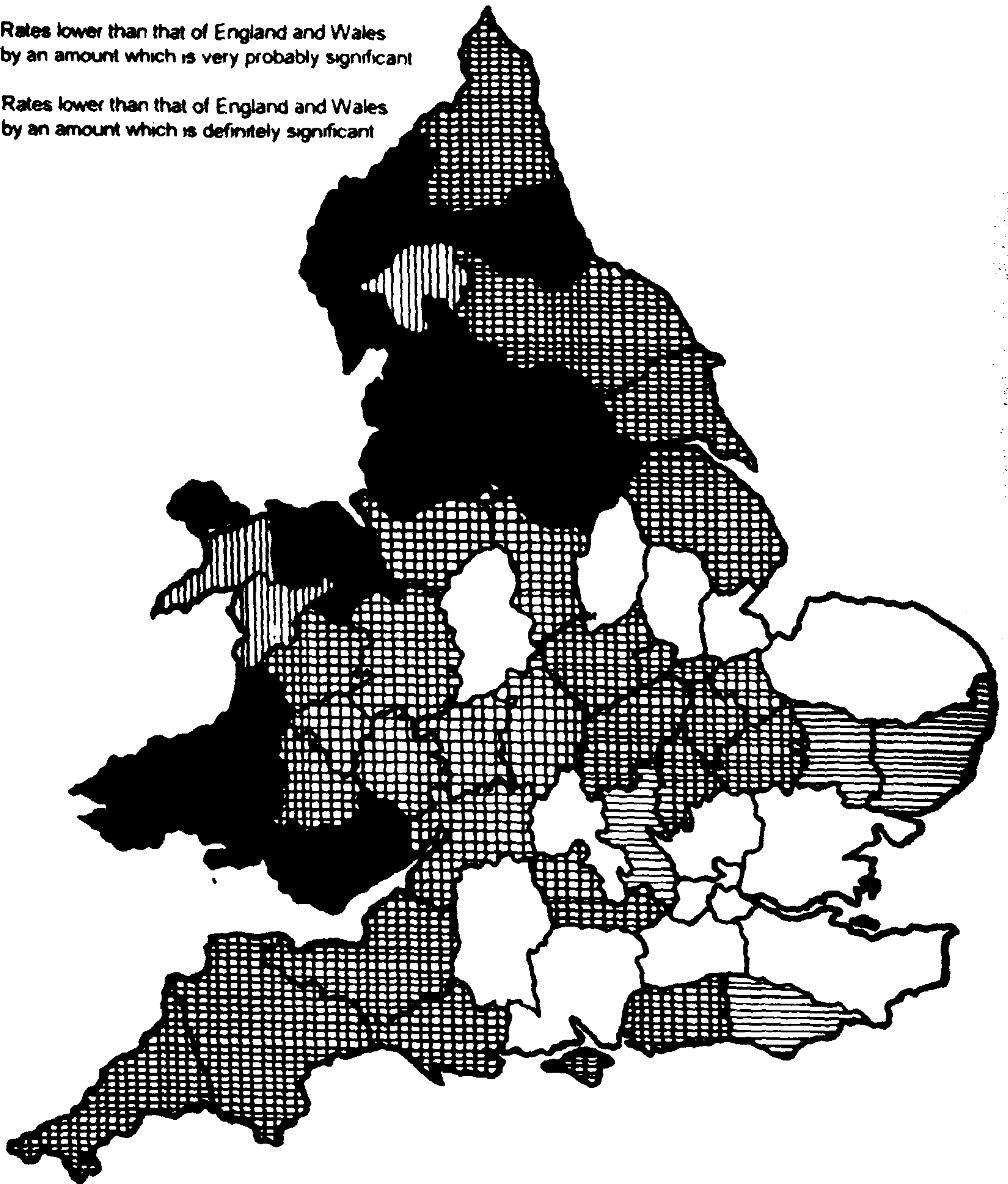


Figure 5.3

Source: A Macfarlane and M Mugford, *Birth Counts*, London, 1984.
Original data from: *Report on an Investigation into Maternal Mortality, 1937*.

reason or another, but generally as a result of overwork and excessive childbearing, is often physically unfit to bear the strain of pregnancy.³⁷

Reverse causality did not, hold true for all areas; most of the special areas investigated in 1932 because of exceptionally high MMR were urban areas of high industrial unemployment and consequent poverty (*Figure 5.3*). In Sheffield, as will be demonstrated, it was the poor areas which exhibited the highest MMR.

If IMR was very sensitive to environmental factors, particularly sanitation and food supply, yet MMR was not at all sensitive, then Loudon has argued, there must be an inverse correlation between IMR and MMR. However, evidence for Sheffield, from MOH Reports, does not demonstrate either high MMR in middle class areas or a negative correlation for MMR and IMR. The population correlation coefficient was calculated for the yearly maternal mortality versus infant mortality per 1000 births for the City. This gave a result of -0.052 , suggesting a total absence of link between the two factors, either negative or positive. However this aggregate figure masks two interesting details. The puerperal fever component of MMR, correlated with total IMR gave a result of -0.407 , tentatively suggesting that fever deaths might have been proportionally higher in better off areas, perhaps as a result of inadequate GP care. Conversely other causes of death, classified as 'accidents of childbirth' gave a figure of $+0.336$ when correlated with total IMR, suggesting that these might have been linked to problems of poverty³⁸. Both of these suggestions are only possibilities, however, as none of the figures were statistically significant. Additionally, it proved impossible to target areas of consistently high, or constantly low MMR. For example in 1925, Handsworth had an MMR of 10.49‰ , and Tinsley a rate of 0‰ . The following year, Handsworth had a rate of 5.55‰ , and Tinsley 27.29‰ . These fluctuations are so big because of the small absolute numbers involved; even in 1926 Tinsley's high rate was caused by only 3 deaths.

It does not appear from the figures, therefore, that in Sheffield more wealthy areas generally exhibited higher rates of MMR and there is no qualitative evidence to suggest that contemporaries believed this to be the case. In fact working class areas such as Brightside, Attercliffe and Tinsley generally appear to have had some of the highest rates, a view supported by local commentators such as the Sheffield Maternal Mortality Committee, the

³⁷ Discussion, 'Puerperal Fever and Puerperal Pyrexia', *Public Health*, 40, 1927, 205–218, p.210.

³⁸ The correlations were based on a run of figures from 1885 to 1939.

Cases of Malnutrition and Anaemia seen at MCWC, Sheffield, 1932-36.

	1932	1933	1934	1935	1936
malnutrition	36	104	48	36	15
anaemia	19	56	33	29	78

Table 5.2

Source: MOH Reports, Sheffield.

Maternal Mortality (per 1000 births) versus Unemployment (thousands) in Sheffield, 1921-1940

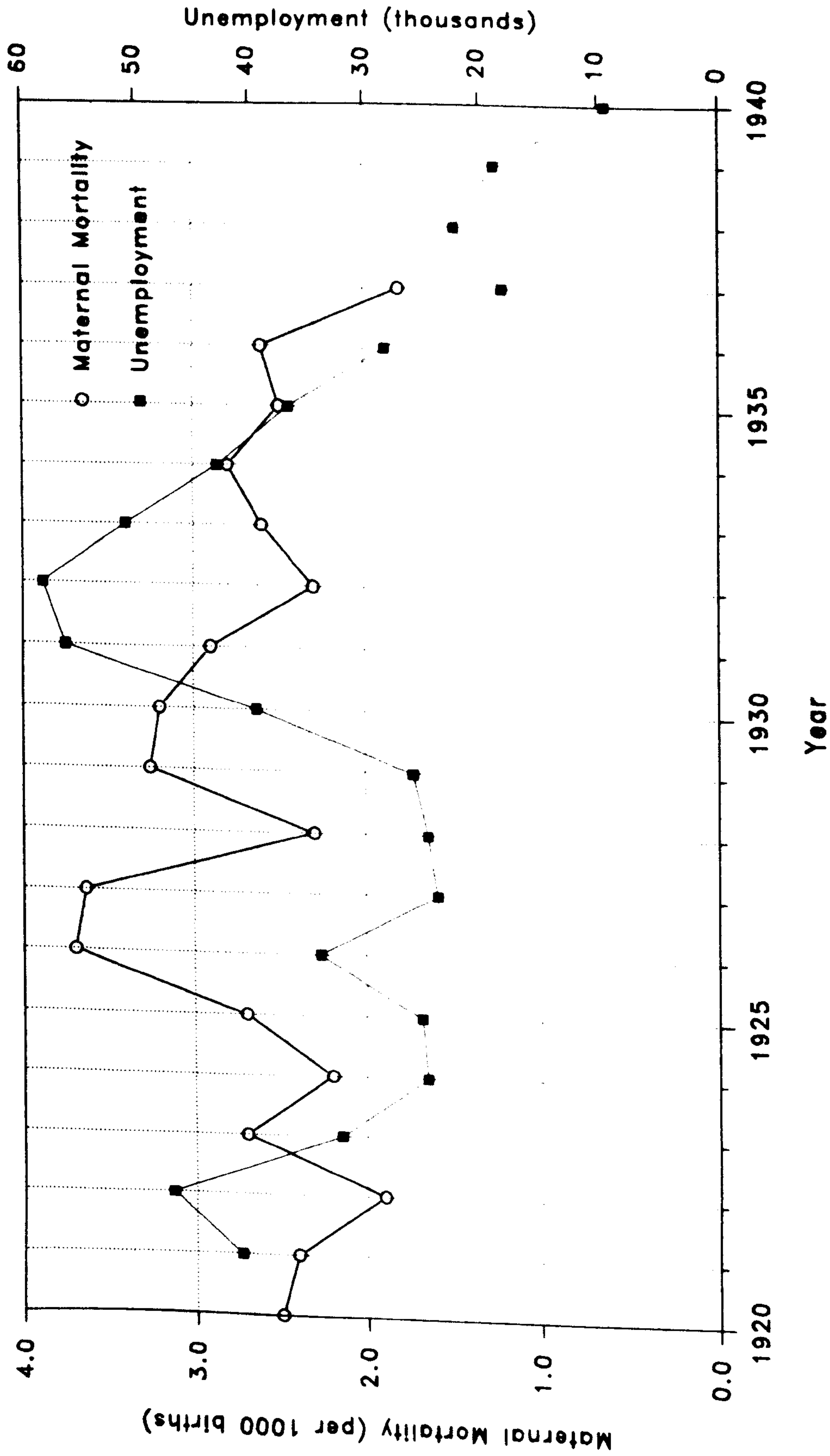


Figure 6.4

Source: MOH Reports, Sheffield

National Council for Women (NCW), and campaigner Elinor Pike, who called for more clinics in these areas to combat the problem. These suburbs were the heavy steel making areas of eastern Sheffield, badly hit by unemployment. As *Figure 5.4* demonstrates, there is no easy correlation between MMR and unemployment in the City, although this is not to discount the cumulative effect of poverty and unemployment on the figures. The Assistant MOH in Liverpool found that of 117 puerperal fever deaths between 1929 and 1933, in 79 cases the standard of living was poor, with many women being wives of dockers or of the unemployed. In 69 cases there was evidence of chronic or acute ill-health before labour³⁹. For Sheffield in particular, it is also important not to discount, although impossible to quantify, the effect of high and possibly rising, abortion rates due to financial worry and unemployment in these areas. This point will be discussed in detail in the following chapter.

Nationally, the effect of malnutrition on MMR was, as Fox has argued, never studied effectively, partly due to the possible implications, financial and social, of discovering that it was a significant factor. As early as 1903, the MOH for Sheffield had commented that the Women Sanitary Inspectors (WSI) found many of the women they visited to be '...anaemic and ill looking, notwithstanding their homes were clean.' There were other veiled references to the economic situation, as in 1926 when of 532 new cases at the maternity clinic 31 resulted in miscarriages or stillbirth and there were 4 maternal deaths. The Medical Officer at the Clinic wrote:

This total number is disappointingly large, but it has been noticed before that in times of industrial crisis this has occurred. Worry is far more harmful than poverty to an expectant mother. The latter one can help, but it is very difficult to treat a worried expectant mother successfully, as the pregnancy alters her mental outlook and magnifies her troubles enormously.⁴⁰

The implication was that unemployment and poverty caused worry, which could in turn result in unfavourable outcomes.

From 1932 the MCWC in Sheffield did take note of the numbers of mothers suffering from malnutrition antenatally (*Table 5.2*). Councillor Asbury, in an article defending Council welfare policies said that malnutrition was not a problem in Sheffield, citing the figure of 36 for 1935 as evidence of its rarity⁴¹. However, there appears to have been no agreed definition of 'malnutrition',

³⁹ RE Bell, 'Maternal Mortality in Liverpool', *Public Health*, 47, 1934, 330-334, p.331.

⁴⁰ *MOH Report*, Sheffield, 1926, p.105

⁴¹ *Sheffield Co-operator*, October, 1936.

either locally or nationally, and this hampered discussions of the issue. Poor nutritional status may have exacerbated other problems, which could lead to a poor maternal outcome. Mothers died of mitral stenosis and other heart problems, caused by weakening effect of earlier bouts of septicaemia, and the inability of the body to recover totally⁴².

Despite a reluctance to get involved, there was even some support for the possible influence of nutrition from Janet Campbell, the Medical Officer for Maternal and Child Welfare at the Ministry of Health:

It is likely that nutrition plays a larger role in maternal morbidity than is generally realised. Some degree of malnutrition is probably fairly widespread among all women in these towns.⁴³

Local campaigners also put forward the suggestion that the blame lay partly with the mass movement from the slums to new housing estates:

When people moved from the slums, they bought new furniture on the hire purchase system, and this coupled with their rents and rates and transport expenses meant that in many cases they were going short of food.⁴⁴

Fox has argued that the view of Loudon and Winter that nutrition was not a factor in high maternal mortality cannot be proved because it was never sufficiently investigated⁴⁵. Loudon has in fact credited improved nutrition with helping to sustain the decline in MMR after 1940, together with the development of blood transfusions, flying squads and improved maternity services⁴⁶. Mayhew and Webster have both discussed the highly politicised nature of the debate on nutrition, and the difficulties this caused in an appraisal of the factors influencing MMR⁴⁷. Reports by groups such as the Pilgrim Trust which suggested 3,200 women per year were dying in childbirth

⁴² Women writing in *Maternity* made constant reference to going short of food during pregnancy, either through a lack of income, or because of the need to save money to pay for medical attention; ML Davies, ed., *Maternity: Letters from Working Women*, 1915, reprinted, London, 1978, eg., p.18, 20, 23, 40, 41. Green and Mellanby tried giving Vitamin A to a group of ante-natal patients in Sheffield as a prophylactic against sepsis. Their results were very inconclusive; HN Green, D Pindar, G Davis and E Mellanby, 'Diet as a Prophylactic Agent Against Puerperal Sepsis', *BMJ*, ii, 1931, 595–98.

⁴³ JM Campbell, ID Cameron, DM Jones, *High Maternal Mortality in Certain Areas*, London, 1932, p.8.

⁴⁴ *ST*, 2/10/36.

⁴⁵ E Fox, 'Powers of Life and Death: Aspects of Maternal Welfare in England and Wales Between the Wars', *Medical History*, 35, 1991, 328–352.

⁴⁶ Loudon, 'Puerperal Fever', p.488.

⁴⁷ Webster, 'Healthy or Hungry Thirties?'; M Mayhew, 'The 1930's Nutrition Controversy', *Journal Contemporary History*, 23, 1988, 445–464.

Maternal Mortality Rates in Selected Towns, 1911-14 and 1923-29

	1911-14			1923-29		
	puerperal fever	accidents of childbirth	total	puerperal fever	accidents of childbirth	total
Sheffield	1.50	2.35	3.85	2.74	3.00	5.64
Barnsley	2.04	3.77	5.81	2.18	3.87	6.05
Bradford	1.95	3.63	5.58	2.42	2.91	5.33
Dewsbury	1.95	3.63	5.58	2.42	3.44	5.33
Halifax	2.44	6.10	8.54	2.21	4.87	5.65
Huddersfield	1.22	5.01	6.23	1.39	3.83	6.26
Wakefield	2.97	3.59	6.56	1.51	3.59	5.10

Table 5.3

Source: High Maternal Mortality in Certain Areas, London, 1932

due to malnutrition and poverty, or the work on supplementary feeding in the Rhondda were accused of being politicised biased and therefore unreliable⁴⁸. The famous 'Rochdale experiment' conducted by the MOH Andrew Topping was an attempt to improve local MMR through improved antenatal care and lowered intervention rates, and received a far more favourable reception. He discounted the views of local doctors on the influence of malnutrition and heavy industrial work, and concentrated on their shortcomings. His work represented a propaganda victory for the obstetricians, three of whom, including Phillips from the Jessop, wrote a very complimentary survey of the work⁴⁹. Mayhew has argued that due to fiscal retrenchment and mass unemployment, unease at the Ministry of Health about the role of nutrition had to be represented as official optimism; they literally could not afford to do otherwise. This situation appears to have been replicated at the local level with fiscal restraint taking precedence over schemes of maternal welfare in Sheffield; resulting in a reluctance to expand clinic provision, despite its popularity, if not efficacy.

5.2c: Puerperal Fever:

It has already been suggested that Sheffield was very unusual in the composition of its total MMR. This was made explicit in the 1932 report on *High Maternal Mortality in Certain Areas* where it was confirmed that in most areas:

It is clear from the figures given in the reports that the excessive maternal death rate is attributable to complications of child-birth in a greater degree than to puerperal sepsis.⁵⁰

This situation was confirmed by figures given for most of the regions with high MMR (*Table 5.3*). Sheffield stands out as having a relatively low accident rate and very high rates of fever. It was suggested that high accident rates

⁴⁸ There are difficulties in assessing cause and effect with the Rhondda experiment as several variables were altered at once; with the provision of more obstetricians, midwives, and free dressings and dettol at the same time as beef extract, ovalatine, marmite and milk. Lady Williams, 'Malnutrition as A Cause of Maternal Mortality', *Public Health*, 50, 1936, 11–20; Lady Williams, 'Results of Experimental Schemes for Reducing the Maternal Death Rate in the Special Areas of Glamorgan, Monmouthshire, and Durham, Carried Out by the Birthday Trust During 1934, 1935 and 1936', *Public Health*, 50, 1937, 231–33.

⁴⁹ WHF Oxley, MH Phillips, and J Young, 'Maternal Mortality in Rochdale: An Achievement in a Black Area', *BMJ*, i, 1935, 304–307; *The Lancet*, i, 1936, 545–547; A Topping, 'Maternal Mortality and Public Opinion', *Public Health*, 49, 1936, 342–9.

⁵⁰ JM Campbell, ID Cameron, and DM Jones, *High Maternal Mortality in Certain Areas*, London, 1932, p.3.

Notification of Erysipelas, Puerperal Fever and Puerperal Pyrexia, Sheffield, 1900-1945

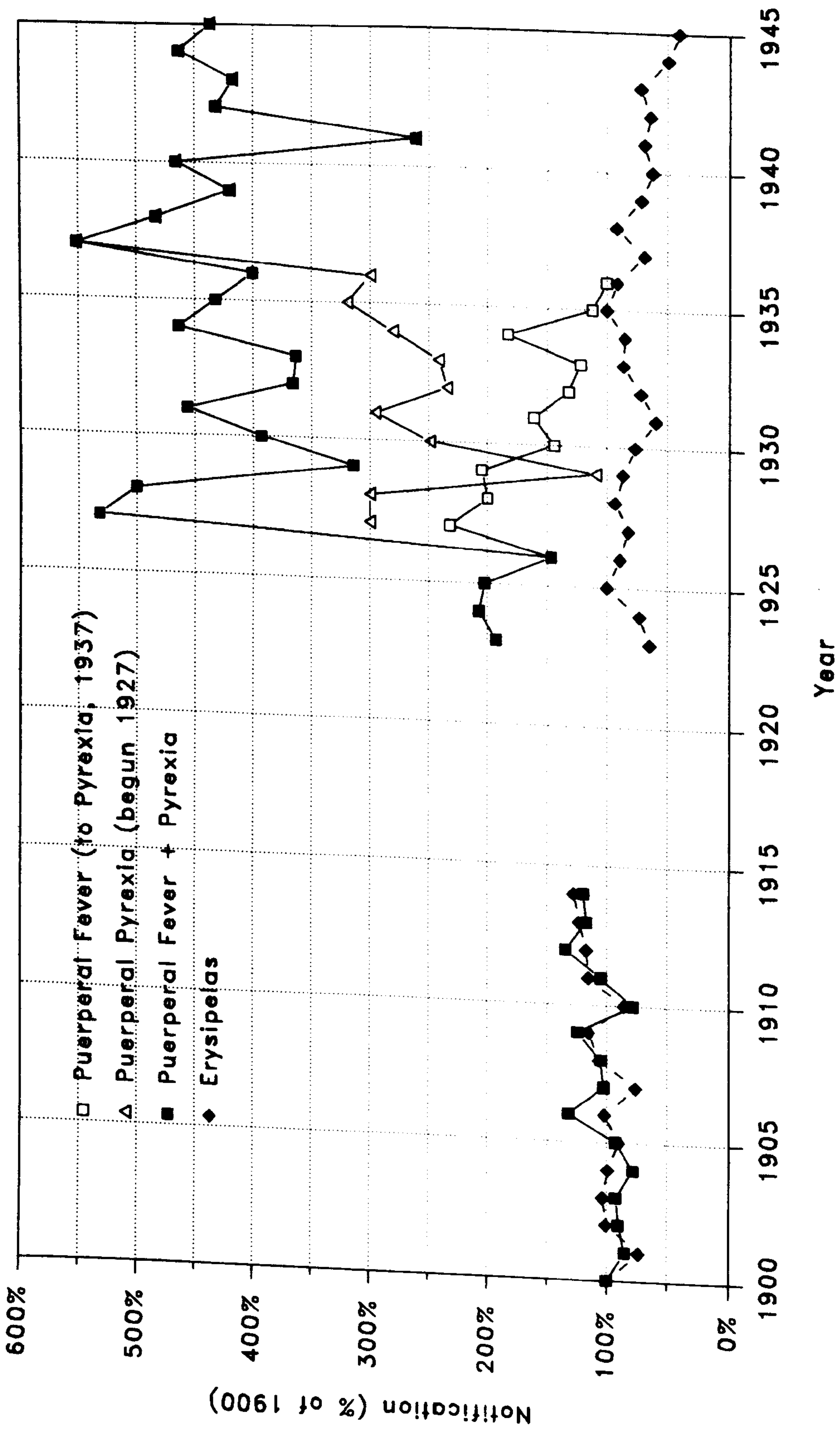


Figure 5.5

Source: MOH Reports, Sheffield

Notification of Scarlet Fever, Puerperal Fever and Puerperal Pyrexia, Sheffield, 1900-1945

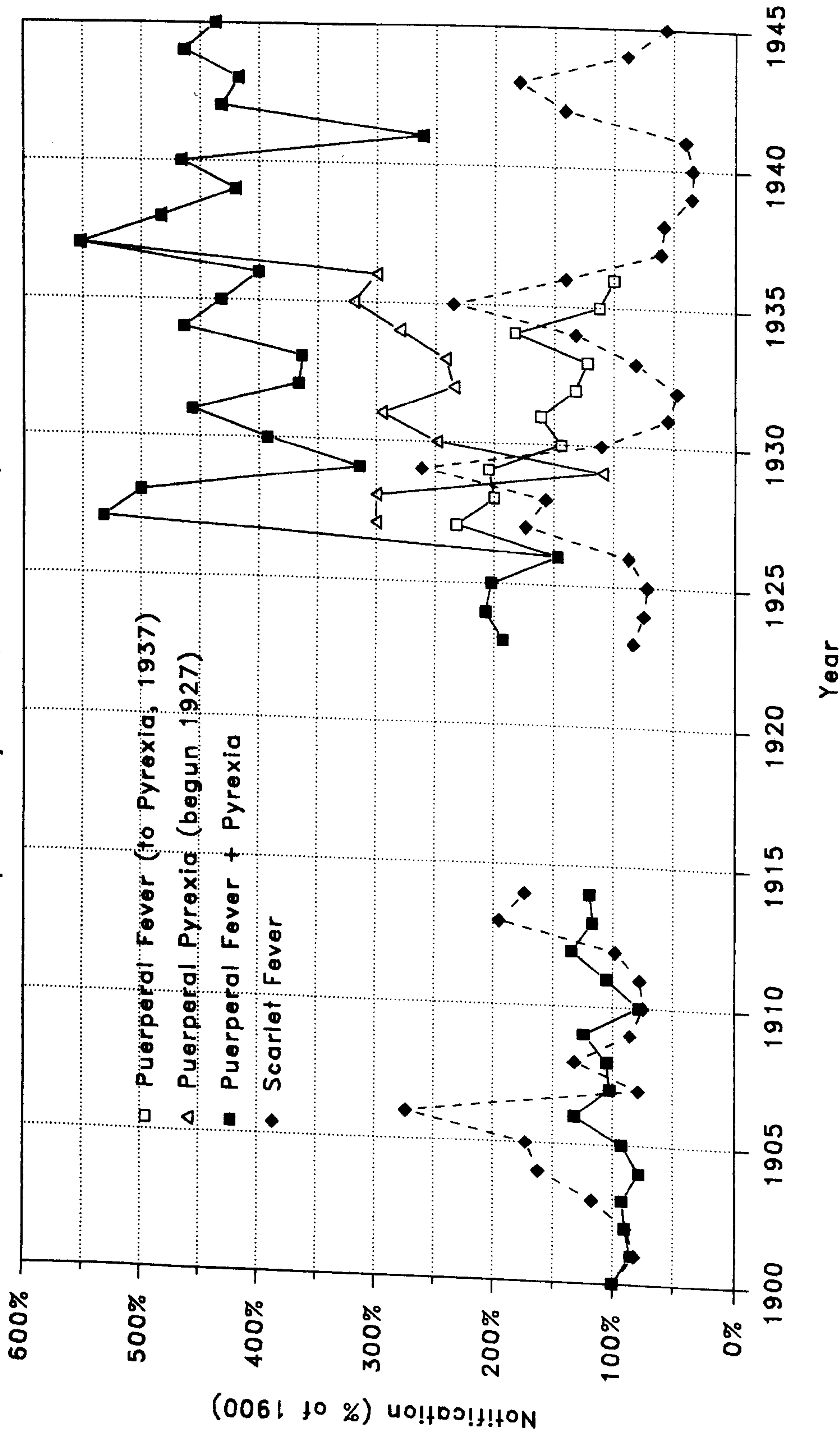


Figure 5.6

Source: MOH Reports, Sheffield

resulted from poor environmental conditions, including poverty and poor housing, but that areas with high sepsis rates had relative good social conditions masked by high abortion rates. The mortality from puerperal fever in Sheffield rose significantly between 1911–14 and 1923–29; it will be argued in the following chapter that this was due to the increased resort to instrumental abortions in the latter period. This was as a result of worsening economic conditions, with the resultant necessity to keep down family size, and also to the outlawing of less dangerous forms of abortion, particularly the use of lead compounds.

Some of the most comprehensive early investigations into puerperal fever were made by George Geddes, a Lancashire GP and researcher who in 1912 reached the conclusion that:

...puerperal infection is largely if not entirely due to contamination directly by, or indirectly through, suppurating wounds and that therefore the high puerperal rate in manufacturing and mining districts is explained by the high accident rate in those districts.⁵¹

Such relationships might be part of the explanation for the high MMR of east Sheffield, the archetypal heavy trade and mining areas. In his analysis of puerperal fever, Loudon drew attention to this link between puerperal fever, scarlet fever, and, in particular, erysipelas (all identified, in the 1920s, as caused by the *Streptococcus pyogenes*). He suggested that the link between erysipelas and puerperal fever was particularly strong as they were both basically wound infections. Ineffective hygiene was obviously responsible for part of this, but it came to be recognised through work on the *streptococcus* that up to 40% of the healthy population can be carriers. Loudon argued that high death rates from puerperal fever in the 1920s and early 1930s had more to do with the increased virulence of *S. pyogenes* than with worsening hygiene.

However, as *Figures 5.5* and *5.6* demonstrate, the comparison of notification rates for the three conditions does not demonstrate any conclusive links for Sheffield. Unfortunately it is impossible to compare death rates, as erysipelas did not kill by this period, and scarlet fever only rarely. Notifications do, however, have major limitations especially when considering puerperal fever, as they bore uncertain relationship to actual incidence, and are further confused by changes in nomenclature. The graphs can only, therefore, be suggestive of the situation. *Figure 5.5* does show that erysipelas and

⁵¹ Geddes, *Statistics of Puerperal Fever*, p.83.

puerperal fever seem to shadow each other very closely, especially in early part of period. The relationship between scarlet fever and puerperal fever seems stronger later in the period. However, neither graph suggests any clear cut relationship in incidence for Sheffield.

5.2d: Maternal Mortality and Neonatal Mortality:

As IMR entered its final phase of decline from the beginning of the twentieth century, it was the post-neonatal aspect that accounted for most of the reduction. Neonatal mortality, associated with prematurity, congenital defects, or birth injury, remained largely stable. Much of the development of inter-war antenatal care therefore centred around efforts to reduce the neonatal mortality rate (NMR) component of IMR, in the belief that the former was linked to endogenous factors related to the pregnancy and birth⁵².

However, Loudon has argued that there was in fact no relationship between NMR and maternal health including MMR, since the most common cause of neonatal death; prematurity [death due to gestation of less than 37 weeks] was rarely linked to maternal problems. Some maternal pathology carries risk to the baby but not the mother, for example, rubella, or cervical incompetence. In the opposite extreme, conditions such as puerperal fever or haemorrhage would probably kill the mother but not effect the neonate although the baby might be at increased risk as a post-neonate due to poor care, or artificial feeding. Data on Sheffield seems to support Loudon's view in that it suggests a weak negative correlation between NMR and MMR; for the period 1905–1937 there is a correlation of -0.304 . Certainly figures from the City General in the 1930s, show that about 75% of stillbirth deaths, and 100% of new-borns (i.e. before they left Hospital) died of causes unrelated to the mother, and which would not have affected her health; the most common being prematurity. Where the condition of the mother did affect her baby, this was usually toxæmia. Antenatal care of the mother, aimed at improving the health of the infant probably therefore had little impact, at least on the health of the foetus. The effect of care on health and outcome for the mother will be considered below.

⁵² The pioneer of ante-natal care, Ballantyne, was interested only in the health of the infant, not that of the mother; JW Ballantyne, *Expectant Motherhood: Its Supervision and Hygiene*, London, 1914, p.xiii; several writers mentioned NMR explicitly as the target of ante-natal care; A Routh, 'A Lecture on Ante-natal Hygiene: Its Influence on Infantile Mortality', *BMJ*, i, 1914, 355–363, p.359; E McConnell, 'The State and Pre-natal Hygiene', *BMJ*, ii, 1918, 365–366.

5.2e: The Effect of the Carer:

Loudon's inverse social class theory of maternal mortality carries the implication that midwives delivering working class women were less interventionist and therefore safer than GP's delivering middle class mothers. Up to c.1920, however the contemporary view was that it was the midwife who was the principal carrier of disease. The MOH in Sheffield, himself of course always a doctor, took this view, reporting in 1895 that:

This disease [puerperal fever] is, with few exceptions, perfectly preventable, provided the ordinary simple rules of practise be observed. Unfortunately, gross and culpable carelessness is too often shewn by so called midwives who attend puerperal women...few of them are specially educated women, and for the most part have very vague ideas of the precautions necessary to be taken to prevent any infection of their patients. This accounts for the large proportion of cases occurring in their practise as compared with those attended by medical men.⁵³

The following year he complained about midwives being, 'wholly uneducated and ignorant of the first principles of cleanliness and methods of preventing this disease'⁵⁴. In 1898 a woman was warned after 1 death, and after 2 was tried for manslaughter at Leeds assizes. She was acquitted. In 1907 the differences between doctor and midwife cases were made explicit:

46 cases of puerperal fever were notified, in 21 of which the confinement was attended by a midwife. In each of the latter cases arrangements were made for the midwife to have disinfectant baths, and for the disinfection of her clothes and outfit. In each case the possible origin of the disease was investigated and the midwife was temporarily suspended from practise.⁵⁵

Doctors received no such attention, despite being responsible for the majority of cases in that year. Geddes, the GP who made a study of puerperal fever, complained that Sanitary Authorities should make both doctor and midwife subject to the same rules on resting and disinfection after infection. In fact Geddes believed that '...the medical practitioner must I am convinced, accept the larger share of responsibility' for the spread of puerperal fever, since he was more likely to attending mixed cases⁵⁶. Analysis of the relative case rates and fatalities for Sheffield is inconclusive. Doctors do appear to have had a higher number of cases, with more fatalities when

⁵³ *MOH Report*, Sheffield, 1895, p.18.

⁵⁴ *MOH Report*, Sheffield, 1896, p.22.

⁵⁵ *MOH Report*, Sheffield, 1907, p.42.

⁵⁶ Geddes, *Statistics of Puerperal Fever*, p.83.

compared to midwives, although there is no indication of how these were spread around the City. It does seem that doctors had fewer cases each, but concomitantly that more doctors were implicated. For example, in 1924, of 23 doctor's cases of fever, 17 had 1 case each and 3 had 2 cases. For the same year, of 27 midwife's cases, 2 had 5 cases each. Unfortunately this is the final year for which breakdowns are given, but it does suggest that the link between GP practice and infection is not clear cut.

Apart from the issue of puerperal fever, two cases which received considerable attention in the local Sheffield press illustrate the potentially fatal muddle that could arise over the provision of services. The first occurred in February 1909 when a woman in labour died alone from haemorrhage because no doctor could be found to attend her without a fee in advance. Her husband approached four doctors who all gave the same answer. The ensuing debate in the papers was long-running, and centred round the defence by local doctors that their skills were their capital and that they had every right to demand payment, or at least a permissory note from the Poor Law Relieving Officer⁵⁷. The *Sheffield Telegraph* suggested that the lack of co-operation between doctors and midwives over the question of fees was leading to the breakdown of the 1902 Midwives Act⁵⁸.

The difficulties of distributing blame between carers were further illustrated six months later when it was claimed that a woman died from want of attention at the birth of her child. Despite having engaged a doctor for delivery the woman was attended by the practice dispenser; an unqualified man. He failed to ensure removal of the placenta and the patient eventually died of blood poisoning. The doctor she had engaged did not attend until four days after confinement, by which time she was gravely ill. The five doctors called to give evidence at the resulting inquest refused to condemn the doctor, and the doctor at the Ecclesall Union Hospital who treated the patient, admitted only with extreme reluctance that there was possible evidence of neglect. The doctor was acquitted of neglect, as no other doctor would speak against him⁵⁹.

After 1920, the role of the midwife appears to have become far less contentious as an issue of blame for MMR, perhaps because of the acknowledgement by obstetricians in particular of her basic competence. The difficulty of fees was met partly by the requirement by Poor Law Boards of Guardians to cover fees in the first instance. The midwife was also a potential

⁵⁷ *ST*, 25/2/09. Also *ST*, 3/3/09, p.6.

⁵⁸ *ST*, 10/3/09.

⁵⁹ *ST*, 7/9/09, p.3.

ally in the battle over blame for MMR which, as far as birth attendants were concerned came to focus increasingly on the role of the GP. The effect of these tensions and disputes will be considered in greater detail in the next section.

The potential dangers of 'meddlesome midwifery' were highlighted in 1931 by Dr Stacey, Honorary Assistant Surgeon at the Jessop Hospital who studied 154 cases of 'failed forceps' between 1924–28. These were women who came into the Hospital after their GPs had tried and failed to complete their deliveries using forceps. Their cases demonstrated either extreme ignorance or mismanagement by medical attendants. In 100 cases (66%) the cervix was not fully dilated before forceps were applied, and in 47 (33%) of cases the only reason for the failure of spontaneous delivery was that the woman was not yet in second stage and was therefore not ready to deliver⁶⁰. In 33 cases (20%) delivery did eventually occur spontaneously. However, 38 cases (25%) resulted in termination by craniotomy (the deliberate breaking up of the infant's skull), and there were 9 cases of Caesarean section, with 4 maternal and 2 infant deaths. Of the total 154 cases, 21 mothers and 88 infants died. Stacey blamed GPs and poor Council antenatal clinics for not identifying potential problems, although it seems that many mothers did not have problems until intervention started⁶¹. He did not make the point that families were to blame for demanding early intervention, although many GPs did suggest this.

The figures for Sheffield do not allow for a comparison to be made between the mortality rates in the practises of GP's, midwives and hospitals. This makes it impossible to draw any definite conclusions about the relative safety of different types of care in the City.

5.2f: The Response to Maternal Mortality:

The first Government report which specifically drew attention to the continued presence of high rates of MMR was the 1915 supplement to the Report of the Local Government Board (LGB)⁶². In it Newsholme, the Chief Medical Officer, made calls for more antenatal care and improved birth attendance, which were to echo down to 1939. The bulk of the early work,

⁶⁰ The neck of the womb (the 'cervix') has to be fully open ('dilated') and the woman ready to push ('in 2nd stage') before forceps can be effectively and safely applied.

⁶¹ J Eric Stacey, 'Remarks on "Failed Forceps" ', *BMJ*, ii, 1931, 1073–78. Crawford made the same points for Liverpool a year later; MD Crawford, 'The Obstetric Forceps and its Use', *The Lancet*, i, 1932, 1239–1243.

⁶² 'Maternal Mortality in Connection with Childbearing and its Relation to Infant Mortality', *LGB 44th Annual Report, 1914–15, Supplement*, Cd 8055.

aimed at description and prescription, was undertaken by Dr Janet Campbell, the Medical Officer at the Ministry of Health in charge of maternal and child welfare. She argued that the problem was not mono-causal and was therefore not amenable to a simple solution, but required improved administrative, educational, clinical, pathological, and social conditions⁶³.

The first major Government reports on MMR were the Interim (1930) and the Final (1932) Report of the Departmental Committee on Maternal Mortality and Morbidity. They suggested that at least half of maternal deaths were preventable, and emphasised the need for more antenatal care, and more hospital beds. This view was in contrast to the earlier defensive line of doctors who argued that there was no evidence of the preventable wastage of maternal lives, and that there was not much room for improvement⁶⁴.

Five years later another Government Report on MMR cautioned against overstating the preventable nature of the problem, and tried to play down the figures quoted in earlier reports, which it was feared had increased public anxiety about why deaths were not being prevented⁶⁵. The Report did attempt to look at social factors in the areas with rates of MMR over 5‰ births, which were concentrated in the north and Wales, although it was criticised for over-emphasising clinical factors at the expense of social ones⁶⁶. Generally the Report suggested no relation between MMR and female employment, or even MMR and general unemployment, and sometimes appeared to be over-optimistic:

Even the widespread working of short-time during the last few years has brought some compensation for the loss of wages in the lessened strain upon the married woman worker.⁶⁷

However, none of the national reports led to significant changes in policy, with the initiative continuing to be taken at local level. The report on the Rochdale experiment traced the success of the policy to 'the mutual co-operation between the public health authority and all those engaged in the

⁶³ J Campbell, *Maternal Mortality*, London, 1924; Campbell, *The Protection of Motherhood*, London, 1927.

⁶⁴ L McIlroy, 'Maternal Mortality and Morbidity', *BMJ*, i, 1926, p.471.

⁶⁵ *Report on an Investigation into Maternal Mortality*, Cd 5422, 1937, p.17.

⁶⁶ i.e., Sir Henry Brackenbury (Chairman of the Council of the British Medical Association [BMA]) also suggested that clinical issues had been over-emphasised at the expense of environmental and sociological factors; H Brackenbury, 'Maternity in its Sociological Aspects', *Social Service Review*, 18, 1937, 37-47.

⁶⁷ *Report on an Investigation into Maternal Mortality*, Cd 5422, 1937, p.115.

maternity services; the doctors, the midwives, the hospital etc.'⁶⁸ This summed up the local ideal.

The debate over maternal mortality at the local level was more vitriolic than that over infant welfare had been, not least because the best efforts of the Council, voluntary bodies, and medical workers seemed to have very little effect on mortality rates. National tensions over the influence of malnutrition and antenatal care had their echo at local level, but it was the Labour Council which was condemned for not taking poverty and nutrition seriously, in contrast to the national view that these were left wing demands. The conference of the National Council for Women (NCW), an officially apolitical organisation, called for 'very careful consideration to be given to the results of recent research on diet and the advisability of providing meals.'⁶⁹ Generally, however, all sides of the debate accepted the basic belief that it was only through improved antenatal care and birth attendance that lower rates could be secured. It is perhaps surprising how little the issue of poverty was taken up in Sheffield given that social conditions had been an accepted feature of the debate on IMR, and were to be prominent again in debates over birth control provision.

Both the Sheffield branch of the NCW and the women's section of the Sheffield Unionist and Conservative Association repeated the complaints about MMR and linked these to inadequate welfare services⁷⁰. The National Conference of Labour Women, held in Sheffield, called for all Local Authorities to carry out their powers under the various Acts relating to maternal and child welfare to their full extent, and urged that clinics should be staffed by women doctors. A Labour Councillor, Mrs Cumming, repeated the contention that the majority of deaths were caused by illegitimate abortion, about which the Council could do nothing⁷¹. One delegate suggested that mothers were effectively being 'murdered' due to inadequately trained carers⁷². Elinor Pike, wife of the Conservative National Party MP for Attercliffe, castigated the Labour Council for its failure with respect to the above policies, and repeated the call for more welfare centres, particularly in the East End where the greatest rates were found⁷³. In autumn 1935, a meeting of the newly formed 'Maternal Mortality Save the Mothers Action Committee' was held in the City Hall. Attendance figures are not recorded, but the group repeated demands

⁶⁸ Oxley *et al*, 'Maternal Mortality in Rochdale', *BMJ*, i, 1935, p. 307.

⁶⁹ *ST*, 23/5/35, p.5.

⁷⁰ *ST*, 23/5/35, p.5.

⁷¹ *ST*, 17/5/35, p.4.

⁷² *SI*, 17/5/35, p.5.

⁷³ *ST*, 21/5/35, p.6; *ST*, 23/5/35, p.6.

for more clinics, together with free milk for nursing and expectant mothers and an allowance of 6/- a week for extra food, suggesting some awareness of possible nutritional issues.⁷⁴ Yet during the local election campaign of October 1935, and the General election campaign of the following month, there was very little local discussion of the issues surrounding MMR. The issue did not come to a head politically in Sheffield until the following year, when a Conservative Councillor, Mrs Longden, called for the establishment and funding of four branch clinics, principally in the East End where one third of all births occurred. The motion was defeated 31 to 50 after a heated party debate about which group could claim credit for the work already done⁷⁵. The following day there was an exasperated letter printed in the *Telegraph* suggesting that reducing the issue to a Party fight was not securing welfare. Other letters in response to this debate suggest that women did want more easily accessible clinics⁷⁶.

The NCW in Sheffield and the 'Sheffield Maternal Mortality Committee' both condemned the failure of the Council to develop services and thereby reduce MMR. They were obviously following the accepted agenda in seeing a link between services and MMR. Elinor Pike called for the Council '...to take immediate steps to reduce this appalling death rate by at once extending the facilities for Maternal and Child Welfare.'⁷⁷ In response to the public meeting called to discuss the issue by these organisations, Councillor Asbury wrote a defensive article for the *Sheffield Co-operator* accusing the NCW of being anti-Labour, and describing their attempts to set up an antenatal feeding station as 'an abject failure'⁷⁸. He commented that 'the acid test of efficient maternal and child welfare work is the infant mortality rate...' which was an unusual comment to make at this stage, when infant mortality was generally considered to be a solved issue⁷⁹.

Attempts to tackle the problem of MMR in Sheffield were directed primarily at antenatal work. Antenatal clinics had been started before the First World War both by the Jessop and by the Council, partly in an attempt to anticipate problems in pregnancy but primarily focused on IMR, for example,

⁷⁴ *ST*, 20/9/35, p.5.; However the group ran into trouble because although avowedly apolitical, it was accused of becoming a communist organisation; Labour and Conservative women withdrew their support, *SI*, 22/6/35, p.7.

⁷⁵ *ST*, 6/2/36, p.5.

⁷⁶ *ST*, 7/2/36, p.6.

⁷⁷ *SI*, 18/5/35.

⁷⁸ In terms of numbers he was probably right; the scheme ran for 9 months, and saw 20 mothers in that time, *SI*, 29/8/35, p.7. There are no extant records for the Sheffield branch of the NCW so it is impossible to examine their motivation or criteria for success.

⁷⁹ *Sheffield Co-operator*, October, 1936.

on attempts to prevent still births. In 1915 the Council also took 2 beds at the Jessop for the treatment of puerperal fever, at £110 each p/a. They also paid 50/- per bed occupied weekly to cover other illness or other abnormality in pregnancy or anticipated difficult confinements. The antenatal clinics appear to have been successful in attracting women, and by 1933, the Health Department claimed that at least 50% of expectant mothers were seen at one of the clinics⁸⁰. Letters printed in *Maternity* repeated calls for free advice to be available:

Now if there had been such a thing as a Maternity Centre where I could have sent for someone, or could have attended without that feeling of expense, I could have been relieved of all that suffering.⁸¹

Interestingly, over half the new cases seen throughout this period came on the recommendation not of health professionals, but through friends. For example, in 1923 of 256 new cases, 104 came advised by friends; and in 1927, of 1281 new cases, 770 were advised by friends. Despite the ideas, particularly of some feminist writers, of a community of working class women passing on advice and information on pregnancy and birth, many women appear to have been very ignorant about all aspects of the experience⁸². The fact that many took the advice of friends does suggest some common cause, however. Women appear to have been convinced of the desirability of more supervision and 'scientific' knowledge. This does point at reasons for the popularity of antenatal clinics, although as most women only attended once and clinics in Sheffield at least were overcrowded and inconvenient, it is uncertain what quality of assistance they would have received and how far it would have matched their needs⁸³. Statistics suggested that they were also ineffective in tackling causes of maternal mortality. Geddes commented that,

⁸⁰ It was claimed that 74% of mothers were seen in Liverpool; RE Bell, 'Maternal Mortality in Liverpool', *Public Health*, 47, 1934, 330-334, p.334.

⁸¹ Davies, *Maternity*, p.34; see also p.58, p.62, p.70.

⁸² Evidence from Leap and Hunter demonstrates why women might have welcomed clinics, as there was profound ignorance about pregnancy and birth, including from where the baby would be born: Leap and Hunter, *The Midwife's Tale*, p.78-81. For the belief in the community of birth see: J Mitchell and A Oakley, *The Rights and Wrongs of Women*, Harmondsworth, 1976, p.18; B Ehrenreich, and D English, *For Her Own Good: 150 Years of the Experts Advice to Women*, London, 1979; A Oakley, *Women Confined: Towards a Sociology of Childbirth*, Oxford, 1980, p.11.

⁸³ Tew has argued that ante-natal clinics were, and largely still are, ineffective because they either over- or under-diagnose and in having few available remedies for problems detected. Given this, she describes the popularity of ante-natal clinics as 'ironic', but in so doing perhaps under-estimates their importance in providing reassurance to women, and also their social role; M Tew, *Safer Childbirth? A Critical History of Maternity Care*, 2nd edition, London, 1995.

'Antenatal supervision as advocated by Sir George Newman will not affect 75% of the victims of puerperal sepsis.'⁸⁴ Loudon has commented on development of antenatal care in this period, but it is unlikely that the reality matched the ideal:

Antenatal care also provided the opportunity for improving the general health of mothers during pregnancy, and the means of selecting high risk mothers (first pregnancies, bad obstetric histories, small stature, contracted pelvis, multiple pregnancy and so on) for hospital care...

In 1929 the scheme of four weekly antenatal visits up to 28 weeks of pregnancy, then fortnightly to 36 weeks and weekly to term (c.40 weeks) was laid down. Original proponents of antenatal care had not seen the need for this level of routine medical supervision of pregnancy, being more interested in identifying pathological cases⁸⁵. The more detailed scheme suggests that antenatal care was perhaps being expanded as much for social reasons concerning advice and supervision as medical ones.

In Sheffield during the 1920s and 1930s efforts were made through the clinics to tackling such problems as stillbirths, vomiting in pregnancy, and treatment to encourage breast feeding. However there were repeated complaints by the Medical Officer of the maternity clinic that women refused treatment or did not carry it through; in one case although offered free. Dr Janet Campbell argued that despite there being nearly 2000 local authority antenatal clinics in 1935 in operation nationally, the care available was poor with overcrowded sessions and inexperienced doctors being major causes of difficulty. The practical problems were in spite of the views of many doctors '...that need for antenatal examination and interview of every pregnant woman was agreed upon by everybody with any knowledge of modern obstetrics', and the complaint of the retired MOH for Sheffield that outside London '...practically no useful antenatal work was occurring'.⁸⁶ Provision does not seem to have matched women's demands either in terms of location or quality; arguments over maternity services will be considered below.

5.2g: Conclusion:

The statistical evidence suggests that in Sheffield maternal mortality did begin to fall decisively after 1937 as a result of the introduction of sulphonamides. However, in some ways this is a side issue since it does not

⁸⁴ Italics in original. Geddes, *Puerperal Septicaemia*, p.167.

⁸⁵ JW Ballantyne, *Expectant Motherhood: Its Supervision and Hygiene*, London, 1914.

⁸⁶ *Lancet*, ii, 1924, p.777-9.

represent the culmination of years of sustained effort by the relevant bodies, including the medical profession, government and women. Whatever the disagreements about degrees of provision, all sides in the disputes over MMR appear to have been using the same language and advocating the same solutions. Even in a Labour led city such as Sheffield with sustained levels of high unemployment, any discussion of social or economic factors was very muted in comparison to the debate raging over antenatal care and birth attendance. The arguments over MMR were inevitably over shadowed by the perceived success of infant welfare programmes in reducing IMR, and it was believed that MMR should be amenable to the same effort of education and supervision.

Sheffield appears to have been atypical in that its high MMR was characterised by very high levels of sepsis rather than the high levels of 'accidents' prevalent elsewhere. The importance of abortion on MMR for Sheffield was undoubtedly critical and will be considered in the next chapter. The debates around MMR in the inter-war years were also prefigured by and included in later debates about the construct of birth in general, quite apart from its morbid aspects. The response of women to MMR will be considered in this context.

5.3: Maternity Services in Sheffield:

5.3a: Introduction:

Significant developments in the care of pregnant and parturient women occurred during the period, partly as a result of worries about IMR and MMR, but partly due to other concerns and pressures. The issues which contemporaries were attempting to tackle went beyond the problem of MMR, and concerned fundamental relationships between different professional groups and the voices of women as patients. This section will look in detail at the development of midwifery training and the growth of the concept of the midwife as a 'professional', albeit subsidiary to the medical profession. Evidence for Sheffield suggests that despite a high standard of midwifery training for at least a section of the midwives in the City, and the influence of various Acts of Parliament, including the 1902 and 1936 Midwives Acts, the social profile of midwives did not alter dramatically over the period. They appear to have remained primarily married or widowed part time practitioners, without much sense of common professional purpose.

The issue of the hospitalisation of childbirth will also be considered, in reference to the institutions concerned and to the people who used them either as staff or patients.

The evidence for this section is, again, not as full as could be wished, particularly as regards the patients. The lack of Poor Law and Jessop Hospital records present particular problems, as both were central to the development of maternity services in Sheffield. The Minutes and Annual Reports of the Jessop, throw some light on its development, and, as in other chapters, MOH Reports and local newspapers provide useful detail. Trade Directories and Census records together with data from the Midwives Roll also allow the study of the lives of at least the most visible midwives.

5.3b: Midwives in Sheffield:

A discussion of midwifery in Sheffield between 1879 and 1939 is best split into two parts; the first concerning midwives trained and working through the Sheffield Hospital for Women (later the Jessop) and the second concerning the independent practitioners in the City. Midwives came from different backgrounds, and brought different levels of expertise and commitment to their work. Before systematic training was introduced in England and Wales following the 1902 Midwives Act, midwives varied greatly in their acquisition of formal and informal training. Those who worked at the Jessop were usually married or widowed like their independent counterparts, but their willingness to spend up to two years undergoing training, must have set them apart from their uncertified competitors, or from the casually employed 'handywomen'. It seems likely that in Sheffield, as elsewhere, midwives were a group deeply divided by class and expectation. Regulation in England did not destroy midwifery as it was almost to do in North America, but it did remove the independence of the service. Midwifery became subsidiary to medicine, probably because its practitioners generally lacked the homogeneity and sense of common purpose necessary to defend themselves effectively⁸⁷. The development of training programmes at the Jessop even before the 1902 Midwives Act, illustrates the growing dependence of midwives on the medical profession, although not always successfully enforced.

⁸⁷ C G Borst, 'The Training and Practise of Midwives: A Wisconsin Study', *Bulletin History Medicine*, 62, 1988, 606–627; ER Declerq, 'The Nature and Style of Practice of Immigrant Midwives in Early Twentieth Century Massachusetts' *Journal Social History*, 19, 1985–86, 113–129. However, Leslie Reagan has found that midwives did band together, as in Chicago in 1910, but only in a defensive alliance against acusations that they wre working as abortionists; LJ Reagan, 'Linking Midwives and Abortion in the Progressive Era', *Bulletin History Medicine*, 69, 1995, 569–598.

Borst has found that in Wisconsin between 1870 and 1920, there was a definite shift in prevalence from 'neighbour-woman' to 'school-trained practitioners'⁸⁸. Using licences and census data, she discovered that 80.2% of midwives were married, and that the same proportion had school age children at home⁸⁹. These family commitments probably made midwifery a good job in that it was flexible, but also limited the extent of any possible practice. She also found that the husbands of midwives were likely to earn a comfortable working income; these women were 'respectable'⁹⁰. Midwives were performing a traditional domestic based service, and even those with training did not take on a professional model but continued to work locally and within their own ethnic group⁹¹. The same distinctions of practice can be seen in Sheffield, where the Jessop midwives are least numerous yet most visible in the evidence. Their names and addresses appeared on each Annual Report, and there is lot of supporting information to be found in Committee Minutes of the Hospital⁹². Independent midwives are harder to identify although many did appear in Trade Directories, which gave addresses. This allows them to be traced through the Census, but these would have been the more 'professional' practitioners. Handywomen and poor midwives; 'women who did'; are the most difficult type to trace, being least likely to call themselves 'midwife' in Directories and Census returns. The self-designation of 'midwife' implied that a woman regarded herself, to some degree, as an 'expert' with skills and knowledge, and therefore those found in the records who described themselves as 'midwives' were a distinct group, and not completely representative of all those practising.

There were less than ten Jessop midwives in districts at any one time throughout the period, so they obviously represented a tiny minority of midwives practising in Sheffield, but given the potential significance of what the Jessop was attempting to achieve, and its relevance to national debates, they are worth looking at in detail, as they illustrate efforts to develop training,

⁸⁸ Borst, 'The Training and Practise of Midwives, p.609.

⁸⁹ Borst, 'The Training and Practise of Midwives, p.620.

⁹⁰ For discussion on respectability see; C Reid, 'Middle Class Values and Working Class Culture in Nineteenth Century Sheffield – the Pursuit of Respectability' in S Pollard and C Holmes, eds., *Essays in the Economic and Social History of South Yorkshire*, Sheffield, 1976.

⁹¹ CG Borst, *Catching Babies: The Professionalisation of Childbirth, 1870–1920*, London, 1995, p.76–77.

⁹² The main sources for the Jessop Hospital are the Weekly Board Minutes (hereafter referred to as *Jessop Minutes*), and the House Committee Minutes (hereafter referred to as *Jessop House Minutes*)

and problems of trying to create and maintain midwifery as a subordinate discipline to medicine.

5.3c: Midwifery at the Jessop Hospital:

The founder of the Sheffield Hospital for Women, Dr Aveling, had strong ideas on the midwifery question⁹³. He was firmly of the belief that there was a place for a suitably trained, and subordinate midwife, in either a Hospital or a community setting. Indeed, one of his chief stated reasons for championing the establishment of a hospital for women was to relieve the suffering caused by 'ignorant' midwives:

In Sheffield we have a few able midwives, who understand their business well, and prove themselves sources of comfort to many poor sufferers; but we also have a larger class, pretentious and ignorant, causing grief and misery... The ignorance met with among midwives in this town is notorious to every medical man...⁹⁴

Obviously such statements should be read in the context of the national debate over the place of midwifery in the practice of the emerging 'general practitioner' and the position of unregulated female midwives in a developing 'professional' structure of medical care⁹⁵.

From its inception in 1864, the Sheffield Hospital for Women operated a system of accredited midwives who would deal with the vast majority of maternity cases as out-patients. Although it had only 6 in-patient beds at the outset, the hospital did not just encompass the physical institution; the buildings and beds, although these were gaining in importance by the end of the century as surgery developed. Childbirth at home was normal and the primary role of the hospital was to influence and direct this procedure; in effect the 'hospital' was wherever the midwives were working.

⁹³ For example, see; JH Aveling, 'On the Instruction, Examination, and Regulation of Midwives', *BMJ*, i, 1873, p.308-310; *Nursing Notes* January 1892; JH Aveling, *English Midwives Their History and Prospects*, ed. and intro. JL Thornton, London, 1967 (originally published 1872).

⁹⁴ *SI*, 12/12/1863. He was being a little disingenuous as the General Hospital, later the Royal Hospital (see *Appendix 2*), had been operating a midwifery service for poor women since 1833.

⁹⁵ *The Lancet* journal, which was very much the voice of the general practitioner, began to support the cause of midwifery training from the early 1860's. It saw that midwives could perform a role subordinate to doctors, which was preferred to the threat of an equal status midwifery profession, or the advent of female doctors: J Donnison, *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth*, London, 2nd Edition 1988. On General Practice see: I Loudon, *Medical Care and the General Practitioner, 1750-1850*, Oxford, 1986; I Loudon, 'Obstetrics and the General Practitioner', *BMJ*, ii 1990, p.703-707.

Unlike the 'Female Medical Society' founded in London in 1862 to promote midwifery as a suitable occupation for 'gentlewomen', Aveling supported midwives as an adjunct to general practitioner services, and believed midwives were of use primarily to working class women⁹⁶. He believed that both Florence Nightingale and the Female Medical Society were wrong in trying to train midwives to be professionals, and argued that midwives so trained would compete with general practitioners for the confinements of middle class women, and do nothing to alleviate shortages of midwives in working class and rural areas⁹⁷. It was to attract poorer women that in June 1879 the Jessop became the first hospital in the country to *pay* its midwifery trainees; '...the Staff are empowered to pay the Midwifery trainers a salary not exceeding £10 p/a to be paid quarterly.'⁹⁸ In return for this money, the Hospital expected twelve months work, followed by the take up of district work if it was available. There were pragmatic reasons for this move as trainees provided a relatively cheap form of labour, with their annual salary being equivalent to the case loads of district midwives, although at least they got their board and lodgings. It is perhaps misleading to see the decision to pay trainees as particularly altruistic, as they were expected to take on heavy, full time work in return for training.

In 1882, the Medical Staff called for the formalising of midwifery training at the Hospital through the issue of certificates on completion of the course:

We are beginning to see good results from the effort [of training] and think that it is now time that the responsible and important office which the Midwives fill should be more formally recognised by the Board.

First – Conferring on the Midwife of a formal document or Licence declaring her to be a competent and duly appointed official; in this way giving her a superior standing to other uninstructed women who have taken up the same calling at haphazard [*sic*].

Secondly – the impressing on the Midwife that her connection with the Hospital is one subject to periodic revision; and that it is an honour and distinction dependent upon her continued efficiency and good conduct;

⁹⁶ Donnison, *Midwives and Medical Men*, p.81. On leaving Sheffield in 1866, Aveling moved to London, and as well as co-founding the Chelsea Hospital for Women, became an influential advocate of midwifery training and registration. He was also editor of the *Obstetrical Journal*: see Obituaries; *BMJ*, ii, 1892, 1349–50; *The Lancet*, ii, 1892, 1477.

⁹⁷ Donnison, *Midwives and Medical Men*, p.88.

⁹⁸ *Jessop Minutes* 9/6/1879.

in this way stimulating her to a faithful discharge of her duties and the maintenance of a good reputation in her district.⁹⁹

The Medical Staff and Board were confident of the importance of trained midwives to the women of Sheffield, but wanted primarily to secure compliant midwives, conversant in the ways of the Hospital. The Jessop was always determined that its midwives should remain under close control. Thus, in 1881, Mrs Ann Brown of 23 Shepherd Street who had been displaying a card in her window reading 'Midwife to the Women's Hospital', despite not being employed by the Jessop, was instructed to at once withdraw the card, or risk proceedings against her¹⁰⁰. In 1875 a midwife of the same name had been struck off at the recommendation of the Ladies Committee, so it is possible that the same woman was trying to cash in on an earlier connection. This incident demonstrates that the Jessop must have been acquiring a reputation for employing competent midwives, if others wanted to be associated with its name. However the price for this reputation was considerable supervision wielded by the Hospital over the practises of its certified midwives. Women who had trained at the Hospital must have felt that it would give them an edge over their competitors, since midwives not having a district to take once their training was over, were given a certificate in the following form:

We hereby certify that

Martha Holmes

has received a systematic and practical training as a Midwife in the Maternity Department of the above Hospital. She has been resident there for a period of twelve months viz.:- from October 1886 to October 1887, and during this time has personally attended, under the supervision of the Medical Staff, thirty cases of labour. She is a competent and trustworthy woman, able to conduct skilfully any case of natural labour, and to take general charge of the lying-in room...¹⁰¹

To have attended thirty cases of labour suggested a fairly thorough grounding in practical obstetrics, although apparently leaving the women only capable of attending 'natural labours'. Unfortunately no training schedules appear to have survived so it is hard to say what theoretical ground was being covered

⁹⁹ *Jessop Minutes* 9/1/1882.

¹⁰⁰ *Jessop House Minutes* 27/12/1881.

¹⁰¹ *Jessop Minutes* 6/2/1888.

in lectures by the Medical Staff. It is likely that most of the instruction was concerned with when to call for medical help, and what not to attempt. However, despite this emphasis on 'natural labour', midwives at this period were probably covering a far wider range of cases than a modern midwife would be happy to deal with in a home birth. Both breech deliveries and twins could be dealt with as 'normal' births, as were older mothers, and those with a high number of previous pregnancies; all of which would be considered 'risk' factors requiring hospitalisation today¹⁰². In addition, many diagnostic procedures which became routine in the twentieth century were not used earlier, even though most were known about; at this time there was no real attempt at antenatal diagnosis of potential problems¹⁰³. Therefore, although midwives were trained to attend 'normal' deliveries, the boundary between what might be perceived as 'normal' or 'abnormal' was not a constant.

Despite their training and their certificates Jessop midwives could still have problems in covering enough cases to make ends meet. An analysis of the quarterly accounts which appear in the Weekly Board Minutes, demonstrates that between 50 and 200 cases were covered by 7 or 8 midwives in each quarter. Although the caseloads for some midwives, or some districts, might have been heavier than others, the average number of cases dealt with by each midwife per week was 1.4. This made it likely that the midwives were either working part-time, or were supplementing their income through private work. However this was obviously not enough for all midwives; in 1891, Mrs Winter, resigned, saying that:

...I find I can not obtain sufficient to even pay my lodgings. I have therefore applied to a Home as a Nurse and been accepted.

I am out since January and earning 5/- a week.¹⁰⁴

At 5/- a case, this implies that she was attending one case a week, which was about the standard level, although work in a nursing home would have meant more regular and certain remuneration. According to the Census taken in that

¹⁰² N Leap and B Hunter, *The Midwife's Tale: An Oral History from Handywoman to Professional Midwife*, London, 1993, p.148-56; S Inch, *Birthrights: A Parents Guide to Modern Childbirth*, London, 1982. Allison found that in Nottingham between 1948 and 1972 52% of women who had home births (6162 of the 11850 studied) did not fulfill the criteria for suitability for a home birth because of their age, poor health, parity or because of multiple births; J Allison, *Delivered at Home*, London, 1996, p.45-6.

¹⁰³ Foetal heart monitoring and abdominal palpitation to assess presentation, were both techniques known of but not widely practised; A Oakley, *The Captured Womb : a History of the Medical Care of Pregnant Women*, London, 1984, p.26.

¹⁰⁴ *Jessop Minutes* 12/5/1891.

year Emma Winter was a 40 year old widow living in a lodging house, and would therefore have needed a regular income in order to support herself. Winter asked for a certificate in recognition of the time she had been at the Jessop, which was granted on condition that:

...it should not be written upon official paper. The Medical Staff at the same time beg to point out to the Board that the granting of this Certificate is a dangerous precedent, as the Nurse in question, Emma Winter, has broken her contract with the Hospital. It opens up the whole question as to training of Midwives for other than the purposes of the Hospital, and any conditions under which that can be done must be entirely different to those under which women have hitherto been trained for our own purposes.¹⁰⁵

The concern of the Medical Staff pointed up the contradiction in their training system. If they were producing midwives of good calibre, whose services were marketable, there was then the question of how to retain the use of these midwives for the primary benefit of the Hospital. They faced tension between providing training for the sake of the Hospital, and for the benefit of individual women, who, once trained, might choose to take their skills elsewhere¹⁰⁶.

Even being attached to the Jessop did not bring automatic benefits in the way of pensions or job security; midwives were subject to control by the Jessop, whilst remaining theoretically independent and not therefore in need of financial support. In January 1901, midwife Christina Eckhardt, who had been attached to the Hospital since it first opened, retired at the age of 73. The Board were loath to award her anything in the way of a pension, but finally agreed to a suggestion by the Medical Staff to give her a certificate saying that she had been an efficient and satisfactory midwife, and awarded her an allowance in kind of 5/- per week. However, the allowance granted to Eckhardt represented almost the same as she had previously been earning weekly by taking Hospital cases. Her family support structure had allowed her to continue working in this way, unlike her counterpart Emma Winter. By 1891

¹⁰⁵ *Jessop Minutes* 14/7/1891.

¹⁰⁶ One trainee wanted to go to a job at the Barnsley Union, which the Board felt would be in breach of her contract. They would not allow her to leave as '...she would be expected to take to charge of one of the Midwifery Districts attached to the Hospital...' when her period of training expired. (*Jessop Minutes* 28/4/1883). A similar problem arose in 1893, when a trainee left with one day's notice, claiming that she had learned enough midwifery to practice in Africa where her husband was a soldier. (*Jessop Minutes* 7/11/1893).

Eckhardt was a widow, but lived with her youngest daughter and her family; she did not therefore have to support herself entirely.

The new century brought a lack of suitable probationers, leading to staff complaints of overwork¹⁰⁷. It also saw differences between the Board (concerned with the Jessop's annual deficit of c.£1500) and the Medical Staff over the philosophy behind the Hospital, and in particular its role as a centre of training, with the Board arguing that:

...it is very desirable that the prevalent impression that the Maternity Dept of the Institution is a Lying-In Hospital should be dispelled. The cases admitted into this Dept should [the Chairman] think be those in which complications are probable or when exceptional circumstances are such as to make it desirable for the patient to be treated in the Hospital. He is of the opinion that all ordinary cases of confinement should be dealt with by the Midwives as out-patients.

In reply the Medical Staff insisted that:

The Jessop Hospital has always been a Lying-In charity and cases of Labour have been taken in when it was fully expected that they would be perfectly natural, as well as when difficulty was foreseen. The necessity for this is obvious, when we remember that cases of natural Labour are absolutely necessary in order to train our Midwives and students for the ordinary emergencies of practice. They must insist on the necessity of continuing this admission of natural cases otherwise all training will have to be abandoned. Difficult cases will, of course, be admitted as heretofore.¹⁰⁸

The Medical Staff felt that the success of its training school, now accredited by the new Central Midwifery Board, depended on a ready supply of 'normal' deliveries. In fact they suggested removing the licensed midwives altogether, and having all out-patient maternity work covered by trainees; a change put into practice by 1905. The Hospital no longer trained midwives who would hopefully work at, or in association with it, and it was accepted that the Jessop was now only a training centre for most of its pupils, and that they would find their work elsewhere. This shift in emphasis led to the scrapping of the

¹⁰⁷ *Jessop Minutes* 17/8/1902.

¹⁰⁸ *Jessop Minutes* 10/5/1904.

system whereby three probationers worked and were trained at the Hospital, receiving Board and salary in the process, for at least a year. From April 1905, there were four probationers, each *paying* £15/15/0 for three *months* training, and supplying their own uniforms. They were to undertake all casework, under the supervision of resident midwives.

However, this change did not make an immediate difference to the type of women training to be midwives at the Jessop because, as early as 1902, of the six midwives operating districts, three were unmarried. This suggests that prior to the implementation in 1905 of the 1902 Midwives Act, midwifery was becoming a more acceptable profession for single women. Even married or widowed women undergoing the training were likely to have been 'respectable' working class; able to read and write, and ambitious enough to want the recognition as a potentially *professional* midwife that training brought¹⁰⁹. Yet after 1905, applicants had to be prepared, and to be able, to *pay* for their instruction. This probably enforced the concept of 'gentlewomen' midwives as working class women would not have been to afford the fees or the uniform. However, another route into training was developing for poorer women, as local councils began to take some responsibility for the provision of midwives in their area. In 1908, Derbyshire County Council, which had rejected as too complicated the concept of establishing a midwifery training school in Chesterfield, was granted permission to send thirteen pupils a year to the Jessop, at a total cost of £200. These midwives were presumably intended for the rural districts of Derbyshire, although it is not known how they could be dissuaded from working in more profitable areas once trained¹¹⁰. In commenting on its supply of midwives in 1910, the Council said that there was 'a serious shortage' in rural districts, although in Derby itself a shortage was not anticipated¹¹¹.

Despite these changes, one problem facing the Jessop was often a shortage of suitable trainees, and therefore of junior staff. The split between 'nurses' and 'midwives' soon became evident; women wanted to train as

¹⁰⁹ C Reid, 'Middle Class Values and Working Class Culture in Nineteenth Century Sheffield - the Pursuit of Respectability' in S Pollard and C Holmes, eds., *Essays in the Economic and Social History of South Yorkshire*, Sheffield, 1976, 275-295.

¹¹⁰ *Jessop Minutes* 10/3/1908.

¹¹¹ *Report of the Departmental Cttee...to consider the Working of the Midwives Act 1902* (volumes 1 and 2, 1909 Appendix IV. p.31). In 1919 West Riding Education Cttee asked for a refund of the £28 fee paid for a pupil who had abandoned her training through ill health, indicating that they too were involved in organising training through the Jessop. (*Jessop House Minutes* 4/6/1919) The Jessop also gave free attendance at lectures to Queen Victoria Jubilee Nurses (12/11/1907), and to non resident pupils at £5/5 per pupil (11/7/1905)

general nurses, not as midwives or specialist women's nurses. Various methods were attempted to alleviate the shortage of midwives in particular. It was eventually decided to pay a salary of £1 per month to probationers if they would undergo free midwifery training and work for 6 months afterwards¹¹². Although wanting the CMB certificate, most nurses had no intention of practising as midwives, which despite the 1902 Act supposedly regulating and 'professionalising' the service, had led to a diminution of their status and reputation, by placing such tight limits on practice and behaviour. By 1915 the Board had accepted differentials in training time for midwifery between nurses and unqualified women¹¹³. In addition, the Jessop itself preferred even its maternity side staff to have a general nursing qualification as well as a midwifery one, although they found it hard to compete with the salaries or prestige of jobs in larger hospitals.¹¹⁴ Most staff members, including junior medical staff, seem to have regarded the Jessop as a short term post and throughout the period 1900 to 1920 the Jessop maintained a high rate of staff turnover.

Despite general agreement, enshrined in the 1902 Act, that midwifery should be a subordinate discipline, the range of topics to be covered in training grew as ideas on ante- and post-natal work developed; expanding the role of the midwife to cover areas beyond the birth itself, and extending her potential influence:

The Honorary Medical Staff considers that it may be necessary to increase the period of training from six to eight months, and from four to six months respectively, and the fees accordingly owing to the great importance of Ante natal and Infant Welfare Clinics which will have to be included in the curriculum, but the Honorary Medical Staff do not consider this feasible for the time being as at present the supply of practising midwives is inadequate.¹¹⁵

Until 1905, when it became bound by the conventions of the 1902 Midwives Act, the Jessop Hospital was unique in allowing its trainees to be

¹¹² *Jessop Minutes* 8/12/1916.

¹¹³ Nurses to train for 3 months, non-nurses for 4 months. (*Jessop Minutes* 12/1/1915) This was raised to 4 and 6 months respectively in 1916, and the fees were £20 and £28 respectively. (*Jessop Minutes* 14/12/1915)

¹¹⁴ At this time there was also consideration of suggestion to team up with a general nursing training school, to send trained gynaecological nurses for shortened general training (i.e. perhaps 2 years instead of full 4) and also to accept their general nurses for midwifery training at modified fee in the hope of making the Jessop training more attractive.

¹¹⁵ *Jessop Minutes* 13/4/1920.

paid for their training period by working on the wards, although this was common practice for nurse training¹¹⁶. In comparison to other regional hospitals where fees of up to £20 were common, and London where a trainee might pay £30 to £50, women training at the Jessop were more likely to be of a poorer class. These were the women whom Aveling and others argued would most benefit from a slight rise in status, and whose patients would benefit from their increased knowledge. However, their impact on midwifery in Sheffield was circumscribed by their limited numbers, and their methods of work controlled to a considerable extent by the Medical Staff at the Hospital. As a group they disappeared in 1905, with probationers taking on casework. However, problems with probationers not acquiring the specified number of cases in their training period must have led to the growing trend for 'normal' deliveries to occur in hospital. It could also be speculated that the development of antenatal care led to conditions such as twins and breech presentations being diagnosed and their care hospitalised. The Jessop's district midwifery was gradually superseded by its in-patient work; the development of the hospital for normal childbirth will be considered in greater detail in the next section. However they did fight hard to keep the external work going in the belief that district work still represented a significant aspect of training for pupils. In 1934 the area covered by district midwives was extended to take in Attercliffe and Darnall in the hope of attracting more patients.

After 1932 the Council had begun to develop its own salaried midwifery service, largely in response to concerns about high MMR, but it was not until the implementation of the 1936 Midwives Act that open hostility developed between the Jessop and the Council over home birth care¹¹⁷. Under the terms of the Act, which legislated for the provision of local authority salaried midwives, and the pensioning off of those no longer required, the Council decided to take responsibility for the whole of Sheffield. This effectively left the Jessop without an external base and they were furious. After representations to the Ministry of Health, it was agreed in 1937 that the Jessop should have 3 of the 40 midwives required by the City under its control, although they were to be paid by the Council¹¹⁸. This situation demonstrates one area where state control and provision superseded that provided by a voluntary organisation, despite the latter being a long standing, and generally successful service.

¹¹⁶ Donnison, *Midwives and Medical Men*, p.120.

¹¹⁷ *An Act to Amend the Midwives Acts, 1902 to 1926*, [26 Geo.5 & 1Edw.8.c.40].

¹¹⁸ *Jessop Minutes* vol 18, 1934-36, p.229, p.790; vol 19, 1937-40, p.658, p.666.

Midwives in Sheffield 1881

name	age	marital status	children at home	age of children	husband's employment	midwife in census?
Mrs Mary Roberts	49	widow	3	21, 13, 9 (2 working)	-	yes
Mrs Mary Scott (J)	55	widow	1 (and son-in-law)	28, 22 (all working)	-	yes
Mrs Elizabeth Simpkins	50	married	4	25, 19, 16, 10 (2 working)	table knife grinder	no
Mrs Mary Somerset	51	widow	2	21, 14 (both working)	-	yes
Mrs Sarah Staniland	54	widow	2 (and 1 son-in-law)	31, 17, 12 (2 working)	insurance agent	yes
Mrs Lucy Steedman	53	married	1 (and 1 boarder)	19	steel maker	yes
Mrs Mary Warriss	60	widow	1 (and 4 member family of lodgers)	20	-	yes
Mrs Emma Warren	49	married	1 (and son-in-law and 4 small children)	25	pensioner	yes

Table 5.4 (continued)

Source: Trade Directory and Census

Midwives in Sheffield 1881

name	age	marital status	children at home	age of children	husband's employment	midwife in census?
Mrs Charlotte Ashforth	62	married	-	-	saw grinder	yes
Mrs Eliza Broadhurst	63	married	3	28, 24, 17 (all working)	knocker up	yes
Mrs Amelia Brown	54	widow	4	36, 19, 15, 12 (3 working)	-	no
Mrs Sarah Coldwell	44	married (but husband not mentioned on census)	2	20, 16 (all working)	-	yes
Mrs Mary Ann Gascoigne	50	widow	24 year old lodger, engine tenter	-	'formerly mechanics wife'	no
Mrs Martha Jennet (J)	59	married	1 (and 1 female lodger)	23 (working)	scavenger	no
Mrs Elizabeth Jarvis (J)	35	married	3	13, 5, 6m	razor grinder	no
Mrs Sarah Law	59	widow	living with her daughter, son-in-law, and their 4 children	30	-	yes
Mrs Eliza May	57	widow	2 (and 1 nephew)	17, 14, 19 (all working)	-	yes

Table 5.4

Midwives in Sheffield 1891

name	age	marital status	children at home	age of children	husband's employment	midwife in census?
Mrs Sarah A Sheldon	42	married	10 (and 1 lodger)	22, 20, 18, 16, 14, 12, 9, 7, 6, 2 (3 working)	spring knife cutter	no
Mrs Maria Straw	50	married	1 (and 1 servant)	19 (working)	labourer	yes
Mrs Hannah Timms	54	widow	2 (and 2 grandchildren)	17, 16 (both working)	scale cutter	no
Mrs Elizabeth Thompson	73	widow	1 (and daughter-in-law and 1 grandson)	34 (working)	—	no
Mrs Sarah Ann Wainman	45	married	7	17, 16, 14, 12, 11, 9, 5 (2 working)	joiner	no
Mrs Jane Walsh	57	widow	lives with widowed daughter, grandchild, son and lodger	25, 16 (1 working)	—	yes
Mrs Betsy Wilde	42	single	living with widowed mother; who lives on own means	—	—	'accouchuee diplomec'

Table 5.5 (continued)

Source: Trade Directory and Census

Midwives in Sheffield 1891

name	age	marital status	children at home	age of children	husband's employment	midwife in census?
Mrs Eliza Innocent	61	married	2 (and 2 grandchildren)	21, 17, 11, 8	engine tender	yes
Mrs Elizabeth Jarvis (J)	45	married	2 (and 1 niece)	15, 10, 5 (1 working)	razor grinder	yes
Mrs Fanny Kaye	45	widow	4	18, 15, 12, 10 (2 working)	–	yes
Mrs Ann Kingston	52	married	–	–	file maker	no
Mrs Jane Kirk	36	married	1	12	labourer	yes
Mrs Esther Longmore	64	widow	1 (and son-in-law, 1 grandson, 3 boarders)	30	–	'helper'
Mrs Mary Ann Martin	47	married	3	29, 14, 12 (2 working)	tool filer	yes
Mrs Ann Pearl	58	widow	2	36, 28 (both working)	–	yes
Mrs Charlotte Rodgers	66	married	2 grandchildren	19, 18 (2 working)	edge tool forger (too old to work)	yes

Table 5.5 (continued)

Source: Trade Directory and Census

Midwives in Sheffield 1891

name	age	marital status	children at home	age of children	husband's employment	midwife in census?
Mrs Emma Bartholomew	50	married	4	20, 18, 16, 14 (all working)	joiner	no
Mrs Ann Case	50	married	3	21, 19, 15 (all working)	vice maker	yes
Mrs Susannah Coggan	66	married	– (employed 1 servant)	–	not working	yes
Mrs Sarah Copley	65	widow	1 (and 1 son-in-law, and 5 grandchildren)	31	–	yes
Mrs Christina Eckhardt (J)	63	widow	living with daughter, son-in-law and 3 grandchildren	–	–	yes
Mrs Emily Ibbotson	68	widow	2	24, 18 (1 working)		yes
Mrs Caroline Ingelby	43	widow	– (2 female lodgers)	–	–	yes

Table 5.5

Source: Trade Directory and Census

5.3d: Independent Midwives:

Below the Jessop midwives in order of visibility in the evidence are the independent midwives who advertised themselves in Trade Directories. The entries gave names and addresses, and using this information, it has been possible to trace a proportion of them through the Census, and discover more about their social, economic, and family status. As with the Jessop midwives, and many people of their class, they were geographically very mobile, and some were impossible to trace, not being at their Directory listed address at the time of the Census. Midwives were not listed as a Trade category in the 1871 Directory, and as the 1901 Census is not yet available, only those for 1881 and 1891 have been pursued. For 1881, it was possible to trace 17 out of the 20 midwives named in the Directory; 10 years later 23 out of 35 were located. *Table 5.4* and *Table 5.5* give details of the findings.

The Table for 1881 (*Table 5.4*) illustrates that there was an even split between married and widowed practitioners, with their ages being in the same range whatever their marital status. There appears to be no difference in self designation according to marital status, although it might have been thought that widows needing to support themselves would have been more determined to style themselves 'midwife' than women with employed husbands. As Borst has found for midwives in the USA, Sheffield midwives had primarily older children who often brought in extra income. Their husbands, where applicable, were generally skilled workers, primarily in the light metal trades which reflected their ages and central locations. The majority of midwives lived and worked in the centre of the City; not until 1891 were 2 midwives from Attercliffe advertising their services, reflecting the changing demographic character of the City.

Generally, *Table 5.5*, for 1891, reveals that the profile of midwives had not changed significantly in 10 years. For the first time a single woman appears, perhaps aiming for the upper end of the market with her self designation of 'accouchée diplomée'. Whether midwives were designated as such in the data, perhaps reflected the views of the head of the household or the enumerator as much as the midwife herself. The relatively high numbers returning as 'midwives' suggests that these who advertised their services were probably fairly professional in the way they viewed themselves and their work, in the sense they felt themselves to have a specific occupational identity.

Unfortunately, the activities of the 'handywomen' who attended deliveries on what was probably a very sporadic basis, are impossible to identify. The very nature of their work, casual and intermittent, with reputations spread by

word of mouth do not lend themselves to written records. The MOH suggested that there were as many as 30 handywomen in practice in Sheffield before 1910, and that in 1909 more than 3% of cases were handled by them. The practice of midwifery by unqualified women 'habitually and for gain' was prohibited after 1910¹¹⁹. The following year, after 3 prosecutions for unqualified practice, the MOH remarked that 'the practice of the "handywoman" seems now to be almost a thing of the past in Sheffield'¹²⁰. There is no direct evidence for Sheffield to indicate whether this optimistic assumption was true or not, but information from other areas suggests that it was likely to have been somewhat premature¹²¹. It was estimated that in Rotherham 1907–8, 25% of births were attended by handywomen, who were scathing of new midwives with only 3 months training. Ten years later it was remarked that 'There are 29 handywomen in Dewsbury and not one of them possesses a bottle of antiseptic'. Finally, in Birmingham in 1929, there were still believed to be about 100 handywomen operating, mostly under cover of doctors¹²². Data from Wakefield City Health Department shows that as late as 1930 there was still significant activity by handywomen in the area. A register kept by the Department between February 1930 and September 1936 detailed 87 cases, probably those which came to the notice of the child welfare clinic. Wilkes has studied these records and found that 25 different handywomen are recorded, 15 of whom appear only once, perhaps the result of genuine emergencies. Others, however, appeared persistently; a Mrs W attended 21 deliveries including twins, a premature birth and a still birth. Wilkes suggested that in some cases handywomen made repeated attempts to call doctors, who refused to attend because they had not been booked; delays often led to solo deliveries. The Register ended with the creation of the salaried midwifery service; women no longer had the economic need to call handywomen, or so the Authority assumed. It is not known whether any might have survived for social reasons¹²³.

¹¹⁹ *MOH Report*, Sheffield, 1910, p.xvii.

¹²⁰ *MOH Report*, Sheffield, 1911, p.42.

¹²¹ Loudon found that many doctors continued to co-operate with handywomen, using them as maternity nurses; Leap and Hunter found the same co-operation between trained midwives and handywomen; Loudon, *Death in Childbirth*, p.218; Leap and Hunter, *The Midwife's Tale*, p.35–6.

¹²² M Chamberlain, *Old Wives' Tales: Their History, Remedies and Spells*, London, 1981, p.115; LA Bullough, 'Midwifery Service in the West Riding Administrative Area', *Public Health*, 31, 1917, 126–132, p.132; E Cassie, 'Maternal Mortality and Allied Problems', *Public Health*, 42, 1929, 329–333, p.333.

¹²³ JB Wilkes, 'The Last of the Handywomen', *Midwives Chronicle and Nursing Notes*, July 1992, p.178–9.

Ages of Practising Midwives, 1911-1931 (% of total)

	<24	25-44	45-64	>70
1911	11	43	44	2
1921	2	46	38	14
1931	4	48	41	7

Table 5.6

Source: BV Heagerty, *Gender and Professionalisation: the Struggle for British Midwifery, 1900-36*, unpub PhD thesis, Michigan State University, 1990, p.190.

Numbers and Ages of Midwives in the West Riding, 1916

	all ages	<30	30-40	41-50	51-60	61-70	>70
Independent	78	7	34	30	6	1	0
Dependent	51	9	25	12	5	0	0
Total	129	16	59	42	11	1	0
-	Untrained	1	1	28	135	161	48

Table 5.7

Source: LA Bullough, 'Midwifery Service in the West Riding Administrative Area', *Public Health*, 31, 1917, 126-132

Numbers of Midwives in Sheffield, 1905-1939

	Certified on Roll	Certified Practising [%of total practising]	Bona fide on Roll	Bona fide Practising	Total on Roll	Total Practising
1905	54	-	79	-	133	-
1906	-	-	-	-	130	-
1907	-	25 [28]	-	65	120	90
1908	46	16 [21]	66	59	112	75
1909	46	23 [34]	58	45	104	68
1910	-	22 [32]	-	46	96	68
1911	36	21 [35]	54	39	90	60
1912	-	30 [45]	-	36	-	66
1913	-	27 [44]	-	35	-	62
1914	-	27 [44]	-	34	-	61
1915	-	30 [49]	-	31	-	61
1916	-	-	-	-	-	-
1917	-	-	-	-	-	-
1918	-	-	-	-	-	-
1919	-	-	-	-	-	-
1920	-	-	-	-	-	-
1921	-	43 [75]	-	14	-	57
1922	-	53 [77]	-	16	-	69
1923	-	53 [77]	-	16	-	69
1924	-	53 [76]	-	17	-	70
1925	-	54 [79]	-	14	-	68
1926	-	60 [81]	-	14	-	74
1927	-	63 [86]	-	10	-	73
1928	-	68 [88]	-	9	-	77
1929	-	69 [88]	-	9	-	78
1930	-	65 [89]	-	8	-	73
1931	-	63 [90]	-	7	-	70
1932	-	65 [90]	-	7	-	72
1933	-	65 [90]	-	7	-	72
1934	-	76 [93]	-	6	-	82
1935	-	81 [95]	-	4	-	85
1936	-	72 [97]	-	2	-	74
1937	-	65 [100]	-	0	-	65
1938	-	63 [100]	-	0	-	63
1939	-	63 [100]	-	0	-	63

Table 5.8

Source: MOH Reports, Sheffield

Annual Case Loads of Midwives in the West Riding, 1916

	<10	10-20	21-40	41-60	61-100	>100
Trained						
Independent	37	10	12	4	8	7
Dependent	29	8	12	2	0	0
Total	66	18	24	6	8	7
Untrained	10	84	92	44	37	15

Table 5.9

Source: LA Bullough, 'Midwifery Service in the West Riding Administrative Area', *Public Health*, 31, 1917, 126-132

After the publication from 1905 onwards of the Midwives Roll, annually listing those midwives available, and those intending to practise, local authorities were able to piece together a more comprehensive picture of midwifery in their area. Regional and local data, together with Heagerty's national figures demonstrate that midwifery did not become a full time career for most practitioners with the introduction of the 1902 Midwives Act.

As Heagerty has shown, the age profile of all practising midwives did not change significantly between 1911 and 1931 (*Table 5.6*) with the vast majority of practitioners being between 25 and 64 years old. However, as figures for midwives in the West Riding, which included Sheffield, demonstrate, there was a demographic influence on the proportions of trained and untrained midwives with the majority of the former being under 40 years old, compared to untrained midwives, the majority of whom were over 50 (*Table 5.7*). The Midwives Roll included two types of midwives; those trained, and those untrained but considered acceptable by virtue of long practice. This latter group were described as '*bona fides*' and their inclusion was for the pragmatic reason that there were not enough trained midwives to cover the workload. Training was a necessary condition of practice for those applying for inclusion in the Roll after 1910, with the implication that the *bona fides* would eventually become too old to practice. *Table 5.8* illustrates the gradual decline in untrained midwives after the 1902 Act. National figures suggested 87% of midwives were trained by 1925, 93% in 1930, and 97% in 1935¹²⁴. Sheffield was slightly behind this average, but given that one *bona fide* leaving practice could make a substantial difference to the proportions, the difference is probably not significant.

As *Table 5.9* demonstrates, however, the influence of the *bona fides* continued to be significant in that they retained the highest case loads. It might be thought that these women were the archetypal part time, non-professionally oriented workers, yet the figures suggest that they were successful in supplying a considerable amount of demand. In the mid 1930s the Midwives Institute took as a definition of full time midwifery 100 cases annually, in which case few of the trained or untrained groups were fulfilling this level of practice in 1916. Data for other areas bears out the impression that midwifery remained a largely part time, low income, low status occupation. In 1933, of 110 practising midwives in Manchester, only 50 were solely dependent on midwifery for a living, and 18 of those lived with relations. The remaining 60 were all married, and of these 45 were definitely stated not

¹²⁴ Heagerty, *The Struggle for British Midwifery*, p.187.

Midwives in Sheffield, 1881–1940

	Total practicing midwives on Roll	Total midwives in Directories	Total midwives with address data	Average age	Married [%]	Widowed [%]	Single [%]
1881	–	20	17	53	8 [47]	9 [53]	0 [0]
1891	–	35	23	54	12 [52]	10 [43]	1 [4]
1898	–	29	26	57*	6 [23]	26 [77]	0 [0]
1905	–	35	28	–	5 [18]	21 [75]	2 [7]
1910	68	52	41	–	10 [24]	25 [61]	6 [15]
1916	–	50	38	–	11 [29]	27 [71]	0 [0]
1920	–	50	38	–	11 [29]	24 [63]	3 [8]
1925	68	56	48	–	6 [13]	32 [67]	10 [21]
1931	70	47	40	–	11 [28]	21 [53]	8 [20]
1935	85	59	54	–	14 [26]	27 [50]	15 [28]
1940	63	58	46	–	16 [35]	9 [20]	21 [46]

* For the 45% of midwives where information was available.

Table 5.10

Source: Trade Directories and MOH Reports, Sheffield.

Marital Status of Midwives in England and Wales (% of total)

	Married	Widowed	Single
1911	51	33	16
1921	33	29	38
1931	33	20	47

Source: BV Heagerty, *Gender and Professionalisation: the Struggle for British Midwifery, 1900-36*, unpub PhD thesis, Michigan State University, 1990, p.189

Table 5.11

to be in full time practice¹²⁵. In 1935, the Midwives Institute conducted a survey into conditions of midwifery practice to ascertain the potential effects of the 1936 Midwives Act¹²⁶. Analysis of the results for Yorkshire, Durham, Hampshire and part of Lancashire showed that married midwives vastly outnumbered widowed or single practitioners, and that 10% of those practising were over 60. 50% of the 562 midwives surveyed in independent practice had fewer than 50 cases per year; only 20% had more than 100 (100 cases were taken to equal full-time practice). 33% of midwives earned less than £50 per year; 1 in 7 received more than £200 per year. The Report noted that; 'Except for a small minority, the practice of the independent midwife does not afford a living wage...'¹²⁷ In 1911, 83% of midwives were married or widowed, and 70% were over 45 years old. Twenty years later, 52% of the total were married or widowed and 48% were over 45. This demonstrates that although the profile of midwives was changing they were still far from being a homogeneous, 'professional' group, but remained divided by age, training, level of practice and income.

To get an impression of the changing nature of midwifery practice in the decades after the introduction of the 1920 Midwives Act, lists of midwives advertising in the *Sheffield Trade Directories* were compiled for approximately five year intervals (*Table 5.10*)¹²⁸. They did not cover all of the midwives listed as in practice on the Roll, nor was it possible to trace the addresses of all of them, but enough of those practising have been recorded to give an idea of the development of the occupation. The figures probably over estimate the numbers of unmarried midwives, and are probably over representative of those who were qualified, as it is likely that these were the more 'professional' full time midwives, most likely to be advertising their services. The marital status of all midwives was given by Heagerty (*Table 5.11*). In comparison with Heagerty's figures, there appear to have been far more widowed midwives in Sheffield than married or single practitioners. Possible reasons for this must necessarily be speculative, but are perhaps connected to the social profile of Sheffield, with few married women working. The social conditions perhaps did not allow for this, whereas for widowed women it was an acceptable occupation.

¹²⁵ *The Lancet*, i, 1935, p.937.

¹²⁶ For a full discussion of this survey see Heagerty, *The Struggle for British Midwifery*, p.246.

¹²⁷ *The Lancet*, ii, 1935, p.1009-10; see also *BMJ*, ii, 1935, p.862-3.

¹²⁸ The intervals are only approximate because Directories are not extant for all years.

Geographical Spread of Midwives in Sheffield, 1881–1940.

Year	Central	North	East	South	West
1881	12	2	2	1	0
1891	12	3	4	4	0
1898	14	4	2	5	1
1905	13	7	2	4	2
1910	8	12	11	14	2
1916	4	12	14	9	2
1919	6	13	11	6	3
1925	5	14	14	13	2
1931	7	12	8	11	2
1935	6	21	9	10	8
1940	2	12	10	16	7

Table 5.12

Source: Trade Directories, Sheffield.

Table 5.12 shows the geographical spread of midwives in Sheffield between 1881 and 1940. At the beginning of the period, midwives were concentrated in the centre of the City, with only a handful in the suburbs. The centre of Sheffield still had a heavy degree of population so it is not surprising that the vast majority of midwives lived and practised there. Until the late 1930s there were almost no midwives in the western districts of Sheffield, indicating that the women of these wealthier areas probably did not rely as heavily on midwives as did women in other areas. There were more midwives in the western suburbs in the late 1930s, the majority of whom were associated with the developing maternity homes which concentrated on attracting a wealthier clientele.

By 1910, the majority of midwives were living and practising in the suburbs; a reflection of the movement of the population out from the City centre as a result of the extension of the Municipal tram network and the house building boom. Unfortunately it is impossible to plot similar information for doctors who practised obstetrics as they were not separately delineated in the Directories. It is likely that more doctors were routinely involved in childbirth in the western suburbs, but it is impossible to say this with certainty. Although MMR was generally higher in the eastern suburbs, this cannot be linked with midwifery practice; midwives were no more or less prevalent there than in the south or north of the City, and would have been practising in a similar fashion.

5.3e: The Professionalisation of Midwifery:

After the introduction of the 1902 Midwives Act, midwives were subject to strict supervision by the Women Sanitary Inspectors (WSI) in Sheffield, themselves all certified midwives¹²⁹. The WSI's seem to have had very much closer contact with the midwives than with local doctors. They visited midwife births, before the latter's statutory 10 day visiting period was up. In the case of doctors, however: '...the aim is to pay the first visit after about a fortnight has elapsed, when presumably the attendance of the medical practitioner has ceased.'¹³⁰ The use of the word 'presumably' suggests that there was little contact, formal or informal, between doctors and inspectors. Each midwife was visited several times a year, although MOH reports do not state what these visits entailed. They are likely to have concentrated on the checking of equipment and on assessment of the midwife's continued good conduct, both

¹²⁹ The background to the passing of this Act has been comprehensively covered by Donnison, *Midwives and Medical Men*.

¹³⁰ *MOH Report*, Sheffield, 1913, p.xxxiii.

professional and personal, as laid down by the CMB. Leap and Hunter have argued that such strictures were designed deliberately to make practice difficult for the poor midwife¹³¹. However the implementation of supervision given to midwives varied considerably between different areas, with Sheffield having one of the more developed systems. Heagerty has recorded cases across England of midwives being struck off for drunkenness or illegitimate pregnancy, and has discussed the use of the procedure as a deliberate method of excluding working class midwives¹³². For Sheffield the evidence is inconclusive as there were very few midwives censured or struck off. Two midwives were struck off for classifying as stillbirths infants that had been born alive. One midwife was censured for lack of cleanliness, and another two for failing to summon medical help quickly enough. None of these three cases was referred to the CMB or struck off, suggesting that relations between the supervising authority and midwives was not a particularly confrontational one. The majority of prosecutions concerning midwives involved the continued practice of unlicensed midwives, the 'handywomen' who were not on the Roll in the first place.

Researchers on midwifery in the USA and in Britain have argued that legislation such as the Sheppard–Towner Act in the USA, and the 1902 and 1936 Midwifery Acts in Britain, downgraded traditional skills and networks in favour of a medicalised, scientific approach to childbirth¹³³. It has also been argued that midwives contributed to their own decline in independence and status by failing to act as a cohesive profession in their own interests. Reagan has argued that in the USA they worked together only in a defensive way to resist claims that they were abortionists¹³⁴. For immigrant midwives in early twentieth century Massachusetts, Declerq has commented that:

There was no sense of association among the midwives; and they apparently had no consistent arrangements to help each other out. In this sense they were like their colleagues in other communities and States, whose failure to organise hastened their legal demise.¹³⁵

¹³¹ Leap and Hunter, *The Midwife's Tale*, p.2–11.

¹³² Heagerty, *The Struggle for British Midwifery*, p.21–22, p.82–83.

¹³³ M Ladd–Taylor, "Grannies" and "Spinsters": Midwifery Education under the Sheppard–Towner Act', *Journal Social History*, 22, 1988, p.255–75; Heagerty, *The Struggle for British Midwifery*, Donnison, *Midwives and Medical Men*.

¹³⁴ JL Reagan, 'Linking Midwives and Abortion in the Progressive Era', *Bulletin History Medicine*, 69, 1995, 569–598, p.584.

¹³⁵ ER Declerq, 'The Nature and Style of Practice of Immigrant Midwives in Early Twentieth Century Massachusetts', *Journal Social History*, 19, 1985–86, 113–129, p.125.

Evidence for Sheffield bears this out. Midwives were in competition, with each other as well as with doctors and hospitals, for a declining number of births. The willingness of one midwife to have another prosecuted for the supply of diachylon, a lead based abortifacient, bears this out¹³⁶. During a long running dispute in the *Sheffield Telegraph* about doctors rights to their fees if called out to maternity cases, a certified midwife complained about being their being described by a doctor as 'scantily qualified professionals' who took cases and fees that rightly belonged to GP's¹³⁷. This illustrates the battles being fought between GP's and midwives over the division of cases, but also the tensions between midwives themselves. The same midwife accused handywomen of being 'old women, absolutely ignorant, very dirty, exceedingly deaf, and constantly drunk'.¹³⁸ She further complained that it was an insult to trained midwives to have *bona fides* on the Register; those with no qualifications, but who were simply of long standing practice. This does suggest that there were distinct groups of midwives, hamstrung by their failure to act in concert, and also that the development of midwifery education was increasing rather than reducing these tensions. Heagerty has argued that these tensions were deliberately fostered by the Midwives Institute, who represented the midwifery leadership, in an attempt to professionalise the activity and to exclude older, working class, ill-educated, and later even married midwives, who did not fit the middle class standard. They believed that working class midwives were responsible for high IMR and MMR¹³⁹. Local tensions do not suggest conspiracy, however, but the result of practitioners having different backgrounds, and differing social and economic needs, together with the effect of a shrinking pool of work available for independent midwives given the reduced numbers of births, and increasing use of hospitals.

There is only one recorded instance of one group of midwives working together in Sheffield, and this was a short lived and geographically restricted action. In August 1910, it was reported that midwives at Pitsmoor and Brightside, heavy trade areas with high birth rates, had gone on strike to demand payment in advance for their services. One midwife stated that:

We are simply sick and tired of being called out at all hours of the day and night to render the skilled attention needed when in so many cases

¹³⁶ ST 24/10/06, p.3; see also chapter 6 of this thesis.

¹³⁷ ST 3/03/09, p.6. It was true that there were calls for training periods to be extended, but that this could not be done without further restricting the supply of midwives; *Report of the Departmental Committee to Consider the Working of the Midwives Act, 1902*, volumes 1 and 2, 1909, vol 1, p.9.

¹³⁸ ST 12/03/09, p.8.

¹³⁹ Heagerty, *The Struggle for British Midwifery*, p.xi-xii.

we can not get our fees...they seem to think that because we are certified we are compelled to come at their beck and call. But we're going to teach them different.

It was further commented that:

I think its time we midwives in Sheffield had a union. The doctors sometimes refuse to attend cases until their fees are paid, and why shouldn't we be equally safeguarded?¹⁴⁰

A resolution was passed by the newly formed 'Darnall, Attercliffe, Tinsley and Brightside Midwives Association' that no work would be undertaken without advance fees. A branch of the National Association of Midwives was set up, surviving until 1915, when the parent organisation folded¹⁴¹. The only effect of the action appears to have been that a midwife, Mrs Maria Goose, was censured by the coroner for the death of a child after she failed to attend. She did not attend when sent for because she was at another case, although she admitted that the rules of her Association would have prevented her from doing so anyway¹⁴². Superficially it appears that this action, limited though it was, did demonstrate that midwives could work together for common cause. However, in addition to the restricted geographical spread of the action, it accurately demonstrated the disunity of midwives in the sense that it was the new certified midwives who were taking action. Their insistence on their expertise and professionalism as justification for their high fees, and their mention of common cause with doctors, hints at attempts to be seen as professionals. It also highlights efforts by certified midwives to distance themselves from the *bona fide* midwives, and from handywomen. The action was therefore at least potentially divisive. Heagerty has suggested that the National Association of Midwives, and a contemporary group, the British Union of Midwives were representing rank and file midwives in calling for less disciplinary supervision and greater autonomy of practice, but those involved in the Association in Sheffield appear to have been the midwifery 'elite' of the area¹⁴³.

¹⁴⁰ ST, 5/08/1910.

¹⁴¹ The National Association of Midwives was created from smaller groups operating in the Manchester area; Heagerty, *The Struggle for British Midwifery*, p.102–11.

¹⁴² ST 7/01/11, p.7.

¹⁴³ Heagerty, *The Struggle for British Midwifery*, p.102–11.

5.4: Hospitalisation of Childbirth:

Perhaps the most visible sign of changing practice in childbirth management in England in the last 100 years, has been the move towards the use of hospitals for normal childbirth¹⁴⁴. Feminist historians in particular have characterised this development as one of coercion with parturient women losing control over the place and pace of birth, and relinquishing traditional methods of female support within the community in favour of managed labours directed in hospital, often by male obstetricians. Writers such as Oakley have suggested that women were largely passive in this change, which occurred for reasons of professional rivalry and the belief that hospitals were safer than homes:

The main change in the social and medical management of childbirth and reproductive care in industrialised cultures over the last century has been the transition from a structure of control located in a community of untrained women, to one based on a profession of formally trained men.¹⁴⁵

However, when the experiences of one area are considered in greater detail, it becomes clear that these generalisations overplay the importance of traditional birthing cultures and underplay the extent to which the hospitalisation of childbirth was demand led, with women themselves calling for more beds to be available¹⁴⁶. These factors have already been highlighted in relation to the admitted ignorance of pregnant women, and the lack of community led support structures.

The debate over the place of birth was primarily an inter-war issue and was closely linked with the problem of maternal mortality. Professional rivalry was of immense importance in structuring the debate but the rivalry was no longer between doctors and midwives, but between general practitioners and obstetricians. Following the implementation of the 1902 Midwives Act, and the

¹⁴⁴ This was also true in many other European countries and in the USA; The Netherlands was the exception in having low levels of institutional deliveries; H Marland, 'Questions of Competence: The Midwife Debate in the Netherlands in the Early Twentieth Century', *Medical History*, 39, 1995, 317-337.

¹⁴⁵ A Oakley, 'Wise Woman and Medicine Man: Changes in the Management of Childbirth', in J Mitchell and A Oakley, *The Rights and Wrongs of Women*, Harmondsworth, 1976, 17-58, p.18: See also: A Oakley, *Women Confined: Towards a Sociology of Childbirth*, Oxford, 1980; MC Versluisen, 'Midwives, Medical Men and "Poor Women Labouring of Child": Lying-in Hospitals in Eighteenth Century London', in H Roberts, ed. *Women, Health and Reproduction*, London, 1981, 18-49. For USA: B Ehrenreich and D English, *Witches, Midwives, and Nurses: A History of Women Healers*, New York, 1976; B Ehrenreich and D English, *For Her Own Good: 150 Years of the Experts Advice to Women*, London, 1979.

¹⁴⁶ Leap and Hunter found in their oral history of midwifery 'no treasure chest of forgotten skills' relating to midwives and birthing culture, *The Midwife's Tale*, p.xi.

attendant bitter struggles for the control of midwifery, midwives were generally accepted as being a vital adjunct to obstetric services. Additionally as Donnison has commented, the passing of the 1911 National Insurance Act gave even poor GP's a certain minimum level of income, removing their need to compete with midwives for cases¹⁴⁷. As has been seen in the previous section, arguments still continued but they were just as likely to be between different types of midwives, as between midwives and doctors. The development of training and ideas of profession divided midwives, but it also divided doctors. The founder of the Jessop Hospital for Women, Dr Aveling, had been a GP, but by 1920, the doctors who were associated with the hospital were specialists in obstetrics and gynaecology, working almost entirely in a hospital setting. Debates in the *BMJ* highlight the bitter struggles for professional pre-eminence in the field of midwifery¹⁴⁸.

The majority of calls for the hospitalisation of childbirth do appear to have stemmed from the belief that this would have a beneficial effect on MMR. Consultant obstetrician Victor Bonney, as early as 1919, suggested that the remedy for high MMR was that 'labour, even normal labour should be considered as an operation'. This required a gowned and gloved obstetrician, working under sterile conditions with the patient in the lithotomy position preferably restrained and anaesthetised¹⁴⁹. GP's attempted to defend their position, arguing that it was 'impossible to base a maternity service either on maternity hospitals or on certified midwives.'¹⁵⁰ Another GP complained that:

The dangers and difficulties of general midwifery practice have been magnified out of all proportion by specialists and public health officials. They are doing their best to frighten the general practitioner from having anything to do with midwifery work...they have put the fear of death into every child bearing woman by their publicity campaign...¹⁵¹

The GP's were forced into these defensive positions by what they felt to be an alliance of MO'sH and obstetricians, many of whom called for GP's to be taken out of midwifery work altogether, as they were unspecialised, carriers of infections, and liable to dangerous intervention¹⁵². Miles Phillips, a senior

¹⁴⁷ Donnison, *Midwives and Medical Men*, p.182-3.

¹⁴⁸ Borst has identified a similar situation in Wisconsin with community based doctors being forced out of childbirth practice by hospital based specialists; CG Borst, *Catching Babies: The Professionalisation of Childbirth, 1870-1920*, London, 1995, p.148-9.

¹⁴⁹ V Bonney, 'The Continuing High Maternal Mortality of Child-bearing: The Reason and the Remedy', *Proceedings Royal Society Medicine*, 12, 1919, 75-107.

¹⁵⁰ *The Lancet*, i, 1934, 242-3.

¹⁵¹ DD Logan, 'The General Practitioner and Midwifery', *The Lancet*, ii, 1934, 1141-3.

¹⁵² *The Lancet*, ii, 1934, 1198-9.

obstetrician at the Jessop Hospital in the inter-war years, supported the total institutionalisation of delivery:

The midwife and the obstetrician of the future, working in co-operation, will, it appears to me, conduct more and more and finally all deliveries in specially equipped institutions.¹⁵³

The British Medical Association (BMA), the vast majority of whose members were GP's, continued to support GP based midwifery arguing that home births were safer than hospital ones¹⁵⁴. There was a feeling that independent GP's and midwives were being squeezed by the growing power of voluntary hospitals, and by the development of Local Authority care. The case for the latter had been put very strongly by both George Newman and Janet Campbell for the Ministry of Health. It was in fact the development of these services that were highlighted by Dawson in his complaint about state medicine 'by stealth'.¹⁵⁵ However, the reality did not suggest an orchestrated attempt by Local Authorities and hospitals to remove doctors but the development of cheap, expedient policies in response to public demand for particular services.

5.4a: The Views of Women:

The acceptance of a 'conspiracy theory' by feminist historians has perhaps been too uncritical. Given the volume of print and vitriolic opinions generated by doctors, in medical journals and the lay press, it is easy to overlook the views and influence of women themselves. Debates at the national and local level were vital in shaping the move of childbirth into hospital. However, the role of women was very significant in ensuring a successful outcome for the obstetricians. In fact it appears that in cities such as Sheffield, voluntary hospitals and local authorities were wrong footed by the levels of demand, which left them urgently expanding hospitals, and in Sheffield's case creating a free domiciliary midwifery service, to try and relieve the pressure on beds.

In her study of Wisconsin, Borst has argued that support for doctors came from women themselves, including a midwife who engaged a doctor for the delivery of her child¹⁵⁶. Leavitt has pointed to the case of 'Twilight Sleep'

¹⁵³ *The Lancet*, ii, 1935, 1107-9.

¹⁵⁴ *The Lancet*, i, 1936, p.736; also BMA 'Memorandum regarding a National Maternity Service', *BMJ* supplement, ii, 1935, 295-8.

¹⁵⁵ Lord Dawson, 'Medicine and the State', *BMJ*, i, 1920, 743-45.

¹⁵⁶ CG Borst, *Catching Babies: The Professionalisation of Childbirth, 1870-1920*, London, 1995, p.152.

in the USA as an area where women championed a particular cause, against the wishes of many doctors¹⁵⁷. Twilight sleep (a mixture of scopolamine and morphine) was an analgesic which blocked the memory of birth and of pain. It required the restraint and constant monitoring of the patient, and therefore meant a hospital delivery. The treatment does not appear to have been taken up so enthusiastically in Britain, but in the USA the issue was debated in popular women's magazines, and championed by the 'National Twilight Sleep Association'. This action appears to run counter to the arguments of Dye, Oakley and others that women attempted to resist moves to managed labour, in favour of traditional woman centred birth¹⁵⁸. However, as Pitcock and Clark have commented; 'Significantly, in the wake of the Twilight Sleep movement, women had assumed control of childbirth and had sought to move its setting from home to hospital.'¹⁵⁹ In 1914, the Women's Co-operative Guild in England had been calling for the provision of a trained midwife for every woman in labour; by 1918 this demand had been changed to a call for hospital beds and medical supervision for every woman¹⁶⁰.

The big debates over MMR during the 1930s in particular, were believed by many to have contributed to women's fears and their demands for pain relief and hospital based experts. Fox has argued that the issue of maternal mortality was not in fact a national scandal, and attracted little attention beyond specialised journals¹⁶¹. Newspaper evidence for Sheffield suggests that this was far from the case; in the early 1930s the subject was canvassed on at least a monthly basis. In 1935, the BMA regretted that:

¹⁵⁷ JW, Leavitt, JW, 'Birthing and Anesthesia: the Debate over Twilight Sleep', in JW, Leavitt, ed. *Women and Health in America: Historical Readings*, Wisconsin, 1984, 175-184.

¹⁵⁸ NS Dye, 'Modern Obstetrics and Working Class Women: the New York Midwifery Dispensary, 1890-1920', *Journal Social History*, 20, 1986-7, 549-64; A Oakley, 'Wise Woman and Medicine Man: Changes in the Management of Childbirth', in, J Mitchell and A Oakley, *The Rights and Wrongs of Women*, Harmondsworth, 1976, 17-58; A Oakley, *Women Confined: Towards a Sociology of Childbirth*, Oxford, 1980.

¹⁵⁹ CDH Pitcock and RB Clark, 'From Fanny to Fernand: the Development of Consumerism in Pain Control During the Birth Process', *American Journal Obstetrics Gynaecology*, 167, 1992, 581-587, p.584.

¹⁶⁰ Lewis, *The Politics of Motherhood*, p.129. Harley has suggested that the view of women as 'passive' in the face of medical change may also be wrong regarding the 'decline' of midwifery in the eighteenth century, and the development of man-midwifery; 'As a corrective to older views that saw women as passive victims of change, the interpretation presented here has laid more stress on changes in women's tastes than on the creation of new demands by male practitioners... The apparent willingness of polite society to be persuaded by this strategy suggests a shift in attitudes towards the value of science and the acquisition of knowledge'; D Harley, 'Provincial Midwives in England: Lancashire and Cheshire, 1660-1760', in H Marland, ed., *The Art of Midwifery: Early Modern Midwives in Europe*, London, 1993, 27-48, p.43.

¹⁶¹ E Fox, 'Powers of Life and Death: Aspects of Maternal Welfare in England and Wales Between the Wars', *Medical History*, 35, 1991, 328-352, p.349.

...the question of maternal mortality has become the subject of widespread political discussion, receiving great publicity in the lay press. Maternal mortality is a scientific and administrative problem which deserves careful and scientific study, but in the experience of practising doctors, the publicity which it is receiving today is tending to terrify child bearing women and is, in itself, a cause of increased mortality.¹⁶²

The *Sheffield Independent* countered this report in an editorial arguing that maternal mortality was 'a blot upon civilisation' which demanded maximum publicity in order to tackle the situation¹⁶³. In contrast, Glyn Davies, the Honorary surgeon at the Jessop, said that maternal mortality had been over emphasised:

There is no real cause for alarm. When all is said, including the very worst conditions, one mother in 250 dies. I am not saying that it is a good thing. At the same time, the real reason why the maternal mortality figures in this country and other countries has not altered, is because they are so good. Motherhood is still a natural process as it was before the flood.¹⁶⁴

Loudon has suggested that women's fear of pain and death in childbirth was not a significant factor in informing their decisions, and one doctor in Sheffield commented that:

I am sure we are beginning at the wrong end of the stick when we talk about maternal mortality, I prefer to talk about maternal health. We know that women do die sometimes, but bearing a child is not a disease, in fact it should be a pleasure.¹⁶⁵

The evidence suggests that women were afraid of the possibility of death, or at least serious disability as a result of childbirth¹⁶⁶. Margery Spring-Rice detailed the responses of working wives to a questionnaire sent out regarding their general health. Women usually self dated health problems from the time of their first or second pregnancy, and only 31.3% felt able to describe themselves as being in good health, with an equal percentage describing themselves as 'very grave'.¹⁶⁷ Calls by women for the management of birth by

¹⁶² *The Lancet*, ii, 1935, p.211.

¹⁶³ *SI*, 23/7/35.

¹⁶⁴ *SI*, 12/11/36.

¹⁶⁵ *SI*, 2/10/36.

¹⁶⁶ JW Leavitt and W Walton, ' "Down to Death's Door": Women's Perceptions of Childbirth in America', in Leavitt, JW, ed., *Women and Health in America*, Wisconsin, 1984, 155-165.

¹⁶⁷ M Spring-Rice, *Working Class Wives: Their Health and Conditions*, first pub 1939, this edition, London, 1981.

well qualified 'experts' suggest that they were accepting of the critique of contemporary practices put forward by many obstetricians. Recalling her first labour in 1937 one woman in London commented:

I wanted to go to hospital because I knew if anything went wrong, everything was going to be right at the hospital. They're magicians. Everything is right there.¹⁶⁸

Marks has suggested that high rates of poverty and poor housing, together with an abundance of reputable teaching hospitals, made hospital a desirable alternative to home for many women¹⁶⁹. Economic issues were also a factor, with hospital being a cheaper option than a certified midwife.

There was little tradition of women led 'community birth' and therefore labouring in an institution might not have been an unacceptable option. As Humphries and Gordon have found, most women who laboured at home did so alone, in silence and in fear. One of their interviewees, whose children were born in the 1920s commented that:

You didn't make a row 'cos the kids was in the next bedroom, weren't they? You didn't want to frighten them to death. No, I never made no noise. I just used to hold meself. Grin and bear it.¹⁷⁰

Lady Bell suggested that in the early years of the century women did not want pain relief as they were afraid of its effects. Significantly she also commented that 'It is illegal to administer it without consent, sometimes refused by the husband.' This has a bearing on power structures within the family; demonstrating again that childbirth was not an exclusively female concern, and perhaps that women felt they were more likely to get what they wanted in hospital¹⁷¹. Certain decisions, such as that by the Jessop Hospital in 1935 that district midwives should not use gas and air apparatus, might have forced women wanting pain relief into hospital for the negative reason that they could not get it at home. Bell's area of study was Middlesborough, a town

¹⁶⁸ LV Marks, ' "They're Magicians": Midwives, Doctors and Hospitals: Women's Experiences of Childbirth in East London and Woolwich in the Inter-War Years', *Oral History*, Spring 1995, 46-53.

¹⁶⁹ see also; LV Marks, *Model Mothers: Jewish Mothers and Maternity Provision in East London, 1870-1939*, Oxford, 1994, p. 151-8.

¹⁷⁰ Humphries and Gordon, p.15. There were also examples of women not wanting their husbands to see or hear them in labour, including one who was told by the midwife to put a pillow over her mouth when she screamed, in order not to upset her husband; p.14, 17, 34, 40.

¹⁷¹ F Bell, *At the Works: A Study of a Manufacturing Town*, London, 1985, p.204 (orig pub 1907.)

Jessop Hospital Maternity Cases, 1896-1938.

	in-patients	out-patients
1896	161	538
1897	161	551
1898	180	537
1899	159	483
1900	128	535
1901	148	571
1902	178	621
1903	261	725
1904	293	818
1905	258	710
1906	298	590
1907	320	453
1908	374	594
1909	403	661
1910	399	513
1911	448	454
1912	536	354
1913-1921	-	-
1922	698	187
1923	741	221
1924	797	233
1925	918	234
1926	938	297
1927	914	303
1928	1064	259
1929	976	189
1930	998	181
1931	984	185
1932	993	183
1933	1014	177
1934	1043	152
1935	1079	167
1936	1029	202
1937	1160	233
1938	1293	205

Table 5.13

Source: Annual Reports of the Jessop Hospital



Plate 11. The Jessop Hospital for Women, opened 1878.



Plate 12. The extension to the Jessop Hospital, built in the 1930's, to accommodate more in-patients.

dominated by male occupations with low rates of female employment. The same situation pertained in Sheffield and probably had a detrimental effect on the domestic power of the woman¹⁷². One respondent to Marks' survey commented that she preferred to be alone in hospital where she could get on with it without having to worry about her family¹⁷³.

In Sheffield demand for hospital beds outstripped supply from the early years of the century, before the issue of MMR, and 'fear' became a significant factor. In 1912, doctors at the Jessop succeeded in securing the appointment of a second house surgeon to oversee demand, and by 1920 were calling for a third or the reduction in the work of the maternity department which 'in view of the pressing demand for Hospital beds...would be deplorable in the extreme'.¹⁷⁴ Concerns arose again in 1926, and three years later pressure on beds meant that patients could no longer be booked for routine deliveries after the 23rd week of pregnancy¹⁷⁵ (*Plate 11* and *Plate 12* illustrate the expansion of the Jessop in response to the demand for beds). The number of in-patient deliveries overtook out-patient ones as early as 1912 (*Table 5.13*).

Part of this demand may have been due to the fact that Sheffield had a tradition of in-patient deliveries; the importance of the supply of 'normal' births to the Jessop's training programme has already been highlighted. As early as 1889 the Jessop had 119 in-patients, out of a total of 570 maternity cases. This compared with Manchester, which had 86 in-patients, out of a total of 868 cases; Oxford with 163 in-patients out of 3261 cases and Brighton and Hove with 18 in-patients out of 1081 cases¹⁷⁶. This suggests that Sheffield had a head start in the local dissemination of the idea that birth in hospital could be normal and acceptable. The use of hospital for normal deliveries was by no means confined to Sheffield. At York Maternity Hospital there were 64 deliveries in 1916, rising to 201 by 1919. The MOH at York attributed this 'unprecedented demand' to mothers who 'realised the value of the peacefulness and skilled attention of a maternity hospital.' 11% of births occurred in hospital in Manchester in 1924; by 1933 the figure was 40%. By 1921 there were 21 municipal maternity hospitals, including ones at Hull, Sunderland, and Leicester. Other areas supported voluntary hospitals;

¹⁷² S Szreter, *Fertility, Class and Gender in Britain, 1860-1940*, Cambridge, 1996.

¹⁷³ Marks, ' "They're Magicians": Midwives, Doctors and Hospitals', p.50.

¹⁷⁴ *Honorary Medical Staff Suggestion Book*, 21/10/1926.

¹⁷⁵ *Jessop Minutes*, p.10; 12/3/1929, p.13.

¹⁷⁶ *Report from the Select Committee on Midwifery Registration*, 1892, p.136.

Sheffield City Council Municipal Midwifery Scheme, 1932-9

	Delivered at Home	Transferred to Hospital	Total
1932	102	5	107
1933	503	23	526
1934	674	44	718
1935	709	44	753
1936	887	59	946
1937*	Jan-Jul 687 Jul-Dec 795 midwife Jul-Dec 254 maternity nurse	41 62	728 1230
1938	2380 midwife 903 maternity nurse	115 midwife 31 maternity nurse	3283 home 146 hospital
1939	2126 midwife 966 maternity nurse	90 midwife 60 maternity nurse	3092 home 150 hospital

*The 1936 Midwives Act, providing for a municipal service, came into effect on 30/7/37, with 36 municipal midwives in Sheffield. A midwife could also be booked as a maternity nurse by a woman employing a private doctor for the delivery.

Table 5.14

Source: MOH Reports, Sheffield.

Birmingham Corporation gave £2000 p/a, and Leeds covered the cost of half the available beds¹⁷⁷.

In Sheffield, the Council made provision for extra beds across the City in 1930s. In 1934, when MMR was still very high, there were 165 beds with plans to extend this to 250; this compared to the provision of 440 beds in Liverpool, and suggested financial constraints were limiting development in Sheffield, as enthusiasm for beds was always high¹⁷⁸. As there were 7500 total births in the City that year the hospital beds available would only have provided for one quarter of them. The Council also instigated a domiciliary midwifery service in 1932, in an attempt to keep women out of hospital, for reasons of cost, and due to the lack of beds. The scheme started four years before the introduction of the Midwives Act which required such action, although Sheffield was by no means the first area in the County to set up such a scheme; Bradford had 7 municipal midwives out of a total of 69 in 1932, and Barnsley had one out of 38¹⁷⁹. The initial scheme in Sheffield was limited to the provision of domiciliary midwifery to economically needy, but medically normal cases, in order to relieve pressure on hospital maternity beds. The scheme was extended after the introduction of a salaried midwifery service under the 1936 Midwives Act. Although many areas contracted out the service to other groups, such as the Queen Victoria Jubilee Nursing Association, in Sheffield the City Council were the direct employers of all but the three district midwives retained by the Jessop. *Table 5.14* illustrates the development of local authority midwifery, and the continued use of home deliveries.

It is impossible to judge the relative safety of home and hospital deliveries as there are no statistics. Local authority hospital deaths, which are detailed in MOH Reports included booked and emergency cases as well as transfers from home, which perhaps artificially inflated their death rates. However, the growing perception that hospitals were safer than home deliveries was at least as important as the statistics themselves, and was vital in changing the culture of birth. A local meeting of Labour women in Sheffield argued that 'maternity work was a specialised branch of the health service, and should not be placed in the charge of doctors who had not had special training and qualification'.¹⁸⁰ This suggests that women were actively

¹⁷⁷ EM Smith, 'The Role of the Maternity Hospital in Public Health Work', *Public Health*, 34, 1921, 69–72; Heagerty, *The Struggle for British Midwifery*, p.157.

¹⁷⁸ Bell, *Maternal Mortality in Liverpool*, p.333.

¹⁷⁹ JM Campbell, ID Cameron, and DM Jones, *High Maternal Mortality in Certain Areas*, London, 1932, p.25–28.

¹⁸⁰ *ST* 17/5/1935, p.4.

Place of Delivery and Attendant in Sheffield (absolute figures), 1935-39

	Attendance at home				Institutional Deliveries			
	Total Births	Doctor	Midwife	Total Home	Municipal Hospital	Jessop	Maternity Home	Total Hospital
1935	7985	2458	2780	5238	n/a	n/a	n/a	2747
1936	8344	2508	2852	5360	n/a	n/a	n/a	2984
1937	8639	2207	2910	5117	2091	1074	357	3522
1938	8843	2203	3104	5307	1956	1210	370	3536
1939	8598	1886	2904	4790	2242	1175	391	3808

Place of Delivery and Attendant in Sheffield (as a % of total births), 1935-39

	Attendance at home				Institutional Deliveries			
	Total Births	Doctor	Midwife	Total Home	Municipal Hospital	Jessop	Maternity Home	Total Hospital
1935	100.0	30.8	34.8	65.6	n/a	13.5	n/a	34.4
1936	100.0	30.1	34.2	64.2	n/a	12.3	n/a	35.8
1937	100.0	25.5	33.7	59.2	24.2	12.4	4.1	40.8
1938	100.0	24.9	35.1	60.0	22.1	13.7	4.2	40.0
1939	100.0	21.9	33.8	55.7	26.1	13.7	4.5	44.3

Table 5.15

Source: MOH Reports, Sheffield.

agreeing with a medical model of childbirth, and contributed to the gradual concentration of maternity services in the hands of obstetricians.

Table 5.15 illustrates the gradual incursion of hospital practice into birth. The figure of 40% for total hospital births in Sheffield in 1938 compares with that of 35% nationally, suggesting that the City was by this time a little above average in its level of provision¹⁸¹. However, the development of the domiciliary midwifery scheme appears to have safeguarded at least a certain level of home births. Midwives had an average of 33 cases each in 1935; 39 in 1936; 45 in 1937; 49 in 1938; and 46 in 1939. It was GP deliveries which were most badly hit by the competition, perhaps not surprising given their supposed responsibility for incompetence and intervention, and consequent high mortality. Sheffield does not appear to have been particularly anti-GP in its attitude, with most blame for MMR being placed on the abortionist by newspapers and politicians, but national perceptions obviously had an effect. Perhaps not surprising given the relatively small size of the middle class in Sheffield, private maternity homes do not appear to have succeeded in obtaining the custom of those seeking a different service to that offered by GP's.

5.5: Conclusion:

The problems and policies surrounding maternal mortality and the wider issues of maternity services demonstrated the impact of pragmatic, piecemeal local authority led policies. All sides in the maternal mortality debate in Sheffield agreed on its basic features, and also that the solution lay in better provision of care; there was remarkably little discussion of wider social economic factors. This could in part be due to the failure of the Health Department to canvas these wider issues as it had been prepared to do with infant welfare, and in preference to concentrate on the development of its institutions. The centrality of the issue of abortion to MMR in Sheffield does appear to have been significant, both in fact and in perception. The reasons behind its changing impact will be considered in the next chapter.

In opposition to the beliefs of many feminist writers in the importance and durability of a shared, particularly working class, female culture of birth, the evidence for Sheffield, backed up by other material, suggests that this overstates the case. Practitioners, in the form of midwives, and mothers themselves were disunited and made little common cause. As with infant

¹⁸¹ C Webster, *The Health Services Since the War, Volume 1, Problems of Health Care: The National Health Service Before 1957*, London, 1988, p.7

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6: 'The subject is a somewhat delicate one': Contraception and Abortion.

6.1: Introduction:

This chapter will look at what for women was often their initial contact with the state of maternity, but was the last area to be tackled by either the state or voluntary agencies.

The nature of the evidence for the practice of birth control in Sheffield as in other places, either through abortion, or through contraception is very sketchy and impressionistic; emphasising how private the subject was. It is evident that the birth rate in Sheffield was declining across all classes by the early twentieth century, but the mechanics of the process and the motives behind it are almost impossible to elucidate. It does seem likely, however, that for working class women in Sheffield, abortion was one of the major methods of birth control. Contemporaries believed that it became more prevalent in the inter war years.

The involvement of outside agencies, beyond the abortionists and the suppliers of patent medicines, came late in comparison to the development of other services. This demonstrates the ambivalence of middle class groups towards the use of birth control, and of the dissemination of its tenets to working class families. The Council in Sheffield appears to have approached the problem along the pragmatic, if extremely restricted, lines suggested by the Ministry of Health in its Memo of 1931 which tacitly approved of Council supplied contraceptive advice on strictly medical grounds. The criteria for attendance do, however, appear to have been widening by the end of the period.

The voluntary group principally involved in the supply of contraception could not take the need for their service, and the rationale behind its provision, as relatively uncontentious, as providers of services such as welfare services for babies had been able to do. Instead they relied on a strong theoretical backing for their beliefs, and demonstrated the greatest support for eugenic theories seen in the maternal and child welfare services in Sheffield. They were helped, however, by the practical situation in Sheffield in the 1920s and 1930s; a rising maternal mortality rate (MMR) which many contemporaries believed to be due to rising rates of abortion. The prolonged economic slump would have also helped to engender pragmatic support for women who were struggling, with poor health and low incomes, to bring up large families.

As in all these topics, the question of the views and practises of mothers themselves is of vital importance; but has the patchiest evidence, and

welfare, there appears to have been considerable demand for advice and assistance, with clinics being heavily supported. Over the hospitalisation of childbirth, women made demands for beds, drugs and expertise to which local authorities and hospitals had to respond. These factors all tend to suggest that women in Sheffield were not forced into hospital delivery through lack of alternatives or through the destruction of their rituals. In the inter war years belief in the relative safety of hospitals was undoubtedly a contributory factor, but positive reasons such as economy and the opportunity for rest were probably also significant.

is hardest to draw out. It seems likely that traditional working class methods of birth control, including withdrawal and abortion, continued to be widely practised. The use of patent medicines for procuring abortion does not appear to have been very prevalent in Sheffield; perhaps reflecting the class bias of the City and the relative expense of these types of products. Other traditional methods of self-abortion appear to have been current; including the use of diachylon, a lead based plaster.

It is obvious that the spread of 'scientific' contraception in the form of caps fitted and dispensed by the Sheffield Women's Welfare Clinic (SWWC) and the Council touched very few women in the City. The reasons for this are again difficult to draw out but must have included cost, practicality, and shyness. The social structure of Sheffield may also have been a factor; it was a strongly patriarchal City and women perhaps did not have the power within the family to allow for contraceptive use.

The use of birth control, although practised as evidenced by the fertility decline in Sheffield, demonstrated the most complete polarity between working class mothers and the potential providers of services. There was far less common ground between them, in terms of method if not motivation, than over issues of child welfare, or even birth. However, there is some evidence that by the end of the period the use of 'scientific' contraception was becoming more popular for planning families from the beginning, on the middle class model, rather than just for spacing or stopping.

Local evidence for this chapter will be drawn from several sources; the most complete of which are the official records of the City's health department, in particular the Annual Reports of the MOH, and the archives of the SWWC. The major drawback with both of these sources, especially that of the SWWC, is that they are very one sided and are propagating a particular point of view about birth control. In effect this means that they are anti-abortion, and pro-scientific contraception, which is emphasised as a solution. The impact of both these sources on the lives of working class women has to be judged with caution. Local evidence has also been taken from newspaper reports, and discussion of the area in national reports such as work by Dr Janet Campbell, the Medical Officer for maternal and child welfare at the Ministry of Health in the inter-war years.

The local situation has to be set in the context of national discussions and developments on the issues of abortion and birth control. This will be done through the use of national reports, medical journals, and other contemporary literature.

Annual birth rate, Sheffield, England and Wales, 1871-1940

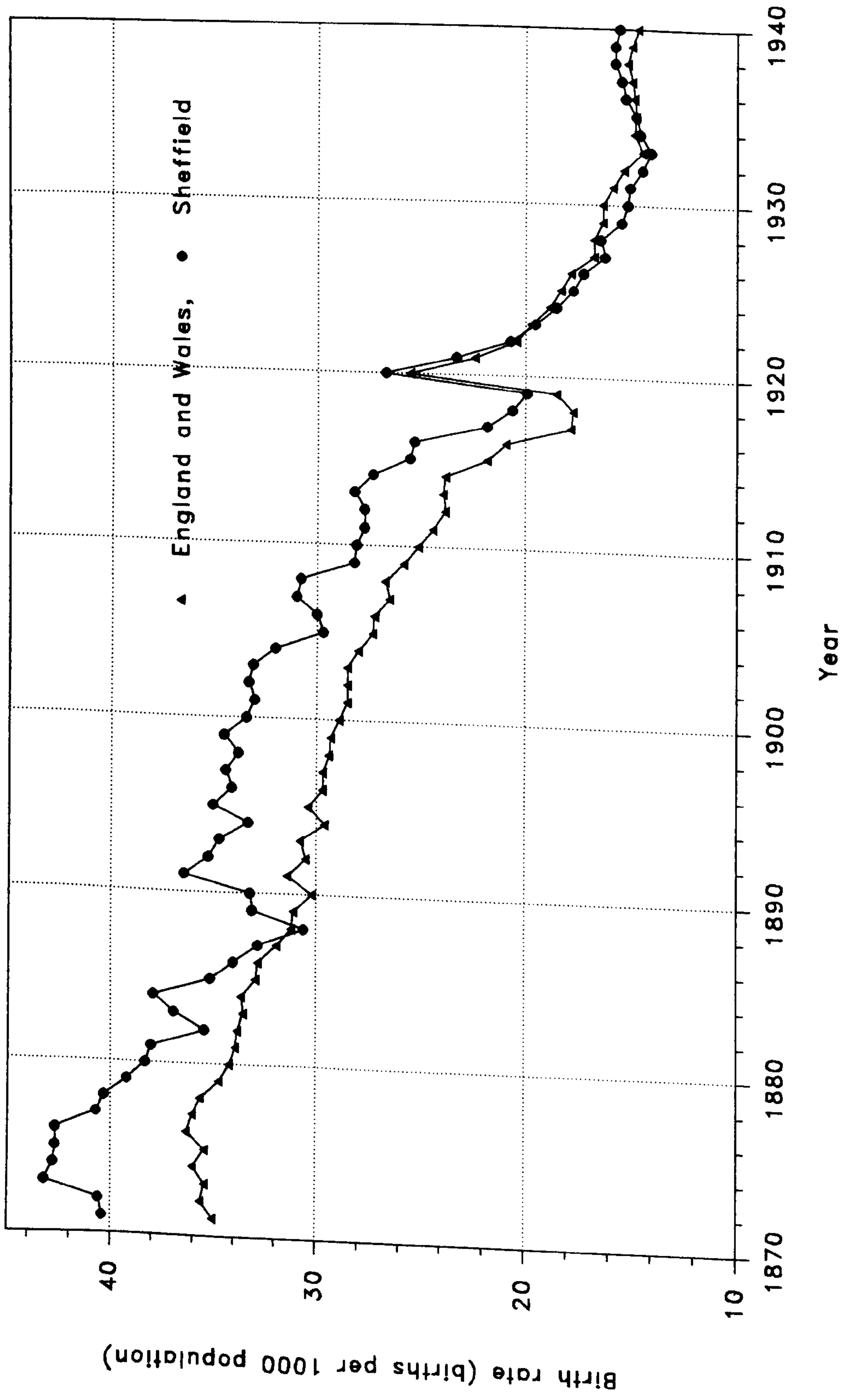


Figure 6.1

Source: MOH Reports, Sheffield

Corroborative evidence will be taken from collections of material which at least give some voice to women as potential users of birth control, and have been used as source material in earlier chapters. These include collections of letters to Marie Stopes and the Women's Co-operative Guild, and oral evidence found in books by Roberts, Gittins and Humphries and Gordon¹. Although there are limitations with such evidence, it does at least provide an illustration of the attitude of individuals towards birth control.

6.2: The Declining Birth Rate:

The birth rate in Sheffield was above that of the English average for the first half of the period. As *Figure 6.1* shows, there was a dip in Sheffield's rate for 1888, caused by the small pox epidemic of 1887/88, but although it closely followed the English rate after the 1914–18 war, it did not dip below it until the 1930s.

It was believed that trade and the birth rate were closely linked in Sheffield; the MOH compiled a graph for Elderton's survey of the English birth-rate which compared dividends paid by several leading Sheffield heavy trades, with the marriage rate. Both peaked 1873, and dropped away at the same rate². Successive MO'sH, together with other local commentators, worried along national lines over the falling birth rate, although in fact the decline did not accelerate in Sheffield until after about 1900.

The natural result of an increase in the marriage rate in former years was an increase in the birth rate. It is, unfortunately, too obvious that unnatural causes are at work. The registered deaths in England and Wales from premature births are increasing, so also are those from abortion and miscarriage.³

In 1900 the MOH suggested that the issue of the declining birth rate '...is one of the greatest importance to us as a colonising nation, and is far more than of mere local interest.'⁴ However in 1895; Sheffield still had the 4th highest birth

¹ E Roberts, *A Woman's Place: An Oral History of Working Class Women, 1890–1940*, London, 1984; ML Davies, ed., *Maternity: Letters from Working Women*, 1915, reprinted, London, 1978; D Gittins, *Fair Sex: Family Size and Structure, 1900–1939*, London, 1982; S Humphries and P Gordon, *A Labour of Love: The Experience of Parenthood in Britain 1900–1950*, London, 1993; R Hall, *Dear Dr Stopes: Sex in the 1920's*, London, 1978.

² EM Elderton, *Report on the English Birth-rate; part 1 England North of the Humber*, London, 1914, p.12.

³ *MOH Report*, Sheffield, 1898, p.10.

⁴ *MOH Report*, Sheffield, 1900, p.16.

Annual birth rate, England and Wales, Sheffield and districts, 1885-1934

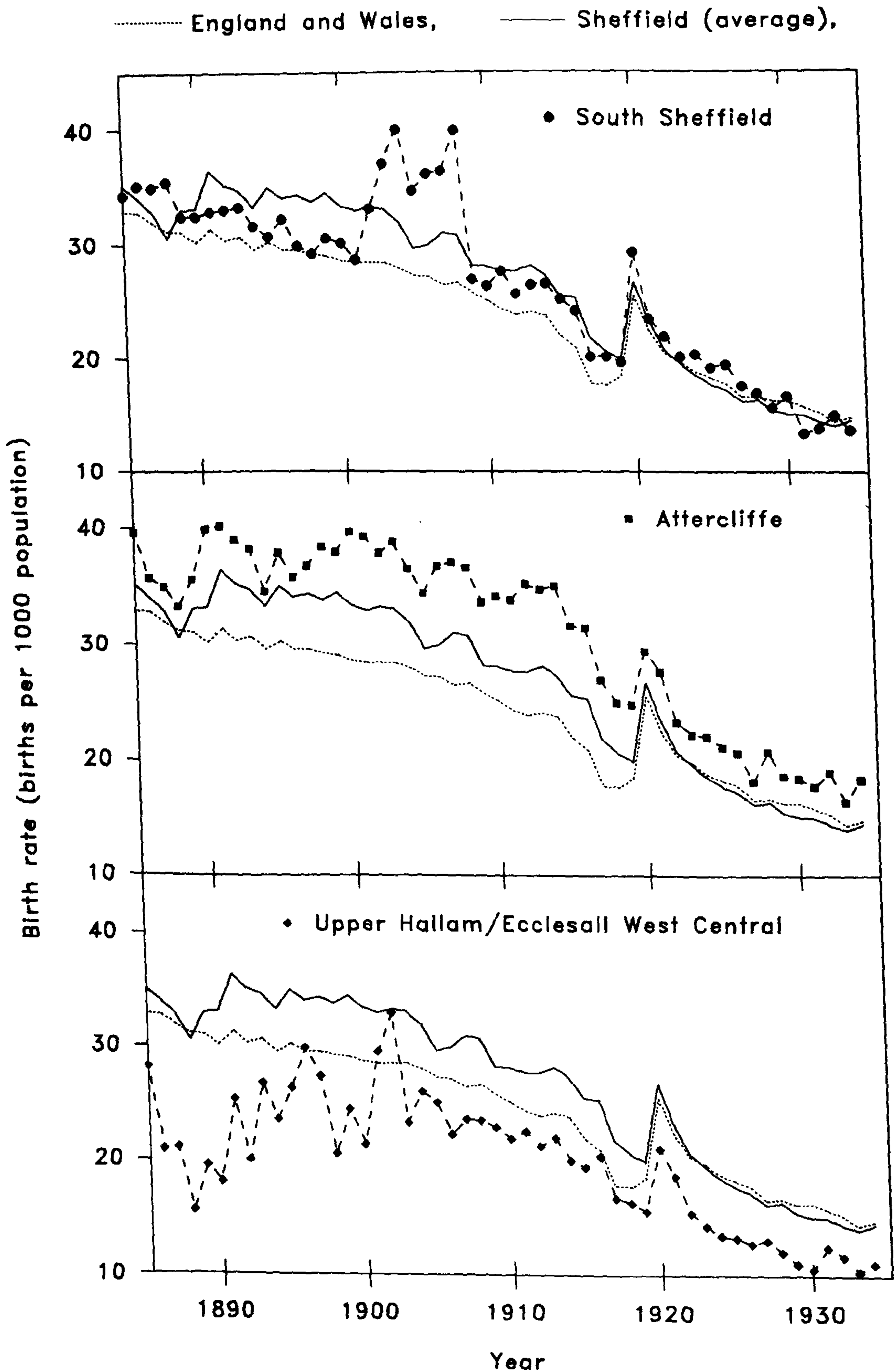


Figure 6.2

Source: MOH Reports, Sheffield

rate of 33 great towns; exceeded only by Liverpool, Salford, Wolverhampton and Sunderland, all equally heavily working class areas⁵.

The fall in the birth rate in Sheffield was precipitous once it started, with the birth rate falling by a half from 30‰ population to 15‰ in the 25 years between 1905 and 1930. During the initial stages of the decline in particular rates did vary across the City, suggesting that more affluent areas such as Upper Hallam, with a rate dropping below 20‰ as early as 1889 (excluding the unusual features of 1888) were exhibiting a much stronger decline than working class areas such as South Sheffield which had a rate of 40‰ as late as 1904. The situation in Sheffield was complicated by the presence of relatively affluent working class areas such as Attercliffe which did not start to show a significant decline until after 1915. *Figure 6.2* illustrates the differing experiences of areas in Sheffield. South Sheffield closely followed the Sheffield average, apart from a period of increase between 1902 and 1908, the reasons for which are unclear. The rate for Attercliffe, by contrast, was always quite high in comparison to other areas, perhaps attesting to the age and income profile of the skilled heavy trades, including mining. Upper Hallam/ Ecclesall West Central did illustrate the concern over the birth rate in professional middle class areas. By the end of the 1914–18 war, if not earlier, it was evident that even in a city like Sheffield, differential fertility was no longer a major factor, although total fertility decline continued to be so.

Eugenic fears of being swamped by the working classes do not appear to have been widely prevalent in the area, perhaps because Sheffield did not have a large 'residuum'; the area with the highest birth rates consisted of well paid, skilled workers⁶. Szreter has drawn attention to the importance of regional and occupational differences in the make-up of fertility levels, and the impact of any 'fertility transition'. He has argued that high fertility was prevalent in areas of secure, well paid employment. In contrast, the self-employed seem to have been those with the lowest fertility⁷. Data for Sheffield agrees with this pattern; fertility was lower in the areas populated by the light trades and the 'little masters', such as South Sheffield than in the heavy trades areas such as Attercliffe.

⁵ *MOH Report*, Sheffield, 1895, p.8.

⁶ For the fears of the middle classes see Soloway, *Birth Control and the Population Question*, p.25–48.

⁷ S Szreter, *Fertility, Class and Gender in Britain, 1860–1940*, Cambridge, 1996, p.360.

6.3: The Control of Fertility by Women up to 1920:

The fertility decline in England generally dated from about the 1870s, but the decisive break in the subject of birth control occurred in the inter war period when discussion became far more general, and more accommodating. In reading the work of Stopes and other polemical supporters of 'scientific' birth control, it is possible to believe that birth control did not in fact occur before 1921; at least not among the working classes. However, although the 1920s did see the development of the first birth control clinics, and prolonged discussion on its merits or demerits from the point of view of the individual as well as the State, for many women the break with pre-war practise was probably not actually that great. Motivation to control family size might have changed, but the methods practised are likely to have remained largely consistent.

Statistics collected by birth control clinics give an idea of the prevalence of attempted family limitation. Himes found that 62% of patients at a Liverpool clinic in 1928 had stated that they had previously used contraception. Two years later the Cambridge clinic found that 72% reported prior use⁸. Of the new patients seen in the first year of operation for the Sheffield clinic, the vast majority had practised withdrawal (293), with the next most popular method being the sheath (50), with 20 people using pessaries, 3 douching, 2 abstaining, and 20 using no method at all⁹. The Clinic's doctor concluded that:

This suggests that this Clinic is not putting a dangerous weapon into the hands of parents who had never thought of Birth Control, but rather that it is giving them a scientific solution to a problem they are already wrestling with.¹⁰

Although dating from the inter-war period, the evidence of Mary Hardie highlights a situation which was likely to have been current before the first world war. She hated the pain of childbirth, and wanted no more children after her first; she and her husband abstained for 7½ years, apart from a couple of tries with withdrawal. Finally she asked the advice of other mothers at the doctor's surgery and was told to use French letters. This couple were probably typical in their mixed use of condom, withdrawal and abstention; all

⁸ NE Himes, *Medical History of Contraception*, (first published 1936), New York, 1970, p.336.

⁹ Szreter has suggested that abstention was probably the most prevalent method of contraception, at least for spacing, but was under-represented in contemporary surveys as it was not considered to be a 'method'; Szreter, *Fertility, Class and Gender in Britain*, p.393-413.

¹⁰ SWWC *Annual Report 1933-34*, p.5.

available without resort to clinics¹¹. In 1949, Lewis–Fanning found that although only 15% of those married before 1910 ever used contraception, this had risen to 58% for the 1920–24 cohort and up to 66% by 1935–39. The biggest jump in recorded use was between 1919–24 suggesting that the First World War did perhaps have a significant impact on attitudes. However, even in 1924, only 31% of women using contraception used barrier methods, rising to 47% by 1934¹². Since these included condoms, they illustrate the slow take–up of the cap and the continued reliance on other methods.

Probably the most significant change in the perception of birth control which occurred in the inter–war years was the deliberate separation of contraception and abortion. Before this period no major distinction was drawn between what were both methods of birth control. In 1898 *The Lancet* carried a series of articles on the sale of patent medicines which it suggested were intended primarily to procure abortion. The mixtures which it investigated and analysed all appear to have been quite expensive, ranging up to 22/–, although one at 7½d was obviously aimed at the lower end of the market. The reports drew attention to the extreme ineffectiveness of most preparations¹³. As *The Lancet* found in 1898 adverts for patent medicines designed to cure women's problems, made no real distinction between abortion and birth control. One catalogue included:

Soluble Pessaries (wife's use),
Rubber Preventatives (husband's use)
Preventative Pessaries (wife's use).¹⁴

Additionally many of the adverts which *The Lancet* investigated suggested that their potions should be taken every month. One suggested that their pills should be taken before and after sexual intercourse '...to prevent further trouble, prevention being much better than cure.'¹⁵ This implies that no rigid distinction was made between birth control at the time of intercourse, and that at the time of an expected or delayed period, by advertisers, and by implication, their customers. Delaying birth control until a missed period

¹¹ They eventually had 7 children; Humphries and Gordon, *Labour of Love*, p.19–22. See also C Davey, 'Birth Control in Britain During the Interwar Years: Evidence from the Stopes Correspondence', *Journal Family History*, 13, 1988, 329–345.

¹² E Lewis–Fanning, *Report on An Enquiry into Family Limitation and its Influence on Human Fertility During the Past Fifty Years*, Papers of the Royal Commission on Population, Volume 1, London, 1949, p7–8.

¹³ 'Quacks and Abortion: A Critical and Analytical Inquiry', *The Lancet*, ii, 1898, p.1571, although one did include savin; a poison which acted on the uterus contracting it; p.1652.

¹⁴ 'Quacks and Abortion', p.1571; see also, p.1724.

¹⁵ 'Quacks and Abortion', p.1652, see also p.1808.

actually occurred was, as McLaren has suggested, cheaper than contraception during sex. This view continued to prevail in the 1920s. No direct evidence in the form of newspaper advertisements has been found for the prevalence of preventative medicines in Sheffield although a local doctor found evidence of several patent medicines available in the area around 1905. 'Mrs O....'s Pills', and 'NursePills' were among those that women in his care admitted to having taken; it is not known whether these were local or more widely available preparations. These medicines contained high levels of lead, and together with together with diachylon pills were being taken in considerable quantities to produce abortion; one woman took 61 pills in one week.

Women were fearful of the consequences of using abortifacients; 'I have resorted to drugs, trying to prevent or bring about a slip. I believe I and others have caused bad health to ourselves and our children.'¹⁶ But women were often defiant about the attempts they made to abort¹⁷. Letters to Marie Stopes in particular illustrate the state of mind of these women:

The first time after being overdue a week I took, at intervals, 19 female pills and a bottle of medicine before I became poorly. Almost the same thing happened during my last period, I was 13 days overdue. My husband swears he will kill himself rather than see me suffer with child again, and I myself would prefer death first.¹⁸

The only hard evidence available on the subject of abortifacient in Sheffield concerns the use of diachylon. Diachylon was lead plaster sold in pharmacies and used domestically to treat minor skin wounds and burns; it was formed into pills which were taken orally to effect abortion. The first mention of its use as an abortifacient occurred in the *British Medical Journal (BMJ)* in 1893, when a Dr Pope discussed two cases which had occurred in Leicester. He commented that two fatal cases in as many years implied that the use of the drug was quite prevalent in the town. It has been suggested that this practice may have originated in Sheffield where in 1886 there was a major outbreak of lead poisoning due to the action of acid reservoir water on lead pipes, leading to high numbers of miscarriages, and establishing a link between lead and abortion. However, a report commissioned into the

¹⁶ Davies, *Maternity*, p.38.

¹⁷ Davies, *Maternity*, p.40 and 45.

¹⁸ R Hall, *Dear Dr Stopes*, p.44. see also p.23 and p.27. Marie Stopes was against abortion, although interestingly she does advocate self help in the form of hot baths and Epsom salts for a middle class couple, where the wife was suffering from syphilis, possibly on eugenic grounds, p.157.

incidence made no mention of the effects on pregnant women. There is also no evidence to suggest that a connection was made by women in Sheffield between diachylon and the effects of the Sheffield outbreak. In fact the use of diachylon does not appear to have reached Sheffield until 1901 or 1902. Although there was a gap after the Pope article until 1898, a steady stream thereafter pointed to its use in Bedford, Nottingham, Birmingham and up to Sheffield. The spread of information about its efficacy may well have occurred by word of mouth; evidence to Stopes and *Maternity* both indicate that was a common method for the dissemination of birth control advice.

The fact that starting at or about Leicester, it has taken twelve years to spread over an area of comparatively small dimensions – namely three or four counties, and that those counties are all adjacent to one another – suggests that it has been handed from person to person rather than by any wholesale advertisement of any particular drug in journals having a wide circulation.¹⁹

The first case history from Sheffield concerned a woman admitted to the South Yorkshire Asylum in March 1901:

Seven weeks before admission the patient imagined herself pregnant, and consulted a midwife as she did not wish to have any more children. She obtained some pills which she took daily. At the end of a fortnight she had to take to bed...²⁰

In 1905, in an article discussing 30 cases of lead poisoning in Sheffield, Dr Arthur Hall, a Physician at the Royal Hospital, attested to its increasing prevalence in the area:

...a few weeks ago I had three women in one ward at the Royal Hospital all gravely ill from this cause, and that at the same time I saw a fourth case in a neighbouring town which proved fatal, and that in none of these four cases had the medical men in charge of them any suspicion as to the true nature of the disease or of this traffic in lead as an abortifacient...²¹

The MOH confirmed that leaded water could no longer be the culprit as alkali was now added to make it safe. He provided details of 7 cases of unexplained

¹⁹ A Hall and WB Ransom, 'Plumbism from the Ingestion of Diachylon as an Abortifacient', *BMJ*, i, 1906, 428–430, p.429.

²⁰ W Wrangham, 'Acute Lead Poisoning in Women resulting from the Use of Diachylon as an Abortifacient', *BMJ*, ii, 1901, p.73.

²¹ A Hall, 'The Increasing Use of Lead as an Abortifacient; A Series of Thirty Cases of Plumbism', *BMJ*, i, 1905, 584–7, p.584.

lead poisoning between May 30th and October 1st; all women of child bearing age living in different parts of the City. Hall detailed a further 18 cases either dealt with by him at the Royal Hospital, or seen by colleagues in their districts, and a further 10 seen as outpatients. Of the 18 cases there were 11 miscarriages, 5 admitted to delayed menstruation, 1 was pregnant, and 10 admitted to the use of abortifacients.

The article gave the ages of 27 of the 30 women whose cases are discussed; the average age was 30. Of 20 cases where biographical information was given, 16 were stated to be married, 1 was stated to be single, and in 3 instances it is not clear from the material. All of the married women had children already. This confirms that abortion was not primarily used by young unmarried women, but by older married women, already bringing up families and not wishing to add to their numbers²². Case notes on one woman stated that:

JM, married woman, aged 28, was admitted on October 1st, 1904. Two children living... No information could be obtained from the patient as to taking pills, but her sister admits that she took some, and her doctor knows she was much distressed at the idea of having another child.²³

Hall and his colleague, Dr Ransom, suggested that the practice had spread primarily between mining towns, and was unknown in rural areas such as Lincolnshire. Of 200 replies received to a questionnaire sent to doctors practising within 30 miles of Sheffield, 50 claimed to have seen cases of plumbism in the previous 2 years. Dr Wrangham, who worked at the South Yorkshire Asylum in Sheffield, had noted in 1901 the difficulty in obtaining accurate statistics as only lead poisoning from industrial processes was notifiable. Hall and Ransom made similar points concerning the very secret nature of the practice:

The subject is a somewhat delicate one, which cannot easily be ventilated in the public press, or by the circulation of warning notices. Moreover there is the fear that publication might tend to spread the evil instead of reducing it.²⁴

²² C Usborne, 'Abortion in Weimar Germany: the Debate Amongst the Medical Profession', *Continuity and Change*, 5, 1990, 199–222.

²³ Hall, 'The Increasing Use of Lead as an Abortifacient', p.586.

²⁴ Hall and Ransom, 'Plumbism from the Ingestion of Diachylon as an Abortifacient', p.428.

Hall pointed to the likelihood of under reporting of the condition by women, afraid to go to their doctors, and also by doctors not wishing to breach their professional code of secrecy.

Although the article detailed only selected cases, apparently to demonstrate the extent of the spread, for Sheffield they indicate that the practise was wholly prevalent in the east of the City; specifically the 'new' steel making and mining districts, such as Attercliffe. This ties in not only with qualitative evidence about where abortion was occurring but also equates with areas which exhibited the highest MMR, which as has been shown, was believed to be related to the practice of abortion.

The involvement of midwives in the dissemination of abortion information is hinted at in several of these articles but not drawn out. The patient from Wadsley had been quoted as having consulted a midwife for her pills. A registered midwife was convicted of selling lead pills and convicted to 12 months imprisonment with hard labour in 1906²⁵. The local Conservative MP, Samuel Roberts, asked the Home Secretary about two women, Polly West and Sarah Elizabeth Carford, found guilty of supplying dangerous pills containing diachylon. The former was sentenced to 6 months with hard labour, and the latter to 12 months, possibly because she was a midwife and her situation was therefore more grave. Roberts asked the Government to schedule diachylon as a poison, but was told that this was impractical²⁶. The case of Carford was in fact a contentious one because she was 'set up' by the Council Health Department. In an attempt to check the spread of the use of diachylon, two women were sent to various addresses asking for pills with which to abort themselves, in order to ascertain how far and by whom drugs were being supplied. One of these women was in fact the daughter of a rival midwife to Carford, leading to accusations about midwives betraying each other, and low tactics by the Council²⁷.

A Government report which looked at the supply of abortifacients suggested that:

That some qualified chemists, however, do a secret traffic in abortifacients, many Medical Officers of Health bear witness. One states that diachylon is sold by chemists and druggists in bulk, and that several

²⁵ *MOH Report*, Sheffield, 1906, p.54. Reagan has suggested that linking midwives to the procurement of abortion was an effective policy aimed at discrediting midwives in the USA; LJ Reagan, 'Linking Midwives and Abortion in the Progressive Era', *Bulletin History Medicine*, 69, 1995, 569-598; for British attitudes see *BMJ*, i, 1920, p.203; *The Lancet*, i, 1920, p.268.

²⁶ *SI*, 31/10/1906.

²⁷ *ST*, 24/10/06, p.3.

keep it ready for sale in 2d packets, from which pills are made and sold by old women.²⁸

Sir Thomas Oliver, a leading doctor from Newcastle-upon-Tyne, said in 1913 that the drug had only appeared in the area in the last couple of years but in view of the fact that 'for two pence abortion can be procured' diachylon should be banned²⁹. In evidence to the National Birth Rate Commission three years later, Oliver stated that as a result of his article the sale of diachylon had been voluntarily outlawed in Newcastle. As a result of his evidence, and that of several other doctors, the Commission recommended to the Government that it should be scheduled as a poison; this was finally done in April 1917³⁰.

6.4: The Changing Debate in the Inter-War Years:

The debate over birth control was characterised in the 1920s and 1930s by two new elements; a more widespread belief in the need for contraception to be made available to working class women for their own sakes and for the sake of the nation, and the determined effort to proscribe abortion. The opening of birth control clinics with their advocacy of 'scientific' contraception carried with it the implication that working class women had not previously been using contraception, or that if they had their methods, including withdrawal or the sheath were unscientific and flawed, not to mention dangerous.

At the same time deliberate effort was put in creating a perceived split between 'good' contraception and 'bad' abortion. This campaign appears superficially to have been successful, but was clouded by two significant flaws; the continued use of 'therapeutic' abortion by the medical profession for an increasing variety of indicators, and the continued use of 'illegal' abortion by women.

Part of the problem that contraceptive campaigners had in getting take up of their services was that there were no new methods available at the beginning of the twentieth century. Vulcanisation of rubber, allowing for thinner stronger condoms, had been invented in 1843. The cap and stem IUDs, both usually described as 'pessaries', had been around for the whole of the previous century. The first birth control clinic was opened in Holland in 1882, by the Dutch Malthusian League; they prescribed what came to be known in

²⁸ *Report as to the Practice of Medicine and Surgery by Unqualified Persons in the United Kingdom*, London, 1910, cd 5422, p.14.

²⁹ T Oliver, 'Diachylon or Duty: A Call to Action', *BMJ*, ii, 1913, 1199–1200.

³⁰ J Marchant, ed, *The Declining Birth-rate: Its Causes and Effects*, for the National Birth-rate Commission, London, 1916, p.58; p.315.

Britain as 'Dutch' caps³¹. This cap, taken up and prescribed in Britain in the twentieth century had considerable drawbacks as an effective device for use in working class households. For real efficacy, it required professionally fitting, and six monthly or annual check ups. It was relatively expensive to buy and needed additional spermicide for effective protection. Finally it required cleaning after every use, and storing where it would not be punctured or damaged. As workers at the birth control clinics found, including that in Sheffield, problems of use and reliability predisposed to failure in many cases.

However, the positive side of professional examinations and equipment was that they allowed Marie Stopes and other pioneers to stress the scientific side of their work. They targeted the medical profession in their attempt to attract support for contraception; but the medicalisation of the subject perhaps put off ordinary women. The attitude of doctors to contraception was considered to be important for its chances of success; as far as working class women were concerned however, the focus on the support of doctors was perhaps misplaced. Letters to *Maternity* and to Marie Stopes suggest that generally working class women did not think highly of the assistance of doctors³². Additionally, in a City such as Sheffield where most deliveries, particularly in working class districts, were carried out by midwives, and relatively few women were covered by National Insurance apart from the maternity cover, due to low female employment rates, doctors were probably little seen and would not therefore have formed a major reference point in women's lives.

Doctors were probably not the best people from whom to seek advice in any case as they had difficulty in accepting the concept of contraception. By 1933, Sir James Young had to admit that: 'it is becoming increasingly difficult for the Medical Profession to maintain its position of passive aloofness.'³³ However, a study of *The Lancet* and the *BMJ*, two of the most widely circulated of medical papers, in the inter-war period demonstrates that birth control remained a potent and contentious issue. One aspect which seems to characterise the debate was the small number of participants; those with strong views who wished to influence others. Beyond the opinions of Scharlieb, McIlroy, Dunlop, or Sutherland, who all had their adherents, it is difficult to extract the view of the majority of doctors; although the fact that both journals came round to contraception suggests that doctors themselves,

³¹ C Wood and B Suttens, *The Fight for Acceptance: A History of Contraception*, Aylesbury, 1970, p.125-7.

³² Davies, *Maternity*, p.44, p.66-7, p.116; Hall, *Dear Dr Stopes*, p.22, p.23, p.39.

³³ *BMJ*, i, 1933, p.219.

who were already practising birth control in many cases, were changing³⁴. As letters to Marie Stopes demonstrate, doctors were not a totally homogeneous group, whatever the British Medical Association (BMA) liked to suggest; age, religion, sex, and type of patient obviously helped to shape individual views. Some of the comments in the *BMJ* do, however, give a flavour of the debate. One prevalent view was of the physical and psychological harm done by contraception, including abstinence and withdrawal³⁵. Halliday Sutherland, who won a libel case brought by Stopes after he accused her of experimenting on vulnerable working class women, wrote of '...the generally accepted clinical opinion that these practices led to physical disabilities'; these were to include sterility, and damage to the nervous system, particularly of the woman³⁶. As late as 1935, Sutherland was suggesting that the use of contraception had contributed to high MMR; 'all this tampering with the natural functions of women was a cause of the increasing mortality.'³⁷

Despite the concerns of younger doctors, such as CP Blacker, the Secretary of the Eugenics Association after 1935, who feared the medical profession being marginalised in the provision of contraception if it did not take a stand, it was lay people who were generally responsible for the first birth control clinics. In this most contentious of areas, the attitudes of central government and of local councils was also significant.

The first British clinic, opened by Marie Stopes in Holloway in 1921 took as its inscription '...motherhood should be voluntary, and guided by the best scientific knowledge available.' She did not intend that her clinic should be the first of a network of private clinics, but like the Malthusian League, who opened a London clinic in the same year, urged that:

Those who have benefited by its help are asked to hand on a knowledge of its existence to others and to create a public opinion which will force the Ministry of Health to include a similar service in Ante-natal and Welfare Centres already supported by the Government in every district.³⁸

Elizabeth Daniels, a nurse at a Maternal and Child Welfare Centre (MCWC) in Edmonton was dismissed in 1922 for giving birth control advice;

³⁴ Dr Mary Scarlieb and Dr Louise McIlroy were both anti-contraception and anti-abortion, as was Dr Halliday Sutherland who was involved in a famous libel action brought by Stopes over his accusations about her work. Dr Binnie Dunlop was a neo-Malthusian, and pro-abortion.

³⁵ *BMJ*, ii, 1921, p.93.

³⁶ *BMJ*, ii, 1921, p.169.

³⁷ *BMJ*, ii, 1935, p.1009.

³⁸ Wood and Suttens, *The Fight for Acceptance*, p.164.

the Council intimated that this was done at the behest of the Ministry of Health who insisted that the dissemination of such advice was down to individual doctors, not Council clinics³⁹.

Generally attitudes among Councillors do appear to have been quite advanced in Sheffield; perhaps due to a recognition of the problems of poor mothers in a city with high unemployment. However, the support for contraception of Labour Councillors in particular was not reflected among the people whom they represented. The first debate on the issue of birth control was in 1926 when Labour Councillor Asbury cited housing difficulties, physical strain, and lack of health provision for working class women. He was supported by Labour Councillor Mrs Cheetham, who suggested there was a class bias at work, with poor women effectively being forced to have children that they could not support physically or economically. Both called for state provision through maternity centres, not the establishment of private clinics. However, the motion was defeated, with the opposing arguments centring on the sacred nature of motherhood, and on the religious and moral dimension. Councillor Lidgett apparently commented 'At home we have nearly a football team, and I love 'em all.'⁴⁰

Apart from eugenists like Marie Stopes, much of the vocal support for birth control in the 1920s came from the political left, including Stella Browne and Dora Russell. The Labour Party conference in fact voted in favour of birth control in 1926, but the decision was ignored by the executive. In 1924, two Labour controlled Boroughs, Stepney and Battersea, were threatened by the Labour government with the loss of their exchequer grants for maternal and child welfare work if they persisted in providing contraceptive advice through clinics⁴¹. In 1923 the Women's Co-operative Guild called for the provision of birth control advice at MCWC⁴². The Workers Birth Control Group was created to press for a change of policy, but as Soloway has suggested, it was the practical demands of some of the big Labour held local Councils, such as Sheffield, which eventually forced the hand of the Government in 1931.

³⁹ Soloway, *Birth Control*, p.282. Marie Stopes disassociated herself from any support for Nurse Daniels; J Giles, *Women, Identity and Private Life in Britain, 1900-1950*, London, 1995, p.114.

⁴⁰ 'It was moved by Councillor Asbury, seconded by Councillor Mrs Cheetham "That this meeting urges the Ministry of Health to issue instruction allowing Medical Officers in charge of Maternity Centres to give information on birth control in cases which they consider warrant such information being given"; rejected: *Council Minutes*, 5/5/1926.

⁴¹ A Leathard, *The Fight for Family Planning: the Development of Family Planning Services in Britain, 1921-74*, London, 1980, p.30.

⁴² J Gaffin and D Thoms, *Caring and Sharing: the Centenary History of the Co-operative Women's Guild*, Manchester, 2nd edit., 1993, p.109.

However, in Sheffield at least, they appear to have been ahead of public opinion in doing so. The Ministry of Health Memo (no. 153 MCW) which freed local councils to give birth control advice through MCWC's did not, however, open the flood gates. Even cities such as Sheffield which had been agitating for a change in policy, maintained a very restrictive policy, although they did open a Council run clinic. Advice was only to be given to women with gynaecological problems for whom further pregnancy would be 'detrimental to health'. This criteria was broadened in 1934 (circular 1408) to include any physical or mental condition as grounds for advice. The wording was vague, with the mental clause in particular allowing Councils to interpret the guidelines quite liberally. By 1939, 282 of the 409 MCWC in the country had a policy on birth control; the majority (143) referred patients to local voluntary clinics.

The views and practises of ordinary women are, as always, hardest to pinpoint. As the next section will demonstrate, take up of 'scientific' contraception was patchy, and it is likely that women continued to rely on natural methods such as withdrawal or abstention, or on the use of sheaths or abortion. Women do appear to have desired family limitation, as evidenced by letters to Stopes and *Maternity*, but were not converted enthusiastically to the use of the cap⁴³. Jane Williams commented that;

Nothing was known about contraception. I'd heard the word 'French letter' when I was quite a grown woman, but I thought it was something you read. And the ordinary common man would never think of buying those things. Not to my knowledge, not in the part of life I lived in.⁴⁴

Although it was perhaps less contentious to discuss issues of economic or personal health as reasons for contraception, rather than the desire for more risk free sex, it does seem that pragmatic considerations were probably at the forefront of women's minds. This was in contrast to the voluntary providers of contraceptive services who stressed the importance of sex. Some feared that the provision of contraceptives would force women to have sex, but others including Stella Browne and Marie Stopes thought that women would be

⁴³ 'There appears to be much less public demand for contraceptive instruction than some suppose; propaganda attempted by a voluntary birth control association in one of the towns was a complete failure'; JM Campbell, ID Cameron, and DM Jones, *High Maternal Mortality in Certain Areas*, London, 1932, p.21.

⁴⁴ Humphries and Gordon, *Labour of Love*, p 25.

enabled to enjoy sex⁴⁵. For radicals such as these, contraception was bound up in a changing view of marriage which was no longer to be primarily a practical and economic union, but was to be based on continuous romantic love, reaffirmed by sex⁴⁶. Holtzman, and Hall have both pointed out that Stopes' views of marital ecstasy was reserved for the middle classes, whom she felt to be capable of demanding and appreciating it in their marriages; her work directed at the working classes, through *John Bull* was of a far more practical bent⁴⁷. This difference is illustrated in the correspondence which she received from different groups. Letters from working class women revolved around the mechanics of contraception, and rarely addressed the issues of pleasure or problems in sex, raised by letters from the middle classes. However, both groups do appear to have shared the belief that a marriage could be good, even if sex itself was poor. This was in opposition to the views of Stopes, Russell and others who insisted on the centrality of sex to a sustainable marriage. Ordinary women, however, were more aware of their continued economic dependence, which made separation traumatic, particularly in a heavily patriarchal town like Sheffield where female employment was limited. Additionally their views of marriage stressed partnership and friendship which were seen as equally important. The view of Lord Dawson, physician to George V, in his famous and influential speech in favour of contraception was that it was necessary in order to allow sex in marriage to be '...the physical expression of lasting affection, blended so as to form a union of body, mind and spirit.'⁴⁸ Most working class women, however, were more likely to have seen it as the chance to have fewer children.

It is hard to pinpoint what informed the views of women on family size, and determined the decision of many to have smaller families. Lewis–Fanning found that the numbers of women planning a definite number of children at marriage rose across all classes between 1910–19. However, 25% of those surveyed said that they used contraception to space an undefined amount of children and 38% said that they could not afford more children, although they

⁴⁵ For evidence of advanced contemporary views on these issues see: LA Hall, 'Disinterested Enthusiasm for Sexual Misconduct': The British Society for the Study of Sex Psychology, 1913–47', *Journal Contemporary History*, 30, 1995, 665–686.

⁴⁶ R Porter and L Hall, *The Facts of Life: the Creation of Sexual Knowledge in Britain, 1650–1950*, London, 1995, p.216–221.

⁴⁷ E Holtzman, 'The Pursuit of Married Love: Women's Attitudes Towards Sexuality and Marriage in Great Britain, 1918–39', *Journal Social History*, 16, 1982, 39–51, p.47; Hall, *Dear Dr Stopes*, p.155; C Davey, 'Birth Control in Britain During the Interwar Years: Evidence from the Stopes Correspondence', *Journal Family History*, 13, 1988, 329–345, p.335.

⁴⁸ *BMJ*, i, 1922, p.105.

might otherwise have had them⁴⁹. Faulkner has pointed to women not wishing to repeat the experience of their mothers; old or dead before their time⁵⁰. Dora Wright, who was born in 1908, one of 8 children remembered her mother:

She used to be blackleading the grate, scrubbing floors and that's how she was ill as a result of it. The doctor told her it was just sheer exhaustion. That's why she was bad all the time as she got older. She was just worn out, her general health was terrible. I think it attacked her nerves because I remember when I was in my teens she would always be ill, crying a lot and she looked so tired. But that was her life. Work and us kids.⁵¹

In deliberate response to this suffering, Dora and her husband decided that they only wanted one or two children. She did use a cap, fitted by the Marie Stopes clinic in Manchester; 'I was as pleased as punch with myself.' This example does seem to illustrate that some women at least were determined to make a decisive, and deliberate break with the reproductive experiences of their mothers. It also hints at changes in marital relationships; Dora had remembered her father as always absent, and never helping with the babies, but her evidence also stresses the joint nature of her decision, with her husband to limit her family. One woman's evidence in *Maternity* corroborates this view; she wrote that she remembered her mother, who bore 15 children, being beaten by her father, and going without food. The writer was obviously bitter that her mother died at 59, whilst her father is still living at 74. She also stressed that she and her husband jointly agreed to limit their family to one child⁵². From the other end of the situation was a woman who wrote to Stopes for birth control advice having borne 12 children to a drunken husband; she wanted the information primarily for her daughters whom she did not wish to see repeat her life⁵³. A writer to *Maternity* argued that:

...no amount of State help can help the sufferings of mothers until men are taught many things in regard to the right use of the organs of reproduction, and until he realises that the wife's body belongs to

⁴⁹ Lewis-Faning, *Report on An Enquiry into Family Limitation*, p.149; p.177.

⁵⁰ E Faulkner, ' "Powerless to Prevent Him": Attitudes of Married Working Class Women in the 1920's and the Rise of Sexual Power', *Local Population Studies*, 49, 1992, 51-61, p.56.

⁵¹ Humphries and Gordon, *Labour of Love*, p.38.

⁵² Davies, *Maternity*, p.73.

⁵³ Hall, *Dear Dr Stopes*, p.23; see p.18 and p.42 for accounts of marriage to violent and demanding husbands.



Plate 13. The Birth Control Clinic at the Central Maternal and Child Welfare Centre, c. 1935.

herself, and until the marriage relations takes a higher sense of morality and bare justice.⁵⁴

6.5: Development of Services in Sheffield:

By the mid-1930s there were two birth control clinics in Sheffield; a Council run one, and a voluntary one. Although they reached very restricted numbers of women, they probably helped to foster local debate and awareness about the possibilities of birth control.

Records for the first Council birth control clinic did not appear until 1933, two years after the publication of the Ministry of Health Memo on local authority provision (*Plate 13*). There was no explicit statement as to why the Council, or at least its Labour component, supported contraception, although reasons can be inferred. Sheffield City Council was debating the possible supply of contraceptive services from the period of the first Labour administration in 1926. In March 1930 the Council supported a resolution put to the Ministry of Health by Shoreditch Borough Council asking that public services be enabled to provide 'working class married women with reliable and private information as to methods of family limitation', and that such women should not be deterred by lack of means⁵⁵. Sheffield was suffering from high unemployment, continued poverty, and historically high MMR. Although the Council clinic was initially worked on the restricted lines set out by the Memo of the Ministry of Health, the criteria did widen during the period. Additionally, the heavy support which the Council gave to the voluntary clinic set up in Attercliffe in 1933 and not restricted by central government policy, demonstrates that it supported family limitation on grounds of economic or personal choice as well as maternal health⁵⁶. This suggests that the Council was willing to co-operate with the voluntary sector to circumvent restrictions on its own activities, allowing the Labour group to pursue its own policies indirectly. The Council was prepared to take up what remained a contentious issue, but also to ally itself with a group whose aims, if not means, were actually quite different. The volunteers associated with the Sheffield Women's Welfare Committee (SWWC), who ran the Attercliffe clinic, were the most theoretically committed of the voluntary groups who worked with mothers, and were in opposition to the more pragmatic views of the Council. The opinions

⁵⁴ Davies, *Maternity*, p.28; see also p.48-9.

⁵⁵ *Council Minutes* 5/3/1930. See also Soloway *Birth Control*, p.309; the MOH wrote to Stopes on the subject; he was a supporter of birth control.

⁵⁶ This was opposed by the Conservative group on the Council, although Asbury explicitly stated that the Clinic deserved support because of the high rate of abortion in the City: *SI*, 3/1/35, p.7.

Attendances at Sheffield MCWC for birth control, 1933–39

	new attendances	total attendances
1933	11	11
1934	10	27
1935	7	38
1936	11	32
1937	21	55
1938	32	66
1939	12	23

Table 6.1

Source: MOH Reports, Sheffield.

of Fred Wynne (MOH, 1920–29) may have been influential in initiating Council support; he was a strong advocate of contraception in the belief that it would lead to smaller and more healthy families⁵⁷.

Both groups claimed considerable success for their endeavours in propagating 'scientific' contraception among working class women in Sheffield. As this section demonstrates, however, the actual use of clinic services by women was very small. Birth control was being practised in Sheffield, but those who used the clinics were in a definite minority, and the lack of instinctive working class support is demonstrated in the failure to attract Trade Union subscriptions. The fact that the subject was still a delicate one probably played a part in this, together with the practical difficulties associated with attending a clinic and carrying out the instructions. Use in Sheffield was perhaps also held back by the nature of the society where women remained economically dependent on men. A clinic was set up in Rotherham in April 1928, but closed in November 1930 due to a lack of funds⁵⁸. Birth control lacked the instinctive support of those with money as well as the working class.

Despite this the SWWC in particular was adept at self publicity, and through newspaper articles and public meetings the possibilities of contraception were confirmed. Celebrating the small family might not necessarily encouraged women to use the cap, however, but might have redoubled their efforts to achieve a better family size through other means, including abortion.

The MCWC birth control clinic first appears in the records in 1933, when 11 patients were dealt with (*Table 6.1*). Of these 8 'received instruction and appliances', and the remaining 3 who were found to be suffering from malnutrition were sent to the City General Hospital for sterilisation. Additionally 33 ante-natal patients were sterilised for conditions ranging from contracted pelvises to TB and malnutrition; these women were pregnant and therefore the surgery which they underwent had the effect of aborting them⁵⁹. The following year saw 2 sterilisations for 'low mentality'⁶⁰.

⁵⁷ *ST*, 12/10/23, p.6.

⁵⁸ Leathard, *The Fight for Family Planning*, p.38.

⁵⁹ *MOH Report*, Sheffield, 1933, p.105.

⁶⁰ *MOH Report*, Sheffield, 1934, p.111. Chamberlain and Williams found that termination was regularly recommended for physical or psychological reasons, between 1934–46; of a sample of 88, 4 were recommended termination: G Chamberlain and AS Williams, 'Antenatal Care in South Wales, 1934–62', *Social History Medicine*, 8, 1995, 480–488, p.483. In 1932, a Dr Stacey had argued that if abortion was deemed to be necessary, it should always be accompanied by sterilisation, to prevent the issue reoccurring. This appears to have been a common view; *BMJ*, ii, 1932, p.255.

There are tentative grounds for suggesting that the type of woman presenting altered over the period, although the time scale is so short and the numbers of patients so few that it is hard to reach any firm conclusions. There are no detailed figures for 1934, but for 1935 and 1936, all of the new cases seen came on what were recognised medical grounds, including maternal and paternal cases of TB, heart problems, or gynaecological problems, including a previous Caesarean section. The following year there were 3 cases of women wishing to space pregnancies, and a further 3 who wanted relief from pregnancies in 'quick succession'. In 1938, 3 presented with over-frequency of pregnancies, and 7 with multiparity. Unfortunately with the outbreak of war no figures are available for 1939.

The MCWC was restricted in its reach by the rules laid down by the Minister of Health. However, this was circumvented through the support of the Council for the voluntary initiative, which faced no such restrictions. It leased the Attercliffe Vestry Hall to the SWWC free of charge, and also provided heat, light and care-taking⁶¹. In addition they voted an annual grant of £50 to the Clinic; the first authority in the Country to do so⁶². This suggests that the encroachment of central government rules on local government, tied up with supplies of grants for services provided, limited local scope for direct action. However, the use of the voluntary sector, and the leverage gained through the provision of premises and grants, allowed the Council to carry out its plans, although necessarily in a more hands off way.

Action by volunteer groups to start a birth control clinic in Sheffield was in fact relatively late. The first provincial clinic had opened in Wolverhampton in May 1925, although total numbers started remained low until the 1930s as groups preferred to campaign for municipal services⁶³. As late as 1932 Campbell had suggested of Sheffield that: 'There is said to be little knowledge of effective contraceptive methods and there has been no demand for the setting up of a birth control clinic.'⁶⁴ The first clinic opened in October 1933, under the umbrella of the National Birth Control Association (Family Planning Association after 1939), which had been formed in 1930, and founded a local branch in May 1933. It initially operated on one evening per week, although an afternoon clinic was later added. A branch clinic was opened at Heeley in

⁶¹ The SWWC had originally wanted to use the premises of the MCWC, but this had been refused; *Sheffield Branch of NBCA, minutes*.

⁶² Later raised to £75; SWWC, *Annual report, 1937-38*.

⁶³ Leathard, *The Fight for Family Planning*, p.31.

⁶⁴ JM Campbell, ID Cameron, and DM Jones, *High Maternal Mortality in Certain Areas*, London, 1932, p.42.

1939. By 1938 the NBCA had set up 66 clinics across the country as a reaction to what its members felt was a failure by the State, at national and local level, effectively to address the issue of contraceptive supply. SWWC said 'Some of us look forward to the day when following the example of the Maternal and Child Welfare Clinics...the work of the Voluntary Birth Control Clinics will be taken over and recognised as part of the General Health Services of the Country.'⁶⁵ Given the considerable backing of Sheffield City Council, this did not seem such an unlikely prospect, at least locally.

Undertaking contraceptive work remained contentious in a city like Sheffield, and the people who started the work were solid middle class people who could cope with possible controversy. The Honorary Secretary was Mrs Basil Doncaster (wife of the owner of a large steel making firm), the Financial Secretary was Mrs Maurice Cole (wife of the owner of local department store), and the Councillors involved came from each side of the political divide; two Labour (Mr Asbury and Mrs Cummings), and one Conservative (Mrs Baker). Although mostly women; three of the original committee were men (1 Councillor, and 2 husbands of women on the Committee) Only married women were ever associated with the Clinic; it was not suitable work for a single woman, and there is no evidence that any tried to get involved. The aim of the group, as attested to in their Annual Report was:

To make available for all married people sound medical advice to help them not only to space their children so as to give both children and mother the best chance, but also to remove the fear and tragedy of unwanted pregnancies.⁶⁶

The first Annual Report gave explicit reasons for starting the Clinic, for the health of the mother and child:

...especially is this true in an area such as Sheffield, where so many heads of families have been faced with continued unemployment, and where, moreover, the figures for maternal mortality and septic abortion are abnormally high.⁶⁷

In addition to support from the Council, finance came from the Women's Co-operative Guild, together with individual subscriptions ranging from 6d to £3. However when in 1937, the SWWC asked for annual contributions of 1d from each Trades Unionist in Sheffield, only £4/5/- was

⁶⁵ SWWC, *Annual report, 1933-34*, p.4.

⁶⁶ SWWC *Annual Report 1937-38*, p.1.

⁶⁷ SWWC, *Annual report, 1933-34*, p.3.

actually raised⁶⁸. This was despite the Sheffield Trades and Labour Council, which represented over 35,000 workers in Sheffield, pledging their 'official support' for the Clinic, and demonstrated the ambivalence felt towards the provision of contraception⁶⁹. The difficult economic situation of the time probably did little to improve matters.

The nature of the subject caused problems with others sections of the community as well. Local papers initially refused to carry advertisements or information for the clinic. The Catholic church was deeply opposed to any scheme, and initially held demonstrations outside the Clinic to try and prevent Catholic women from entering⁷⁰. Perhaps more significant for the impact of the Clinic in terms of respectability and financial support was the antipathy of local doctors, who when requested to support the clinic in 1934, replied that they followed the national policy of the BMA, and '...did not wish to associate themselves with the society in any way.'⁷¹ At a public meeting held in 1936, Dr Helena Wright, doctor to the North Kensington clinic, voiced the often repeated complaint that; 'Many patients tell us that their own Doctors have told them not to have any more children, but have not instructed them on how to do this.'⁷² The SWWC itself argued in 1938 that, given the scattered provision of birth control clinics, family doctors were the people that married couples should be able to approach for advice. However, local doctors in general appear to have shown indifference to the work of the Clinic; a meeting to which 2000 doctors were invited attracted only 50, most of whom were medical students. Significant local support did come from Dr Miles Phillips, a consultant based at the Jessop Hospital, who visited the Attercliffe Clinic in its first year and agreed to send senior medical students to train there⁷³. The 'scientific' aspect of birth control was also stressed by the SWWC in advertisements, articles and speeches. However, the overwhelming failure of doctors in Sheffield to support the clinics must have been a blow for those committed to 'scientific' birth control, and determined to make it more medical in approach.

Mrs Donald Wilson, the Chair at the inaugural meeting of the Sheffield group spoke of '...the great opportunity for spiritual progress which knowledge

⁶⁸ *SI*, 6/7/1937; SWWC, *Annual report, 1937-38*.

⁶⁹ *SI*, 7/7/1937.

⁷⁰ J McCrindle and R Betterton, *Interview with Mrs Cunnington on the Sheffield Women's Welfare Clinic*, 1st November 1981; (see *Appendix 3*).

⁷¹ *Minutes of Sheffield Division of the BMA*, 12/1/1934.

⁷² SWWC *Annual Report 1937-38*; see also Hall, *Dear Dr Stopes*, p.39-41.

⁷³ A measure of his personal support came in his offer to pay for the special lighting which he suggested the examination cubicles required; *Sheffield Branch of NBCA, minutes*.

of the means for voluntary parenthood, by the use of scientific contraception, has brought to the race...'⁷⁴ The theoretical underpinning behind the work of those principally involved in the SWWC took two main forms; their belief in the importance of sex in a healthy marriage, and, although less explicitly stated, their support of eugenic ideas. These were allied to a pragmatic view of the difficulties faced by women in poor economic circumstances. They also stressed the psychological role of sex in cementing a marriage. It was suggested that:

Combined with love in marriage the sex function has two distinctly different purposes. One is for the continuation of the race, and the other is for the necessary and physical expression of love, resting in mutual peace and serenity.

How can these two different purposes be reconciled in the formation of that ideal unit, a happy family? Leading doctors and psychologists think that it can only be done by the application of the modern humanitarian science of birth control, or contraception.⁷⁵

Responsible parenthood was an important aspect of their ideas. Of the patients attending the Clinic in its first five weeks, the Clinic doctor '...formed the opinion that most of the women were really happy in their married life and that they and their husbands had a sense of parental responsibility.'⁷⁶

Some time ago a new visitor to the Clinic looked at the photographs of helpers' children on the wall with a puzzled expression, and then said, "Oh, I didn't think you'd have children if you worked here." And because many people still think of a birth control Clinic as a place where people are taught not to have children, it is as well to stress the constructive side of the work that has developed because of the demands made upon it.⁷⁷

Mrs Cunnington, the Secretary to the SWWC wrote that the '...clinic staff believed in children, and average two and a half each...Yes indeed, fewer, better babies, in healthier, happier homes, is our ideal.'⁷⁸ This encapsulated the middle class view of marriage as a loving partnership as well a particular attitude towards children. Yet pragmatic concerns were also very important. In interview, Mrs Cunnington stated that:

⁷⁴ *Sheffield Branch of NBCA, minutes.*

⁷⁵ HG Cunnington, 'The Place of Birth Control in Marriage', *S.Co-op*, 10/1936.

⁷⁶ *Sheffield Branch of NBCA, minutes.*

⁷⁷ *SWWC Annual Report 1937-38*, p.2.

⁷⁸ HG Cunnington, 'The Place of Birth Control in Marriage', *S.Co-op*, 10/1936.

Attendance Figures for SWWC, 1933-40

	1933-4	1934-5	1935-6	1936-7	1937-8	1938-9	1939-40
New patients	177	219	300	358	396	440	292
Repeat patients	-	152	n/k	480	626	747	508
Total	177	371	n/k	838	1022	1187	800

Table 6.2

Source: Annual Reports of the SWWC.

Most members of the Committee had read Marie Stopes and had access to books and information which they wanted to share...eugenics was not the primary concern of those involved in the clinic, but rather their concern was for working women who suffered with bad housing, a high abortion rate, and unemployment.⁷⁹

However, the theoretical background and language provided by eugenic beliefs were obviously of some significance to the SWWC. Mr and Mrs Cunnington were both members of the SWWC committee and of the Eugenics Society. At the AGM of the SWWC in 1938 there was a showing of two films supplied by the Eugenics Society. These were entitled 'From Generation to Generation' and purported to show the effects of hereditary on animals and humans, including the reproduction of feeble minded people. They were said to have aroused 'much interest' at the meeting⁸⁰. These ideas must have informed the attitude which clinic workers had towards the women they saw. At a conference of the NBCA held in Sheffield in 1938, Dr Margaret Owen, the doctor attached to the Sheffield Clinic, spoke of women with chronic conditions such as TB, kidney or heart disease, who should not have children at all. She thought that '...it must come about eventually that [such] women would have to voluntarily agree to sterilisation.'⁸¹

6.5a: The Take-up of Clinic Services:

The Clinic did not strike a popular chord with Sheffield women and was not taken up as child welfare and ante-natal clinics had been. The reasons for this can only be speculative, as the SWWC probably over emphasised its popularity, and there are no other real sources of information. Evidence from Humphries and Gordon etc suggests that 'scientific birth control' was too alien to working class women in terms of the way it was presented and the effort involved. The fact that it was run by middle class do-gooders perhaps with thinly veiled eugenic objectives, rather than offered by right as a Council service perhaps also made it less popular. '...most of our patients have taken a carefully considered step in coming to the Clinic...'⁸² This quote from the first Annual Report of the Clinic suggests that women attending were not casual visitors, and were perhaps not typical of their class. *Table 6.2* gives the attendance figures for the Clinic. These figures included several patients

⁷⁹ J McCrindle and R Betterton, *Interview with Mrs Cunnington on the Sheffield Women's Welfare Clinic*, 1st November 1981; (see *Appendix 3*).

⁸⁰ *Sheffield Branch of NBCA, minutes, 5th AGM, 5/5/1938.*

⁸¹ *ST*, 17/2/1938.

⁸² *SWWC Annual Report 1934-35*, p.5.

from Doncaster, Barnsley and Nottinghamshire, who were supplied by a postal service. They give no idea of the numbers attending only once, or how many women failed to get along with the prescribed methods and gave up.

Attendance has increased steadily all through the year, reaching its climax during February, when the room was several times so full, that patients, patients' babies, patients friends and helpers jostled one another in a closely packed crowd. On these evenings we began at six and went on until between ten and eleven...⁸³

This probably said more about the time it took to process each applicant, with full medical histories being taken as well as physical examinations, than the press of numbers attending. These figures obviously represent only a tiny proportion of fertile married women in Sheffield, perhaps partly because the Clinic was on the outskirts of town, in Attercliffe, and presumably served a quite limited geographical clientele, as well as for reasons of culture.

The Annual Reports gave examples of the type of women they were treating:

Patient 42, 13 pregnancies, 9 born alive, 2 stillborn, 2 miscarriages. Husband labourer.

5 Children alive out of 14 pregnancies.

Patient 7 pregnancies, including 2 miscarriages, 2 dead. Husband has fibrosis and heart disease. Patient very anaemic.

6 children; none lived more than 2 years.

9 pregnancies, including 2 miscarriages and 1 stillbirth. Husband has silicosis, "wife looked very ill"

Patient with 3 child and TB. Husband in mental hospital 2 years; suicide attempt 3 times.⁸⁴

These show that the Clinic was determined to be seen to be acting in a responsible way, assisting those who had done their duty and needed help, out of humanity. They commented that; 'To see weary ill and overburdened mothers returned to us looking healthier and happier is to know that immediate good is being done' and also stressed that; 'A restriction of sound birth control knowledge leads to unwanted children, more widespread use of quack contraceptives and an increase in illegal abortions.'⁸⁵ The indirect benefits of the Clinic were also stressed, suggesting that the SWWC felt that it's mission was a wider one than just the provision of birth control:

⁸³ SWWC *Annual Report 1934-35*, p.4.

⁸⁴ SWWC *Annual Report 1936-37*.

⁸⁵ SWWC *Annual Report 1936-37*.

Ignorance, superstition and wrong knowledge are so prevalent that the Clinic has often to act as a sex education centre and a marriage advisory bureau before it can fulfil its aim.⁸⁶

Another woman who came full of the miseries of her married life learnt so much from the friendly talk of patients in the waiting room as well as from the staff, that she now finds herself much better able to manage her husband.⁸⁷

One woman at a SWWC public meeting in Sheffield denounced the teaching of birth control as 'wicked and un-christian'. She described herself as the a 'happy healthy mother of a large family', and suggested that self control should be taught, 'without all this rubbish and expense of birth control'. But in opposition to this another mother of 18 children said, 'Only a poor mother knows what it is to be without knowledge. A mother of 14 said, 'I wish I had known something about birth control'.⁸⁸ Related to this, the clinic provided 'sound' books on marriage for loan or sale, and the provision of sex education literature also became available in City libraries for the first time⁸⁹. All these factors point again to the extreme ignorance of many women concerning their own bodies and fertility, and the desire for information as much as products. As Seccombe has postulated, this was perhaps related to increased standards of basic education among women, allowing them to turn to private sources of information such as printed material⁹⁰.

Of the new patients seen in 1936–7, 71 wanted to stop on economic grounds, and 32 wanted to space their conceptions. Only 2 newly married women were seen; both wanting to plan their families from the beginning. This appears to have been unusual at this stage; the vast majority of women presenting had already undergone several pregnancies. Women generally appear to have been controlling fertility late. One correspondent told Marie Stopes:

⁸⁶ SWWC Annual Report 1937–38.

⁸⁷ SWWC Annual Report 1933–4, p.5.

⁸⁸ *SI*, 30/4/1936. see also Davies, *Maternity*, p.59, p.61, p.89 and p.115.

⁸⁹ *SI*, 22/4/1937.

⁹⁰ W Seccombe, 'Starting to Stop: Working Class Fertility Decline in Britain', *Past and Present*, 126, 1990, 155–188.

I am 35 years of age and have up to the Present given Birth to Seven Children Six of which are living so that I do not think I am asking Advice before I have at least Done my Duty as a Woman.⁹¹

This can be seen in the number of previous pregnancies experienced by the women presenting at the SWWC. The first Clinic medical report gave the reasons for attendance stated by patients:

1. Economic limitation; would have more if circumstances changed; i.e. 'spacing'.
2. Women with 7 or more children, wanted no more children; i.e. one woman had 18 pregnancies in twenty years. 'Stopping'.
3. Medical grounds; i.e. 13 pregnancies, resulting in 1 live birth, TB, heart disease.
4. Physiological effects; "I'm always frightened to death.", "I get no pleasure out of it."
5. Sterility.

In 1937–8, the figures gave 87 'stopping', with no explicit reason, an additional 34 who wanted to stop on economic grounds, 137 'stopping' for health reasons, and 130 'spacing'. The 87 'stopping' figures therefore exclude health and financial grounds, suggesting that other factors were at work; perhaps including a concept of ideal completed family size. In the same year there were 35 newly married women, with no previous pregnancies, seeking to plan their families. These two factors represented a significant shift in the way in which women viewed their fertility; it was now seen as something over which it was possible and desirable to exert control from the outset. However, control does not appear to have extended, or to have been sanctioned, beyond the bounds of matrimony; the Clinic would not see unmarried women until the 1950s. Provision was geared to the deserving; those with large families, health problems, or suffering from economic strain. The inclusion of newly married women did show, however, that the element of choice was creeping into the domain of necessity. At a meeting on birth control held in Sheffield, a doctor from Halifax commented that:

Fifty years ago a mother of ten or twelve children was regarded as a noble woman. People thought how happy and interesting her life must be. Today the first thought of anyone on meeting a woman with ten children is "I'm glad it is not I".⁹²

⁹¹ MC Stopes, *Mother England: A Contemporary History Self-Written by Those Who Have Had No Historian*, London, 1929, p.11; letters to Marie Stopes were generally from older women, bearing out this view; Hall, *Dear Dr Stopes*, p.37, 40, 41, 44.

⁹² *SI*, 22/4/1937.

Two examples from the 1937–8 report illustrate the 'old' and 'new' behaviours:

woman, 29, married 1925, 6 children, 1935–37 had 3 abortions because couldn't support more children;

woman, 29, married 1936, birth control for 1 year then had voluntary pregnancy, now birth control again to space next pregnancy.⁹³

A major drawback in the potential success of the Clinic, and one which can be overlooked if the eulogies of workers such as Stopes are taken at face value, is that there were no simple reliable and cheap methods of contraception available. The type of contraception favoured by the clinic was the Dutch cap, together with spermicide. They also provided sheaths. Patients had to join the Association, at a cost of 1/- and pay up to 5/- for prescriptions; although attention was free to those who could not pay. In the first year of the Clinic, 25% of patients paid half or less of the cost price for their prescriptions; which as the Clinic pointed out, corresponded to the proportion of unemployed attending:

We have a few better off patients who pay more than cost price; but as most of our patients are mothers of families very near the poverty line, it should be our aim to keep the cost down, and help as many as possible.⁹⁴

On the whole our patients have paid wonderfully well, being almost always anxious to give as much as possible and coming back faithfully to wipe off their debts in small amounts.⁹⁵

Mrs Cunnington, the Secretary to the SWWC, commented that generally women did not have much knowledge of their own anatomy, and found the cap difficult to use '...with work hardened fingers.'⁹⁶ They were also afraid of losing it in their bodies, and trying to keep the whole procedure secret from their husbands. It was admitted by the SWWC that 'Whatever method of Birth Control is taught to these patients they find it difficult to apply for lack of privacy.'⁹⁷ Mrs Cunnington also commented that 'There was little discussion of sex and most women had no words to describe it. There was no

⁹³ SWWC *Annual Report 1937–8*.

⁹⁴ SWWC *Annual Report 1933–34*, p.4.

⁹⁵ SWWC *Annual Report 1934–35*, p.4.

⁹⁶ J McCrindle and R Betterton, *Interview with Mrs Cunnington on the Sheffield Women's Welfare Clinic*, 1st November 1981; (see *Appendix 3*).

⁹⁷ SWWC *Annual Report 1936–37* p.6.

acceptance of the idea that women should have pleasure from sex.' These comments do suggest that there was little equality in marriage between men and women in Sheffield, with no discussion of sex or family planning.

The Clinic suggested that no failures were reported in its first two years, apart from two women who reverted to withdrawal because the method taught was "too much trouble"⁹⁸. They both got pregnant and subsequently had to be refitted. But the Clinic would not always know about failures if people did not return; in the first two years, 555 patients visited, but only 377 made follow up visits⁹⁹. Contemporary clinic data from North Kensington found that over half of the women who attended had stopped using the diaphragm within two years; they found it difficult and complicated to use, particularly in unhelpful domestic circumstances¹⁰⁰. Similar data from the Cambridge Clinic also found a failure rate of 50%, for the same reasons, and including the poor quality of contraceptives¹⁰¹. Data from the Birmingham Clinic suggested that of 216 women advised the cap, only 171 actually tried it, of those that did, only 116 claimed that it was at all successful¹⁰².

6.6: Abortion in the Inter-War Years:

By 1930, abortion and contraception were accepted by policy makers as well as partisans, as two unrelated issues. The latter was increasingly seen as unavoidable if not wholly desirable; a view reflected in the Ministry of Health Memo which sanctioned contraception. However, it was also felt that whatever the official view, abortion rates and deaths caused by sepsis were on the increase. This was significant for the effect it had on the birth rate, but also on the highly sensitive issue of MMR. At the end of the decade came the Government's response to the issue of abortion; the Inter-departmental Committee on Abortion (known as the 'Birkett Committee', after its Chairman), created directly as a result of the 1937 Report on Maternal Mortality. The Birkett Committee made no new ethical or policy suggestions beyond attempting better to apply the law as it stood. The initiative over abortion lay

⁹⁸ SWWC *Annual Report 1934-35*, p.5.

⁹⁹ *Sheffield Branch of NBCA, minutes*, 9/10/1935; Related to this problem, Soloway has highlighted the efforts of researchers to develop a more reliable, and more fool proof contraceptive which could be used by all classes in all circumstances; RA Soloway, ' "The Perfect Contraceptive": Eugenics and Birth Control Research in Britain and America in the Interwar Years', *Journal Contemp History*, 30, 1995, 639-664, p.645-6.

¹⁰⁰ RA Soloway, ' "The Perfect Contraceptive" '.

¹⁰¹ For the work of the Cambridge Clinic, see; LS Florence, *Birth Control on Trial*, London, 1930. For examples of failed cap use see Hall, *Dear Dr Stopes*, p.35 and p.76.

¹⁰² E Charles, *The Practice of Birth Control: An Analysis of the Birth Control Experiences of Nine Hundred Women*, London, 1932, p.127-30.

outside local or national government, and rested with doctors, lay volunteer groups, and women themselves.

The central issue in the abortion debate was the fact that it remained illegal, with stiff penalties for conviction. Evidence suggested, however, that it was heavily, and possibly increasingly, practised by women, either as a form of birth control or as a response to contraceptive failure. Dorothy Thurtle, a member of the Birkett Committee, submitted a Minority Report in which she argued that:

...it is unsatisfactory for the law to be flouted with impunity; but when such a situation has arisen, it is necessary to consider whether the law is in accordance with modern thought and tendencies.¹⁰³

This response did find favour with several campaigning women's groups, including the Women's Co-operative Guild, the National Council for Women, and the National Council for Equal Citizenship; all of whom voted for a change in the law at annual conferences during the period. Support for abortion was seen partly as a question of women's rights over their bodies; not to have to have a child which they did not want. Some middle class women campaigned for the relaxation of the law through the Abortion Law Reform Association. Supporters of abortion reform included those such as Stella Browne, who were not generally in the mainstream of middle class thought. Browne supported abortion for women simply because their bodies were their own, and suggested that if reproductive control through contraception was acceptable, then abortion was simply another method.¹⁰⁴ Opinion also emphasised the high rates of MMR, which it was popularly felt were exacerbated by the incidence of septic abortions. During the debate which the Women's Co-operative Guild held at its annual conference in 1934, one delegate argued that:

In advocating the legislation of abortion, we emphatically claim to have that operation carried out by skilled members of the surgical profession. The high maternal death rate is largely reflected in the practises of quacks and by making it legal for a woman to have an abortion, it would remove the dangers that arise through the employment of quacks.¹⁰⁵

¹⁰³ HM Govt., *Report of the Inter-departmental Committee on Abortion*, London, 1939, p.143.

¹⁰⁴ FWS Browne, AM Ludovici, H Roberts, *Abortion*, London, 1935, p.31, p.38.

¹⁰⁵ Gaffin and Thoms, *Caring and Sharing*, p.107.

The difficulties which the medical profession had in dealing with the question of contraception were dwarfed by the difficulties they had with the issue of procured abortions. This was because though they all abhorred 'illegal' abortions; self performed or procured because of the wishes of the expectant mother; they demanded the right to perform 'therapeutic' abortions for mental or physical conditions which they reserved the right to determine. A comment by an obstetrician and gynaecologist, TW Eden, which suggested a more liberal view, reverberated around the pages of the *BMJ* for several years. His original comment was that:

It is an ethical question of great interest to what extent we as doctors have the right to insist that a woman shall pass through an ordeal which she is unwilling to face, even if we do not think she will sustain any permanent injury from doing so.¹⁰⁶

Dr Louise McIlroy, a strong opponent of both contraception and abortion, replied that 'no social or economic interests apart from the medical needs of the case should be taken into account'. A Dr Evers further argued that 'A patient's or her husband's reasons for getting rid of an ovum should never be accepted, as there will generally be some selfish or sinister reason undisclosed.'¹⁰⁷ It was argued that it was not just an issue affecting individual women; 'With a stationary or falling birth rate the ... prevention of abortion is today a responsibility which involves not only the welfare of the individual but also that of the family, and the State.'¹⁰⁸ '...the State must exercise control over the destruction of its future citizens.'¹⁰⁹

By the 1930s there was a feeling that doctors were themselves carrying out abortions for a far wider range of reasons than previously¹¹⁰. In 1934, a national BMA committee on the Medical Aspects of Abortion came down in favour of abortion in certain circumstances, such as after rape, incest, or when the life, or even health of the woman was threatened. However, the BMA balked at making this their official policy, although it was seen as an indication of the liberalisation of the views of the profession¹¹¹. By 1937 the basic fear of doctors about abortion had come to a head in the *BMJ*; that they would be prosecuted for performing illegal abortions, as even though they felt

¹⁰⁶ *BMJ*, ii, 1926, p.237-240.

¹⁰⁷ *BMJ*, ii, 1926, p.240-48.

¹⁰⁸ B Whitehouse, 'Abortion: Its Frequency and Importance', *BMJ*, ii, 1929, 1095-98.

¹⁰⁹ S Smith, 'Abortion: A Discussion on its Social, Legal and Ethical Aspects', *BMJ*, i, 1932, p.844.

¹¹⁰ *BMJ*, ii, 1932, p.255; p.337-41.

¹¹¹ B Brookes, *Abortion in England, 1900-67*, London, 1988, p.61.

themselves to be acting properly they were still technically on the wrong side of the law¹¹². In 1938 an obstetric consultant, Aleck Bourne allowed himself to be prosecuted for performing an abortion on a 14 year old rape victim and was acquitted. This was felt by doctors to clarify the situation and gave them greater confidence to perform abortions¹¹³.

Generally the views of women, particularly those of the working classes, were not prominent in the debates over abortion, although it was their action in continuing to use abortion which fuelled debate. The evidence suggested that for many women abortion was not a moral or medical issue, but a necessity. In it's articles on the sale of female correctives in 1898, *The Lancet* had objected to the dispassionate discussion of the removal of 'obstructions' in the adverts it studied rather than referring to the procedure as 'abortion'. However, the concept of abortion as the destruction of infant life was a value laden one used with a specific intent by many writers who were, as has been seen, attempting to separate abortion and contraception¹¹⁴. Evidence suggests that for most women, however, a missed period was caused by an 'obstruction'; the use of such language was perhaps sub-consciously designed to allow the problem to be seen as one of female health rather than a new life. Women do appear to have continued to make a distinction between abortion before and after 'quickening', that is the first perceived movements of the baby. Before about eighteen weeks of gestation, when movement can first be distinguished, 'putting yourself right' was acceptable. After this point, with the presence of a baby confirmed, attempted removal was perceived to be wrong. Given the lack of tests for pregnancy, quickening was the first unambiguous evidence of pregnancy, given that a missed period for ill nourished and harassed women was probably not necessarily a fool proof indicator. Faulkner, in her work on letters written to Marie Stopes, has found that women would try anything to abort, but if they failed they would then worry about whether they had harmed the baby¹¹⁵. A letter published in the *Maternity* collection bears this out:

The result is she begins to take drugs. I need hardly tell you the pain and suffering she goes through if the baby survives, or the shock it is to the mother when she is told their is something wrong with the baby.¹¹⁶

¹¹² Leading article 'When is Abortion Lawful?', *BMJ*, i, 1937, p.393-4.

¹¹³ Leading article, *BMJ*, ii, 1938, p.225-7.

¹¹⁴ The women interviewed by Leap and Hunter 'usually talked as though contraception and abortion were the same thing'; Leap and Hunter, *The Midwife's Tale*, p.95.

¹¹⁵ Faulkner, ' "Powerless to Prevent Him": Attitudes of Married Working Class Women in the 1920's, p.55.

¹¹⁶ Davies, *Maternity*, p.42.

Marie Stopes, no advocate of abortion, drew attention in 1929 to its incidence:

Experience at our Clinic has brought staggering facts to light. Two illustrations will suffice:—

1) That in three months I have had as many as twenty thousand requests for criminal abortion from women who did not apparently even know that it was criminal.

2) That in a given number of days one of our travelling clinics received only thirteen applications for scientific instruction in the control of conception, but *eighty* demands for criminal abortion.¹¹⁷

One of the difficulties in the debate over abortion, and its effect on MMR, centred around measurement of incidence and fatality. The Birkett Committee estimated that of c.110,000 abortions per year, 66,000 were probably spontaneous, and 44,000 procured. Abortion statistics can only really be impressionistic; an incalculable proportion of abortions, natural, self-induced or procured were never reported, and never found their way into statistics. The figures which are available probably over estimate the danger from abortion because it was generally only if things went wrong and cases were seen by doctors that they came to light. As the Birkett Committee accepted, however, with even apparently clear cut cases ending in death, cause could be impossible to attribute. They tried to make a distinction between natural and procured abortions but failed to this¹¹⁸. The report admitted that procured abortion could be made to look natural by skilled practitioners; this was borne out by a Sheffield case of abortion in 1934. Dr John Blakely was acquitted of the abortion related death of his lover, because although the doctors who examined the victim obviously believed she had taken something, there was no direct evidence that it was not natural. Dr Clark, the Medical Superintendent of the City General Hospital, admitted that it was possible for a doctor to 'procure abortion without leaving evidence'.¹¹⁹

An article on abortion cases admitted to the Derby City Hospital between 1930–37, showed the difficulties in obtaining accurate figures for procured abortions. Of the 350 cases considered, only 117 were prescribed to a definite cause; nearly 50% of these (63 cases) were natural, due to maternal disease or foetal abnormality. Of the remainder, 57 were adjudged

¹¹⁷ M Stopes, *Mother England*, p.183.

¹¹⁸ The report specified 3 different types of abortion: spontaneous, natural abortion; therapeutic, undertaken by doctors in what they believed to be the best interests of the patient; criminal abortions. *Report of the Inter-Departmental Committee on Abortion*, London, 1939, p.3; see also p.9.

¹¹⁹ *ST*, 21/3/34, p.5.

**Abortion cases treated in the Gynaecology department
of the City General Hospital, 1930–40.**

	Abortion Total	Required Surgery	Deaths
1930	318	no data	8
1931	309	243	7
1932	327	247	4
1933	280	230	5
1934	337	no data	15
1935	385	287	3
1936	461 ¹	336	7
1937	403	286	10
1938	412	306	7
1939	440	264	7
1940	379	260	0

Table 6.3

Source: MOH Reports, Sheffield.

¹ A record abortion rate for any hospital in the country; Dr Clark thought that 400 of these were procured; *SI*, 24/3/37, p.5.

'probably natural', 91 'probably procured', and a further 80, 'indefinite'.¹²⁰ For pre- and post-war patients in Birmingham, there was an estimate of 1 abortion for every 4.7 births; giving a percentage of 17.2 pregnancies which ended in abortion; figures for Glasgow were slightly lower at 12.5%¹²¹. Doris Pindar, a Registrar at the Jessop Hospital, studied 6444 gynaecological patients seen there between 1925 and 1929, and found that of 20,260 pregnancies, 3518, or 17.4% were aborted¹²².

Regarding the incidence of abortion in Sheffield, the evidence is perhaps more full than for some other areas because it was, believed locally, by the MOH and by doctors, but also nationally by commentators such as Dr Janet Campbell, Medical Officer for maternal and child welfare at the Ministry of Health, that, as the Medical-Superintendent for the City General Hospital suggested: '...not an inconsiderable proportion of the death rate of Sheffield is due to abortion.'¹²³ He also argued that: 'We have one of the highest mortality rates from abortion, if not the highest of any town in the country.'¹²⁴ Councillor Asbury said 'even if it should result in Sheffield being regarded as an abortionist City, we intend to focus public attention on this grave problem and shall continue to do so until this foul thing disappears from our midst.'¹²⁵ It was suggested that at this time, the City General Hospital had more cases of abortion than any other hospital in the country, with the Jessop Hospital second (*Table 6.3*). It was commented that; 'So long as the rate of infected abortions continues at this high level, the maternal mortality rate for the City must be abnormally high.'¹²⁶ At the Jessop Hospital there were 1341 abortions admitted in the period 1923-30; 88 in 1923, up to 268 in 1930. These figures included 49 deaths, and 18 therapeutic abortions carried out by doctors¹²⁷.

In 1925, the local branch of BMA had said that of 25 puerperal fever deaths, 11 were associated with abortion: 'puerperal fever is much more

¹²⁰ RG Cooke, 'An Analysis of 350 Cases of Abortion', *BMJ*, i, 1938, i, p.1045-7; see also TN Parish, 'A Thousand Cases of Abortion', *Journal Obstetrics and Gynaecology British Empire*, 42, 1935, 1107-1121.

¹²¹ *Report of the Inter-Departmental Committee on Abortion*, p.8. For Glasgow figures; JM Munro Kerr, *Maternal Mortality and Morbidity: A Study of Their Problems*, Edinburgh, 1933, p.129.

¹²² D Pindar, *Investigation into Abortions; Their Incidence, Causative Factors and Sequelae*, PRO MH/71/28, p.6.

¹²³ *SI*, 18/2/1937.

¹²⁴ *SI*, 18/2/1938.

¹²⁵ He was speaking at the Sheffield National Council for Women's Health Conference; *SI* 24/5/35, p.7.

¹²⁶ *MOH Report*, Sheffield, 1934, p.96.

¹²⁷ *High Maternal Mortality in Certain Areas*, p.42.

frequent in connection with abortion than it is with normal labour.'¹²⁸ The 1937 Government report into maternal mortality also made the point that high MMR in Sheffield was due to high rates of abortion¹²⁹. Abortion was not high in all areas with high levels of MMR; of 25 areas with MMR over 5‰, Bolton and Sheffield were the only places singled out as having high abortion rates¹³⁰. In England and Wales between 1927–35, abortion was estimated to account for 22.4% of deaths from puerperal sepsis; in Sheffield in 1934, abortion made up 59.6% of such deaths¹³¹. This meant that abortion deaths in Sheffield made up 39% of total MMR in the City.

Reasons for the observably high rates of abortion in Sheffield compared to other areas are impossible to draw out with any certainty. It seems that the vast majority of those aborting were working class women, and given the employment and social structure of Sheffield, perhaps abortion was the only option practical to them, given that they did not have the independence within the family to demand other forms of control. Power relations within the family can never be fully elucidated. Dr Janet Campbell commented of Sheffield in 1932 that 'It is possible that rising unemployment and consequent poverty might account for an increase in attempts to procure abortion...' Szreter has argued that abortion was not generally a feature of textile towns with high female employment because women had the power within the domestic sphere to secure the use of contraception. Abortion was, therefore, an expression of female weakness in a patriarchal society¹³². However, although the social structure of Sheffield explains its position, this reasoning cannot easily be extrapolated to other areas. Bradford, an area of high female employment also exhibited a relatively high rate of sepsis, which was believed to be linked to its abortion rate¹³³.

There was no section on MMR in the reports of the MOH until 1934, when the high levels of deaths from abortion were blamed for the high total maternal mortality rate for Sheffield; 13 of the 15 abortion deaths recorded by the City that year were due to sepsis¹³⁴. In retrospect this year proved to be a

¹²⁸ *Minutes of the Sheffield BMA*, 22/1/1926.

¹²⁹ HM Govt, *Report on an Investigation into Maternal Mortality*, Cd 5422, London, 1937, p.71.

¹³⁰ *Report on an Investigation into Maternal Mortality*, p.216.

¹³¹ Council figures; *SI*, 24/5/35, p.7.

¹³² S Szreter, *Fertility, Class and Gender in Britain, 1860–1940*, Cambridge, 1996, p.426; see also C Chinn, *They Worked All Their Lives: Women of the Urban Poor in England, 1880–1939*, Manchester, 1988, p.148.

¹³³ Campbell, Cameron, and Jones, *High Maternal Mortality in Certain Areas*, p.28; p.42.

¹³⁴ Spontaneous abortion ending in sepsis was very rare, so in practice, septic abortions were taken to equal illegal abortions.

watershed, and in the following year the numbers of septic deaths dropped dramatically. The MOH made no mention of the a possible reduction in the virulence of the *streptococcus*, or of the later use of sulphonamides in combating infection. As *Table 6.3* shows, numbers of women with abortions who presented at hospital continued to rise after 1934, but the death rate was dramatically reduced. As this began to happen before the introduction of sulphonamides, it does suggest that the natural virulence of the bacteria may have been in cyclical decline.

Both quantitative and qualitative evidence appears to support the view that it was married women with families who were resorting to abortion:

Abortion appears to be attempted almost entirely by married women on economic and social grounds, and the greater the poverty and general distress, and the greater the desire to retain employment, the greater is the temptation to avoid further pregnancies.¹³⁵

Hilda Cunningham, Secretary of the SWWC commented that:

Most abortions were carried out by women on themselves or by neighbours or relatives. There were women who also performed back-street abortions for money. Most women had tried to abort themselves at least once. Women talked freely about abortion to some of the clinic members. The clinic policy was to discourage women who were pregnant from having abortions, but agreed with it in extreme cases, e.g. of rape.¹³⁶

Councillor, Mrs Mitchell claimed that '90% of women in some time in their married life have purchased pills and other strong drugs for purposes of abortion.'¹³⁷ It was found that of 1000 abortion cases studied in Camberwell, London, the average patient age was 28.4 years. 397 of the cases had 3 or more children, 193 had 2, and 207 had 1¹³⁸. For Sheffield, Pindar found that of the 1802 total cases of abortion seen at the Jessop Hospital 1923–36, 1715 were of married women¹³⁹.

The SWWC claimed to have come across 13 cases of self-induced abortion in 1935–6. These included a 36 year old woman who had had 11 pregnancies, resulting in 9 living children; she had attempted abortion 'several

¹³⁵ Campbell, Cameron, and Jones, *High Maternal Mortality in Certain Areas*, p.19.

¹³⁶ P Dennell, *Attercliffe Clinic; a Study of a Local Initiative in the History of Birth Control, 1933–43*, unpub BA Hons Dissertation, Sheffield Polytechnic, 1989, p.44.

¹³⁷ *SI*, 24/5/35, p.7.

¹³⁸ Parish, 'A Thousand Cases of Abortion', p.1108.

¹³⁹ D Pindar, *Investigation into Abortions; Their Incidence, Causative Factors and Sequelae*, PRO MH/71/28, p.4.

times' but had only succeeded twice. A 42 year old with 8 children, and an unemployed husband '...stated that she had procured on herself anything up to 20 abortions, nearly losing her life over the last one...'140 The Committee commented on those who used abortion to try and limit their families and 'staggering amounts of money – up to two guineas a box – have been paid for dangerous pills, and even larger amounts to equally dangerous abortionists.'141 This last comment is significant, and highlights possible changes in the type of abortions attempted.

There was a belief by doctors that abortion had been increasing since the war, in particular the use of instruments, as drugs including lead became harder to obtain142. The use of drugs, particularly lead derivatives for attempted self abortion has already been discussed. Newspaper evidence suggests that these types of cases were concentrated in the early years of the century143. Later in the period the abortionist does appear to have become a more prominent figure in newspapers, possibly bearing out the suggestion that as drugs such as lead became harder to obtain, women were forced to turn more to instrumental methods144. This suggestion is necessarily very tentative, but might provide some explanation for rising MMR due to sepsis in the City. Abortions were not necessarily increasing in number but the use of instruments did carry a greater risk of septic death. In the Camberwell study it was found that abortions due to drugs had a 53% infection rate, whereas those due to instruments had a 88% infection rate145. The MOH of the rural Borough of Thurnscoe, near Sheffield, commented in 1935 that '...we are almost completely at the mercy of the abortionist.'146 In 1935 a midwife, Florence Ellen Deakin was sentenced to 10 years for conspiracy with intent to procure an illegal operation. At her trial it was commented that she first came to the attention of the police as an abortionist in 1929, but that her conviction failed:

...she has undoubtedly performed a large number of operations, both at her own home and at the homes of women who have visited her. She can properly be described as a clever professional abortionist...

140 SWWC, *Annual report, 1935-36*, p.6.

141 SWWC, *Annual report, 1937-38*, p.2.

142 *BMJ*, i, 1929, p.202-4; *BMJ*, ii, 1929, p.59.

143 *ST*, 23/3/06; 3/4/06; 24/10/06; 16/3/09; *SI*, 5/1/11.

144 *ST*, 3/1/30, p.9; *SI*, 24/3/37, p.5.

145 Parish, 'A Thousand Cases of Abortion', p.1109.

146 *SI*, 8/8/35, p.7.

It was stated that since the beginning of January 1935, 11 people had apparently been arrested on abortion charges¹⁴⁷. Chamberlain has suggested that 'the vast majority of abortionists were untrained midwives', but that they were not prosecuted because of a lack of state and professional interest in working class midwifery¹⁴⁸. Evidence concerning efforts to regulate midwives and their conduct throughout the period of this study demonstrates that this was not the case. Chamberlain offered no specific evidence for her comments about abortionists. Leap and Hunter have suggested that midwives and handywomen would not generally have been abortionists, as this would have risked their reputations, although they would have known of, and condoned the practice by their silence¹⁴⁹. However, whoever the abortionists were, the changing nature of abortion practice in Sheffield, perhaps fuelled by poverty and ideas about family size, probably gives the best guide to the high rates of MMR in Sheffield.

6.7: Conclusion:

This chapter has necessarily been the most speculative in this study, as knowledge of attitudes and behaviour surrounding abortion and contraception is so limited and incomplete. However, the evidence for Sheffield does suggest certain features. The social class split in perception and use of birth control was wider over this issue than other areas of maternity, including infant welfare and birth. This may have been partly due to the more overtly theoretical and eugenic ideas of some of the birth control campaigners, but was probably primarily to do with pragmatic differences over the practicalities of 'scientific' contraception and the acceptability or otherwise of abortion. Working class women do appear to have absorbed ideas about ideal family size, either through literature and observation, or through their own families experiences. However, in Sheffield at least they do not appear to have absorbed the middle class route to preferred family size. Falling birth rates in Sheffield suggest that reproductive behaviour was changing, at different times and rates across areas, but the motivation behind this is hard to assess and probably involved a multiplicity of factors, including unemployment, and standards of living and education.

More certain is the continued centrality of abortion as a method of birth control, and its link with MMR in the City due to the increasing use of

¹⁴⁷ *SI*, 17/5/35, p.7.

¹⁴⁸ Chamberlain, M, *Old Wives' Tales: Their History, Remedies and Spells*, London, 1981, p.116.

¹⁴⁹ Leap and Hunter, *Midwives Tale*, p.101-4.

instrumental abortions and resulting sepsis. Abortion related deaths were very high in Sheffield compared to most of the rest of the country, and it was the influence of these which gave Sheffield such a high total MMR. There is some circumstantial evidence to suggest that a decline in the natural virulence of the causative *streptococcus* resulted in the fall in abortion related deaths after 1934, together with the use, after 1936, of sulphonamide drugs. However, the total numbers of abortion cases seen in hospitals in Sheffield continued to rise throughout the period.

The chapter agrees with the conclusions of the previous chapters in that it points to the importance of policies based on pragmatic considerations; whatever the views of people such as the Cunningtons, it was issues of poverty, health, and the reputation of the City in the face of high MMR which encouraged the Council and voluntary groups to act. Again, central government was responsible for enabling statements, but did little to advance the practical cause.

7: Conclusion.

As with any area of historical study, there are as many questions, qualifications and uncertainties raised by this thesis as there are answered. Nevertheless, this wide ranging local study has been able to challenge some assumptions about the issues of maternity and welfare.

One of the general themes of this thesis has been the interaction of state and society, in particular the development of welfare policies mediated through the state. This study helps to demonstrate that in Britain action by the state was taken primarily at the level of local government. The attitude of Sheffield Council and its Health Department had a significant impact on the policies considered and implemented in the area of maternity. Sheffield was initially held back by the failure of the Council actively to support its Medical Officer of Health (MOH) and to commit resources to public health, but after c.1900 the Council did attempt to tackle some of the new welfare issues. The reasons for this change of attitude were probably due to the national stigma increasingly associated with being a 'diarrhoea town' with high infant mortality rates (IMR), and also to a growing confidence that such problems could and should be ameliorated. The revenue from utilities recently acquired by the Council, including electricity, water, and in particular the tram network, was also important in allowing new spending commitments to be made.

Issues discussed nationally, including infant mortality, were important as a spur to action, but Sheffield Council pursued its own practical initiatives rather than following instructions from central government. Local authorities generally were ahead of central government opinions and ideas on maternity welfare. Support for Maternal and Child Welfare Clinics (MCWC) and later birth control clinics, came before there was any national government commitment to such ideas. In the inter-war years this radicalism did diminish in Sheffield, probably due primarily to economic difficulties in an area which experienced high unemployment. Sheffield bears out the theory that health departments in the 1930s became bogged down in administration with the take-over of hospitals, after the break-up of the Poor Law. The MOH devoted the bulk of his time and resources to curative services rather than preventative health. This had an impact on the development of welfare policies; the solutions suggested to the problem of maternal mortality were not as radical as those for infant mortality had been twenty five years previously.

The provision of birth control was one area where Sheffield Council was ahead of national political, and also local public, opinion at this time. The Council was one of several which pressed the Ministry of Health for the right to

offer contraceptive advice, and gave significant support to the voluntary birth control clinic set up in Sheffield in the 1930s. However, neither Council or voluntary clinics were taken up with enthusiasm by Sheffield women, who continued to rely on methods other than the cap, including abortion.

The co-operation between the Council and the Sheffield Women's Welfare Committee (SWWC) over the voluntary birth control clinic, demonstrates an important facet of what Lewis has described as the 'mixed economy of welfare'¹. Although Council initiatives, including infant welfare clinics and home visiting by the Women Sanitary Inspectors (WSI's) did become significant, they did not, nor were they expected to, supersede voluntary welfare. Co-operation between the Council and other bodies, including the voluntary hospitals, was generally good in Sheffield. The most successful voluntary groups were those which were able to work closely with statutory bodies, either helping to implement policies, such as the Motherhood League, or tackling areas where the Council was by law limited in its field of action, such as the SWWC.

Both the Council and voluntary groups pursued policies that were not based on ideology but depended on pragmatism and consensus, informed by what was financially feasible. Some groups such as the Hospital Samaritan Societies retained the language of patronage, and the SWWC did use eugenic language, but generally the tone of all groups was pragmatic rather than ideological. It involved a high degree of awareness of social and environmental issues such as the effect of poor sanitation or unemployment. There was no real theoretical underpinning to any of the welfare work, which was conducted on a fairly *ad hoc* basis, and probably contributed to the success of the majority of policies. The MCWC, for example, proved adaptable in form and content, evolving from an infant milk depot into a welfare clinic in response to women's needs. Nationally or internationally developed policies were not used uncritically by local communities, but were adapted to suit local conditions. This is again illustrated by the infant milk depots which were first tried in France, but proved to be of only marginal benefit in Sheffield given the very high levels of breast-feeding occurring in the City.

Medical and welfare developments cannot be viewed in isolation, but should be seen within the context of local society. An important feature of Sheffield's society was its patriarchal nature which impacted on the experience of motherhood in the City and on the development and success of

¹ J Lewis, 'Family Provision of Health and Welfare in the Mixed Economy of Care in the Late Nineteenth and Twentieth Centuries', *Social History Medicine*, 8, 1995, 1-16.

welfare policies. Employment was primarily in the well-paid and male dominated mining and steel-making industries and opportunities for women's employment were very few, particularly after marriage. These factors weakened women's bargaining power within the domestic environment. As a reflection of this, the birth-rate in Sheffield, remained high to quite a late period in comparison with the English average. Women's choice of birth control was also affected since women in male dominated societies appear to have been less likely to use contraception, because the nature of the relationship between the couple made discussion and co-operation over the issue problematic. Despite this, the birth-rate fell fast and far with the economic difficulties of the inter-war years. The need to reduce family size led to high and rising levels of illegal abortion in the same period, since this was a method of fertility control which did not require the co-operation, or even consent, of a husband.

However, women's power, although circumscribed by the nature of Sheffield society, was far from totally lacking. The development of the Council milk depot into a wider ranging infant welfare centre, the emergence of hospitals as an option for normal childbirth, and the rejection of contraceptive clinics, were all areas where women exerted an influence. This demonstrated that they were able to affect the welfare measures they were offered, if only by making individual decisions about services to demand, reject or adapt. This is illustrated, for example, by the issue of childbirth; women were not coerced into hospital childbirth against their traditions and wishes as some writers have suggested. In reality the demand for beds outstripped the supply in Sheffield. In response, the City Council set up a municipal midwifery scheme before the statutory requirements of the 1936 Midwives Act, in order to try and encourage home births.

Changing attitudes to motherhood also had implications for women other than mothers. Sheffield was one of the first local authorities in the country to appoint municipal WSI's. Their work could be characterised as being subordinate to that of the male state, particularly through the office of the MOH. However, they exercised a considerable degree of autonomy in their work. This included a separate office and support staff, the right to testify in Court, give public lectures, and even appear before government committees. The early WSI's were instrumental in developing concepts of professionalism within the service through their involvement with professional bodies, and through the books and journals to which they contributed. The development of infant and maternal welfare work allowed them to create for themselves an area of specialised knowledge. Their work with infant welfare

was perceived to be successful in reducing the IMR before the First World War, and this informed attitudes to the desired reduction of MMR in the inter-war period.

The women who worked as midwives were not as successful in adapting to the professional model as WSI's, despite the efforts of the Midwives Institute nationally to promote midwifery as a career for middle class women. Superficially it appears that early attempts to professionalise midwifery were occurring in Sheffield; the Jessop Hospital for Women in Sheffield was among the first in the country to develop training for midwives, and was the first to pay its trainees, which it did from 1879. This pioneering role appears, however to have had little impact on the way that midwifery was practised in the City. The Jessop trained only small numbers of women, whose cases loads were not high. This was probably deliberate; the medical staff at the Jessop had no intention of creating a numerous, professional and articulate body who would compete with doctors for wealthy patients. Instead they wanted to ensure the survival of midwifery as a necessary and safe craft, but one ultimately subordinate to the medical profession. Throughout the period, midwives generally continued to be older working women, who were married or widowed part-time workers. They remained individual, independent practitioners, and there was only one short-lived attempt by a group of them in Sheffield to make common cause.

The midwifery training programme begun by the Jessop was also vital for the development of childbirth in that it required cases of 'normal' childbirth to occur in hospital, and in so doing helped to contribute to the belief that hospital was a sensible and safe place for birth to occur. The development of hospital based childbirth in the inter-war years saw the diminution of the role of the general practitioner (GP) in birth rather than that of the midwife. This reflected the increased influence of the hospital obstetrician, who championed the midwife, admittedly as an aide rather than as an independent practitioner. GP's, in contrast, were castigated for dangerous practises. Women themselves demanded 'expert' care and called for birth to be regarded as a medical speciality. Hospital childbirth reduced the independence of the midwives who worked there, but allowed for the continued practice of midwives attending home births by increasing the respectability of the whole group.

It has been seen that the development of maternity services had a wide ranging impact on many aspects of society, including women's work and the growth of state welfare. However, the majority of maternity based welfare services were designed for a very specific, and fairly easily quantifiable

purpose; the reduction of mortality rates, initially IMR, and in the inter-war years, MMR. Both IMR and MMR began falling after the introduction of targeted services; IMR from c.1902, and MMR precipitously from 1935. However, cause and effect are not easily linked. The causes of high IMR, and therefore the reasons for its reduction, are complex and it is impossible to point to any one defining factor. Sheffield's high IMR was due not to high maternal employment, or low rates of breast-feeding, both seen by many contemporaries as significant contributory factors, but was linked to poor domestic and municipal sanitation. In Sheffield IMR was accepted to be strongly associated with working class areas, particularly the inner districts which were the most over-crowded and unsanitary. Very high IMR was caused primarily by high rates of mortality from diarrhoeal diseases around 1900; Sheffield failed the 'sanitary test' caused by a run of hot dry summers². The gradual removal of privy middens, and a programme of slum clearance, would have had an effect on IMR. However, the development of services aimed at individuals and families, in the form of clinics and of home visiting was also significant in contributing to improvements in domestic hygiene, and for the propagation of assistance and advice. The success of micro policies was believed to be crucial and set the pattern for inter-war welfare schemes. It remains true, however, that whilst IMR declined absolutely across the period, it failed to decline relatively to any significant degree, with working class areas continuing to experience proportionally higher IMR than wealthy ones.

Sheffield exhibited a fairly standard urban pattern with respect to IMR. Its position as far as MMR was concerned, however, appears to have been more unusual. MMR was rising throughout the 1920s and early 1930s in Sheffield; a feature common to several other regions, principally the northern industrial areas and Wales. However, the experience of MMR in Sheffield was different from other areas in two vital respects; the types of districts in which it occurred, and its major component.

The first difference was that the City's highest MMR occurred in working class districts, not in wealthy districts as was the case in other cities such as Leeds and London. The latter two fit a pattern which has been described by Loudon as 'reversed social class mortality'.³ MMR usually occurred in wealthy areas due to poor care of the mother around birth, as a result of women

² Rl Woods, PA Watterson and JH Woodward, 'The Causes of Rapid Infant Mortality Decline in England and Wales, 1861-1921', (2 parts), *Population Studies*, 42, 1988, 343-366 (part 1), *Population Studies*, 43, 1989, 113-132 (part 2).

³ I Loudon, 'Obstetric Care, Social Class, and Maternal Mortality', 293, *BMJ*, 1986, 606-608.

employing more expensive doctors who were often ill-trained and over eager to intervene in the normal process. Women in poorer districts were more likely to have assistance from midwives who were generally more experienced, did not intervene, and were therefore often safer than doctors. In contrast, high IMR, was not considered to be affected by care at birth but was due primarily to exogenous factors including methods of feeding and sanitation. Given that high IMR was highest in poorer districts, and MMR highest in wealthy districts, the two sets of data should be negatively correlated for most cities. In Sheffield, however this was not the case. The lack of a negative correlation demonstrates that there was no simple class based difference in incidence, indicating that Loudon's theory of reversed social class mortality is perhaps not universally applicable.

The second vital respect in which Sheffield's experience of MMR was different from other areas provides the explanation for Sheffield's failure to conform to the standard class distribution of MMR. The major component of MMR in Sheffield was puerperal fever. This was in contrast to other cities and regions which experienced high MMR, where the major component of the total were high rates of 'accidents of childbirth', including toxæmia and hæmorrhage. Sheffield's high fever rate, and therefore its high MMR, was found in the eastern districts of heavy trades, low maternal employment, and high pre-war birth rates. These areas had not suffered from the highest IMR, which was found in the inner districts, probably because the housing was newer and less unsanitary and overcrowded. Wages, and therefore the standard of living, were also higher. However, the economic dislocation of the 1920s and 1930s caused high unemployment and underemployment in the steel trade. This unfavourable situation probably had a direct, though impossible to calculate, effect on MMR through factors such as the under-nutrition of mothers. However, it had little effect on IMR which appears to have become resistant to external pressures, and continued to fall. This suggests that factors causing high MMR in Sheffield was not the same as those causing high IMR, and is demonstrated by the fact that there was no positive correlation found between MMR and IMR.

The high fever component found in the Sheffield figures was caused by high and rising rates of instrumental abortion in the City in the inter-war years, and probably had more to do with social and economic factors than medical ones. Contraception was not a realistic option for many given the nature of society in Sheffield, but the unemployment and short time working in the previously fairly wealthy heavy steel trades forced women to attempt abortion for reasons of economic necessity. The resulting deaths from sepsis had a

significant effect on total MMR. When MMR did begin to decline from 1935, it was primarily as a result of the introduction of sulphonamides, which reduced deaths from sepsis after 1937. The initial years of reduction were probably due to a natural cyclical decline in the virulence of the causative *streptococci*.

The reduction in MMR after 1935 was the one issue highlighted in this thesis where a medical discovery, that of sulphonamides, did have a significant impact on health and mortality. All the other areas of intervention, such as ante-natal clinics, were only of marginal direct medical benefit. However, social factors were often more important than narrow medical ones in determining the success and impact of the services. This is emphasised by the popularity of infant clinics, for example, despite their failure to offer medical treatment. It highlights the need to consider more than explicitly medical factors when assessing the impact of welfare on mortality.

Although it is misleading to generalise widely from the study of a particular area, a detailed study is vital in drawing attention to the multi-causality of mortality problems and solutions. Local conditions acted on specific areas; for example in Sheffield there were very few married women in paid employment and therefore this factor, considered significant in informing levels of infant and maternal mortality in areas such as Lancashire, was not important in Sheffield. Maternal mortality was as high in some other areas as it was in Sheffield, but Sheffield was unusual in that it had high rates of sepsis, reflecting the large numbers of illegal abortions occurring in the City, which do not appear to have been so prevalent in other areas. Such factors demonstrate the importance of local studies in refining generalisations about areas which may appear similar, but in fact have very different features. They also highlight the importance of considering specific issues not in isolation, but in relation to the wider social and economic situation in an area. In Sheffield, the social and economic structure led to a strongly patriarchal society which in turn affected decisions about contraception and abortion, as well as women's employment. The break down of the economic situation in the inter-war years also had a considerable, though difficult to quantify, impact on the health of women.

Finally, as with all studies, there are possibilities for the further development of the project in order to shed more light on some of these issues. A comparative study of another area, perhaps a geographically close, but socially and industrially different one, such as the West Yorkshire textile towns with their high rates of female employment, would allow for greater understanding of the factors which acted upon the problems and solutions around maternity. An oral project would also be of interest in drawing out

women's fears and hopes for maternity within the local and national context, and the response of occupational groups such as midwives to changing ideas and work conditions. However, the difficulties inherent in attempting to discuss such difficult issues as abortion would be considerable and possibly limiting.

**Medical Officers of Health in Sheffield
1872–1939**

Dr Francis Griffiths:

MOH 1872–1878

Previously Poor Law Medical Officer for Sheffield. Left Sheffield after being sacked in 1878. Died 1879.

Dr Thomas Whiteside Hime:

MOH 1879–1883

Only part-time appointment, published no Annual Reports. Became MOH for Bradford, until 1889.

Dr Vincent Whitgreave:

MOH 1883–1885

Only part-time appointment, published no Annual Reports.

Dr Sinclair White:

MOH 1885–1887

Dr Theodore Thomson:

MOH 1888–1890

Dr Harvey Littlejohn:

MOH 1891–1896

Later became Professor of Forensic Medicine at Edinburgh University.

Dr John Robertson:

MOH 1897–1904

Previously MOH at St Helens. Left to become MOH at Birmingham; first of the 'career' MO'sH to pass through Sheffield.

Dr Harold Scurfield:

MOH 1904–1920

Previously MOH for his home town of Sunderland. Left Sheffield on retiring. Had eight children by his second wife.

Dr Fred Wynne:

MOH 1920–1929

Previously MOH in Wigan. Died in office in Sheffield. Also a novelist and playwright.

Dr John Rennie:

MOH 1929–1947

Previously TB Officer for Sheffield.

Hospitals in Sheffield

The **General Infirmary** opened 1797. It became the **Royal Infirmary** in 1897.

The **Dispensary** opened in 1832 providing out-patient care and midwifery. Its first casualty ward opened in 1854. It became the **Sheffield Public Hospital** in 1875, and stopped providing midwifery services. It became the **Royal Hospital** in 1895.

The **Sheffield Hospital for Women** opened in 1864. It became the **Jessop Hospital for Women**, on a purpose built site, in 1878.

The **Sheffield Free Hospital for Sick Children** opened in 1876. It became the **Children's Hospital** in 1880.

Sheffield Union Workhouse Hospital at Fir Vale, covering the north of the Town, opened in 1881. It was run separately from the Workhouse after 1906. It was taken over by the City Council after the break-up of the Poor Law in 1930, and became the **City General Hospital**. The Hospital had a maternity department from the time it opened.

Ecclesall Union Workhouse Hospital, covering the south of the Town, opened in 1842. It was taken over by the City Council after the break-up of the Poor Law in 1930, and became **Nether Edge Hospital**. It had a maternity department.

**Transcript of the interview with Mrs Cunnington on the Sheffield
Women's Welfare Clinic, November 1st 1981**

Jean McCrindle and Rosemary Betterton

[NB the questions asked are no longer extant]

1. The women who worked at the clinic and who were on the committee were both intelligent and courageous women who at that period were aware of the hardships and bad conditions under which many working women lived and wished to do something about them. No questions of politics arose, and the list of subscribers as well as the committee was drawn from across the political spectrum. The first committee members were as follows;

Hon. Secretary	Mrs Basil Doncaster (Doncaster's steel firm)
Co. Secretary	Mrs Whittaker (husband an architect)
Hon. Financial Secretary	Mrs Maurice Cole (Cole Brothers [shop])
Hon. Treasurer	Mr Cunnington
Docter	Dr Evelyn Roberts
Sister	Mrs Alice Rusby (from City General Hospital)
Committee	Councillor Asbury (Labour)
	Councillor Mrs Baker (Conservative)
	Councillor Mrs Cummings (Labour)
	Mrs Cunnington (teacher and voluntary social worker)
	Basil Doncaster (steel firm)
	Mrs Finch (husband a surgeon)
	Mrs Freeth (Northern organiser of the NBCA from Rotherham)
	Mrs Parkin (husband owner of butchers shops)
	Mrs Swithenbank (husband in the Navy)
	Mrs Freda Tustin (husband at Metro Vickers)

2. There were no regular major subscribers, but a wide list of subscriptions between 6d and £3.00. At first these came mostly from friends of the committee members, but work was done to get support from local Co-op and Labour Party branches. The Women's Co-op Guild held regular and well organised meetings to which speakers were sent. The Co-op Guild was a

major source of subscriptions and of clinic patients. There was no church support at all for the clinic. Sheffield City Council Health Committee gave £50.00 grant annually.

3. There was opposition from doctors who saw birth control as taking away their trade since confinements were paid for. Most doctors were male or unmarried women and had little knowledge or personal experience of birth control methods which were not part of their medical training.

There was active opposition from Roman Catholics, some of whom in the early stages stood outside the clinic stopping Catholic women from entering.

Sheffield newspapers refused to take adverts for the clinic in 1933, but began to accept them in the mid-1930's. Mrs Cunnington wrote an article on the work of the clinic for the Sheffield Forward in 1936.

The Council gave free premises at the Attercliffe Vestry Hall as well as free light, heat and caretaking.

4. The motivation for Mrs Cunnington and friends who supported birth control was to try and bring more happiness into marriage by enabling parents to have children by design and not by accident. There was also an awareness of dreadful housing conditions in Sheffield. Most members of the committee had read Marie Stopes and had access to books and information which they wanted to share. there was no ulterior motive for setting up the clinic and all committee members were unpaid except for the Doctor and Nurse. Mr and Mrs Cunnington were members of the national Eugenics Society whose policy was that good stock should breed and those who were unfit should not. Eugenics was not the primary concern of those involved in the clinic, but rather their concern was for working women who suffered with bad housing, a high abortion rate and unemployment. All of them had children themselves.

5. Most patients already used some form of birth control, usually coitus interruptus or other unsuccessful methods. The methods recommended by the clinic were the Dutch cap or the Marie Stopes cap and spermicide and the sheath for men. Patients paid 1/- to join the Association and 5/- for all prescriptions, but it was free to those who could not pay.

Women generally did not have much knowledge of their own physiology. They found the cap difficult to use and were afraid of losing it, finding it difficult to put in place with work hardened fingers. The cap was also seen as being

an interruption to love making and as inconvenient to fit, store and to look after. Many women kept their birth control method secret from their husbands. Dutch caps in the 1930's were of thicker and rougher texture than modern ones, made of red or grey rubber. During the war rubber was diverted from France which was multi-coloured and intended for bathrooms, which shocked the users. The pre-war suppliers were Swedish (?).

6. Most abortions were carried out by women on themselves or by neighbours or relatives. There were women who also performed back street abortions for money. Most women had tried to abort themselves at least once. Women talked freely about abortion to some of the clinic members. the clinic policy was to discourage women from having abortions, but agreed with it in extreme cases eg. of rape. It was thought that good and freely available birth control should make abortions unnecessary. In 1937 a government enquiry into abortion sent questionnaires to the clinic which were answered by women patients.

There was little discussion of sex and most women had no words to describe it. There was no acceptance of the idea that women should have pleasure from sex.

7. Unmarried women were not given advice at the clinic until the 1950's and sex before marriage was thought undesirable, although unmarried mothers were sympathised with and not castigated.

8. The most influential books were by Marie Stopes, whom Mrs Cunningham had personally known, Dr Helena Wright's 'The Sex Factor in Marriage', and works by Van der Velde and Havelock Ellis. Mrs Cunningham had not heard of Stella Browne.

9. There are no other detailed records than the Annual Reports and the Minutes kept at the FPA in Cumberland Street.

10. There was no professional training for clinic staff and most were amateur who had to read up on particular problems.

Mr and Mrs Cunningham set up the first men's clinic session in the world in the 1950's.

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